How can a child psychoanalytic psychotherapy assessment contribute to the understanding of the individual experiences of children who are refugees?

Ms Lynne Taylor

A thesis submitted in partial fulfillment of the requirements of the University of East London for the degree of Professional Doctorate in Child Psychoanalytic Psychotherapy

May 2017

Abstract

A small scale research project was undertaken to explore how child psychoanalytic psychotherapy assessments could contribute to an understanding of refugee children who were living with their parent(s) in the UK. A literature review examined previous research and clinical work relating to child psychotherapy research, assessment, trauma and loss, work with refugees and research from other modalities. The research was conducted within a specialist refugee service in a NHS CAMHS clinic. The research method was adapted from previous work (Bradley, 2013) and comprised of 4 assessment sessions, an initial appointment with the child and their parent(s) and a follow up appointment with parents. Participants were 3 children aged 9 years old. Detailed observation notes were written after each session and analysed using a thematic analysis technique (Braun and Clarke, 2006). The child psychotherapy assessments demonstrated that each child had individual ways of understanding and relating to their experiences, growing up as refugees living with their families in the UK. Findings that were common to the children were; sensitivity to separations from their family and the end of the sessions, re-enactment of refugee experiences, 'best' behaviour, denial, feelings of deprivation and loss, impact of parental mental health and trauma, good experiences in school. The children showed differences in how they related and responded to issues of identity, understanding their own refugee experiences and the defences they used when anxious. Implications for clinical work related to how clinicians may respond to states of deprivation, loss, and trauma by 'wanting to do more and more' and the need for careful consideration of issues relating to the institution, interpreters, time boundaries, parental mental health and trauma, anger and ordinary child developmental tasks faced by the children and families. Child psychotherapy assessments were found to be able to contribute to identifying needs for some accompanied children, and additional parent work/parent individual work was recommended. Further research in child psychotherapy assessment and working with refugees was recommended.

Contents

Acknowledgments

I would like to thank all the children and parents who participated in this project.

Thank you to my supervisors, Professor Barbara Harrison and Ms Biddy Youell, for their continued encouragement, patience and determination to help me begin, undertake and complete this work.

Thank you also to Ms Nsimire Bisimwa and all my colleagues in the Refugee Service, from whom I have learned so much.

I would also like to thank my parents, partner, family and friends for their ongoing support and love during this project and throughout my training and work.

Dedication

This thesis is dedicated to all the children, young people, families and parents whom I have had the privilege to work with and learn from over the years.

Chapter 1) Introduction

This chapter will describe the research project, which arose from my work as a child and adolescent psychoanalytic psychotherapist[1] (during my training and post qualification) in a Refugee Service within a NHS Child and Adolescent Mental Health Service (CAMHS). I will give an overview of the background and rationale for this research, including issues relating to refugees and also mental health policies in the UK. I will then describe the clinical work setting that the research was conducted in. The theoretical context, including a description of child psychotherapy assessments will follow this. The chapter will conclude with my research question and aims of the study.

Background and rationale

The 1951 Refugee Convention defines a refugee as:

> *"A person who is outside his or her country of nationality or habitual residence; has a well-founded fear of being persecuted because of his or her race, religion, nationality, membership of a particular social group or political opinion; and is unable or unwilling to avail him— or herself of the protection of that country, or to return there, for fear of persecution (see Article 1A(2))"* (UNCHR, 2017a).

The legal definition above captures the fear of the person and that their own country is unable to protect them, and so they have no choice but to leave their home and country. It is this that distinguishes them from other types of migrants, who often have some choice about leaving. Refugees who flee or who are forced to flee, from their own country, usually have been exposed to high levels of violence, or threat of violence or persecution and leave in fear (Hodes, 2000). Family members may have been killed, threatened or assaulted. The journey out

[1] *For ease of reading I will refer to this as child psychotherapy throughout this thesis.*

of their country and to another is often dangerous and traumatic, although some refugees are able to flee more directly by air.

Political and social context

I began this research in 2012 during my clinical training and completed the work in 2017. During this time, the number of refugees had increased rapidly across the world and in Europe. From the most recent data collected in 2015, the UNHCR reported that:

> *"We are now witnessing the highest levels of displacement on record. An unprecedented 65.3 million people around the world have been forced from home. Among them are nearly 21.3 million refugees, over half of whom are under the age of 18. There are also 10 million stateless people who have been denied a nationality and access to basic rights such as education, healthcare, employment and freedom of movement.. ..nearly 34,000 people are forcibly displaced every day as a result of conflict or persecution" (UNCHR, 2017b).*

In 2013, 431,000 people applied for asylum in the 28 EU member states. By 2015, due to the war in Syria and advance of ISIL (Islamic State of Iraq and the Levant, also referred to as ISIS and Daesh) in Iraq and surrounding areas, this had increased to close to 1.3 million people (Eurostat, 2017).

Within the UK, 23,584 people claimed asylum in 2013. This increased to 32,733 people in 2015. Within these figures, there were 1,265 unaccompanied children in 2013. By 2015, this had risen by to 3,253 unaccompanied children, 89% of whom were over the age of 15 years old. In addition to these figures, in 2013, there were 4,571 dependent children (aged 0-18 years). By 2015, this had increased to 5,202 dependent children. In both 2013 and 2015, the majority of the dependent children were under the age of 10 years old (77%) (Refugee Council, 2017).

In response to what was being described as a refugee crisis, in September 2015, the UK government announced that the UK would take 20,000 Syrian refugees over a period of 5 years. In December 2015, Germany who had opened its borders to refugees, had registered over 1 million refugees. However, at a time when there were huge numbers of people in need, the political and social response in EU countries started to become less sympathetic and by March 2016, some EU countries began to close their borders, leaving children, families and adults trapped.

The vulnerability of refugee children and families continues, because currently immigration is increasingly being presented as a political issue both within the UK, EU and US. On the 23rd June 2016 there was a national referendum and the UK voted to leave the EU, and racist attacks and crimes increased by 42% (NPCC, 2017). In the US, political sympathy towards refugees reduced. In January 2017, 7 days after becoming president, Donald Trump signed an executive order that closed the US borders to refugees for 120 days and banned individuals from seven Muslim countries from entering US for 90 days and closed borders indefinitely to all refugees from Syria. Although this order was then rejected by the courts, it does reflect an increasingly common point of view in the US.

I am setting out this political and social context because I believe that it has had a direct impact on the experiences of children and families who are refugees. These changes have occurred over a relatively short amount of time, and it is evidence of how the lives and experiences of refugees are affected by political systems and public attitudes beyond their control. Refugee experiences are complex, involving those they had before they fled, those while on the journey and their experiences once they have reached and are living in another country.

Mental health needs of refugees

Refugees are often assumed to be traumatised from their past experiences and this can dominate as the focus of concern. The impact of loss is often overlooked, and yet the losses that refugees have experienced are profound; loss of home,

loss of community, often loss of family, friends, a sense of belonging and identity (Papadopoulos, 2002).

However, a focus on trauma and loss, can risk overshadowing the idea that all refugees are individual people, who have all had their own life experiences and relationships before, during and after they become refugees. They will have had different experiences as children themselves, growing up, in their families and culture, they will have their own individual experiences in their relationships, jobs, their community, which still remain as part of their personal history when they become refugees.

The idea that everyone is different, with their own predisposition, as well different experiences in their lives, is of particular interest to psychoanalysis and child psychotherapy. Psychoanalysis grew from recognition that people each have an internal world, constructed from powerful, dynamic unconscious and conscious influences. Freud's work showed that this internal world drives people's behaviour, thoughts and emotions. The internal world develops through early care giving relationships. Representations of these relationship experiences (objects) are internalised and both affect, and are affected by, the individual's predisposition. The internal world is thought to affect a child and adult's development and ways of understanding and relating to their own self and others. I will discuss this in relation to child development later in this chapter. In regards to adults, psychoanalytic work with adults who have experienced trauma suggests that an adult's internal world and internal object relationships can result in marked differences in the ways that they understand and relate to the external trauma they have experienced (Bell, 1998).

Therefore, although people who have fled their homes are defined as refugees, this generic term needs to take into account that all refugees are individual people. They all have different internal worlds and as a result will all have different ways of relating to themselves, their experiences, and their needs. Many refugees show very high levels of resilience and have internal resources that alongside good enough experiences in the new country enable them to cope.

However, in my clinical experience, these internal resources can be severely challenged by different events across their lives, some of which relate to being a refugee. In addition to the experiences of loss and trauma, there are also day to day difficulties that cause refugees ongoing stress and distress. For refugees in the UK, the social and political situation is difficult. On arrival, they have to apply for asylum, which is often an extremely lengthy and harrowing process, during which adults are not allowed to work and are often in temporary and unsuitable accommodation, resulting in many changes of location. This has a direct impact on children, many of whom have to change schools frequently. Unaccompanied minors are usually given limited leave to remain until they are 18 years old, which may involve an age assessment and they are placed with foster carers. Children, who arrive with family or caregivers, are assessed as part of the adult and family claim.

So what do we currently know about the mental health needs of these adults, young people and children? Within the adult population of refugees in Western countries, it has been reported that 9% have post-traumatic stress disorder (PTSD), about 5% have depression, 4% have an anxiety disorder and 2% have a psychotic disorder, (Fazel et al, 2005). The same study reported that approximately 11% of refugee children have PTSD. Trauma and PTSD are often focused on for refugee children, when in fact, their presentation is often much more wide ranging. Montgomery (2011) suggested that 77% of newly arrived children showed anxiety, sleep disturbance and/or depressed mood, and these were present in 25.9% of children up to 3 years later. However, the prevalence of mental health needs of both adults and children who are refugees is difficult to accurately assess, measure and compare, due to their diverse experiences and differences between measures. Overall, research suggests that adults and children have higher rates of mental health needs than the general population (Montgomery, 2011, Fazel, 2012, Fazel, 2017).

For children who have arrived with their parent(s) or caregivers, they rely on them to help them make sense of their past and ongoing experiences. However, their parents may be struggling with their own loss, trauma and every day experiences of being a refugee. I have not been able to find any statistics about the number

of refugee adults who are experiencing high levels of distress and/or mental health issues, who are identified as parents or carers of children. Therefore, what is less clear, is the impact on the children of their parents' mental health, as well as the impact the children themselves have on their parents' mental health (Montgomery, 2011).

Therefore, accompanied children could be at risk of the impact of ongoing parental mental health and trauma, which may not be as apparent when compared to the needs of unaccompanied children. There is something profoundly immediate, painful and desperate, when working with an unaccompanied child; these are children who often have no contact with anybody in their family and no knowledge of what has happened to them and if they are ever going to see them again, or they may have witnessed extreme violence against family members. When compared to the immense pain that this provokes, accompanied children who are living with their parents or family members, are likely to be seen as much less affected. However, research suggests that they actually have similar levels of psychological distress and presenting issues and that they have a higher level of risk of conduct disorder when compared to unaccompanied children (Michelson and Sclare, 2009). I do not believe that this implies in any way that the needs of unaccompanied children are not great; I am commenting that accompanied children may also have significant needs.

There has also been discussion about whether the application of a western model of mental health is appropriate in relation to refugees, both in terms of cultural validity, but also whether it risks pathologizing normal reactions to abnormal events (Hebebrand et al, 2016). Many refugees show remarkable levels of resilience, both within themselves, but also within their families and community. However, in my clinical experience, distress and mental health issues can arise at different stages. Some refugees present with high levels of distress when they first arrive. Others may still be in 'survival mode' in these early stages and it is not until they get their right to remain, and confirmation of safety, that mental health issues surface. One unaccompanied young person that I worked with previously became very depressed when he received his right to remain in the UK. For him it seemed to confirm the reality and magnitude of his loss and end

his hope that the war would finish and he could go home. For others, being granted right to remain in the UK, can also provide a sense of relief and safety. Of course, many refugees never need or want additional support.

Mental health and other services in the UK

So what services are currently available for children, young people and families who are refugees in the UK? Access to services is often dependent on where the family lives and what services are available. Some geographic areas in the UK can provide assessment and support through charity, education and health services, for example, The Red Cross, The Refugee Council and Freedom from Torture. In some parts of London, children and families can access services through the local NHS CAMHS or charity organisations such as The Baobab Centre, The Refugee Therapy Service.

However, across the country, this support may not be as widely accessible, especially within CAMHS. A recent review from CentreForum, (Frith, 2016) reported that there is a great variation of service provision for all children across CAMHS in the UK. Thresholds for assessments vary across services and on average, 23% of young people who are referred are not offered a service. For those who are seen, waiting times also vary, from 2 weeks to 19 weeks. The report did not discuss refugee children as a specific group, so it is unclear about provision for these children. However, in general, it is known that refugee children often present and engage less, even when mental health services are available (Barghadouch et al, 2016).

Currently there are no National Institute of Clinical Excellence (NICE) guidelines for working with the complex emotional needs of children and families who are refugees. There are guidelines for treating children with PTSD, which recommend cognitive behavioural therapy (CBT) or eye movement desensitization and reprocessing (EMDR). The effectiveness of these treatments may be limited as refugee children have not usually suffered one traumatic event in isolation.

Therefore, how can different services, both across CAMHS, charity organisations and education, identify the needs of the individual and their family and ensure that the most appropriate treatments and services are available? I shall now describe the NHS refugee service that I worked in, and the issues that arose from this work that led me to think more about how to understand and identify the needs of accompanied children.

Work Setting

The Refugee Service is a specialised service within a NHS CAMHS, in a large city in the UK. It offers mental health assessment and treatment for children, young people and families who are refugees and who are displaying symptoms of emotional distress, behavioural difficulties and psychiatric conditions, for example, PTSD, depression and anxiety. Referrals are received from parents, social workers, schools, voluntary groups, GP's and other health professionals. The service is provided by a small multidisciplinary team, comprising of psychology, child psychiatry, specialist community CAMHS practitioners (Congolese and Somali), systemic psychotherapy and child psychotherapy.

The team works with first and second generation refugee children and young people, those who were born in their home country and those who were born in the UK, but whose parents were refugees. When I began working in the team in 2009, the majority of the referrals seemed to be for second generation children, but over the years, there have been an increasing number of unaccompanied young people referred to the team. The team is in an area which has a large population of Somali, Congolese, Iranian, Afghani and Kosovan families. In more recent years, the team has had more referrals for children and families from the Middle East (Iraq, Libya, Syria) and Africa (Eritrea, Sudan and Nigeria).

Engagement with families is a key focus for the team, who work both in clinic and community settings (for example, in schools) and work closely with interpreters and the local community. There is an acknowledgement that emotional and mental health services are often viewed as a western model and as such, for some children and families, different approaches are required and with an

understanding of the holistic, complex needs of the families in the community. (Papadopoulos, 2002, Hughes, 2014). It is also understood that therapeutic support from CAMHS cannot be offered in isolation, when the children and families may have more immediate needs, for example, housing, education, welfare, social isolation, physical health. Therefore, the work often involves liaison with schools, social workers and other professionals and providing reports for solicitors as needed. Within my role, I was able to offer both generic and child psychotherapy assessments, as well as short and long term individual work. I also joined colleagues for family or parent work and group work.

During my work, I observed that children and families showed differences in the types of therapeutic support they needed or wanted or were able to make use of. I became interested in how this could be assessed, as part of the initial generic assessment, to help inform treatment decisions. Decisions about treatment were something that I became interested in when I had observed in myself and the team, that some children and families had a strong impact on us. I wondered if this could affect the outcome of assessment, for example, for some children and families, different and multiple treatments were offered at the same time, after a relatively brief assessment.

Child psychotherapy colleagues and I thought about this and tried to understand the feelings provoked in us when working with these children and families and what may be a result of their external experiences, and what may relate to their individual internal states. We wondered if there were other factors, perhaps based more on the children's individual experiences of earlier care giving relationships that could also have an impact on the child's and families' ways of relating to their experiences and therapeutic assessment and treatment. For example, a group of unaccompanied minors from Afghanistan all showed markedly different ways of relating and accessing therapeutic services, which didn't only seem to be a reflection of the level and type of trauma that they had experienced (Biddy Youell, personal communication).

I became increasing interested in the different ways the children and families related and understood their experiences and their internal and external

resources. Some of the referrals to the service seemed to assume that all children and families were traumatised and needed to talk about their traumatic experiences, with an idea of it being possible to “work through” or “come to terms” with their situation. Many children were referred straight for individual work or family work in the clinic or community.

However, many of the children that I worked with did not want to talk about their experiences in a direct and conscious way. For the unaccompanied young people, who were usually older, some of them reported high levels of anxiety and distress when they thought that they were being encouraged to talk about their past experiences. With this group, I found that there was a high risk of re-traumatising them by asking them to do so. Many young people found the word and thoughts of ‘home’ unbearably painful. My work with these young people focused on being a consistent and containing presence, someone who was there every week, in the same room, providing a quiet space to think together, without many questions, which were often experienced as intrusive and painful. They wanted me to understand their day to day lives and be able to acknowledge and bear their loss, pain and anger in the present.

The accompanied children that I worked with were often much younger, and had been referred due to issues at home or school. They often did not want or were unable to talk about their past experiences, either because of their ability to understand and verbalise their thoughts, or because they were more preoccupied with their present day to day experiences at home and at school. Often they could make use of a receptive, thoughtful space, in which I could begin to try to understand their thoughts and feelings and put these into words, and attend to their thoughts about the present and future, as well as the past.

As referrals to the team increased, especially of unaccompanied, highly traumatised young people, I noticed that the accompanied children were often referred straight to treatment with their families, either in the clinic or community. There seemed to be a general feeling that their parents would be able to recognise and respond to their emotional states and that with some support in school, their behaviour would settle.

I wondered how we could respond to this and try to gain an understanding of these children's individual needs. Could a short term child psychotherapy assessment help identify their individual needs? Could a child psychotherapy assessment observe and understand the interaction between these children's internal and external experiences? I shall now describe some of the theoretical context surrounding these questions and the research.

Child development: The internal world

Child psychotherapy assessment is embedded in a psychoanalytic and child development framework, which centres around an acknowledgement that all infants and children are different (as are adults). Child psychotherapy has developed from the clinical work of Freud, Anna Freud, Klein, Bion, Winnicott and others. It is now acknowledged that child development and individual differences are affected by many different and interacting components of children's internal and external experiences. These individual differences are due to a combination of their own predisposition which is affected by many and complex variables such as genes and pre-natal influences and how this interacts with their nurture, for example, experiences of growing up, care giving relationships, family and culture (Music, 2011).

Child psychotherapy is interested in how a child has internalised these early experiences into internal representations (internal objects), and in turn, how these internal representations can then affect how a child understands and reacts to their actual, live external experiences. Klein believed that childhood is focused on overcoming internal anxieties and that 'good' internal objects can nourish the child in times of anxiety (1946). Klein emphasised the importance of external reality checking; that a child's external experiences with adults can modify their internal anxieties and phantasies.

Bion went on to develop these ideas further, and his work revealed how important the relationship between child and mother is[2]. Bion described how a child learns to think and understand his own emotional experiences through his relationship with his mother. The mother provides a function as a 'container' to take in and reflect on her baby's emotional state which he is as yet unable to process or understand and projects into his mother (Bion, 1962). This idea developed Klein's work on projection and projective identification further by suggesting that this was a means of communication between child and mother. Bion proposed that a child gets rid of feelings and states that cannot be understood and cause anxiety, (or are experienced as 'bad'), by projecting these into his mother. The mother, being open to receive the projected feeling, reflects upon it and gives it back to the child in a digested form, one which helps the child make sense of the feeling. The child has an experience of being attended to and understood. Through repeated instances of this (containment), the child is able to introject this 'containing mind' and develop a mind that is able to think, learn and manage a great deal for himself (Bion, 1962).

The ability to recognise and integrate the 'good' and 'bad' aspects of the object as a whole, (Klein, 1952) is critical to child development as it enables a child to attach thoughts to his feelings and so represent them in his own mind, through symbol development and then through words (Shuttleworth, 1989). For example, a hungry child will develop from crying with a bad feeling in his tummy, to recognising the feeling and reaching for the breast, to eventually being able to tell his mother that his is hungry. The mother must be able to tolerate the frustration involved in this process; the times when she does not understand what the baby is feeling and cannot immediately relieve her child's distress. Similarly, the baby has to learn to bear it when there is no immediate comfort. Bion suggested that a degree of frustration is a necessary spur to learning and development and Winnicott pointed out that there is something called 'good enough mothering' and

[2] *For consistency, I will use the term mother and male pronoun for child. I use the term child to include infants, children and adolescents and mother, to include fathers and other family members and main care givers.*

that there are dangers inherent in ‘too good mothering’ where the child’s every need is anticipated and dealt with before it has really been felt (Winnicott, 1960).

Impact of trauma and loss

Freud suggested that traumatic events are intrusive experiences that interact with an individual’s own internal world and can be repressed to defend against further anxiety. Freud believed that if trauma remained repressed in the unconscious, then there was a risk it would be re-enacted through symptoms or behaviour, *“A thing which has not been understood inevitably reappears; like an unlaid ghost, it cannot rest until the mystery has been solved and the spell is broken”* (1909, pp. 122). His discovery of the ‘talking cure’; that by helping an individual to think and so talk about their thoughts and experiences, making the unconscious, conscious, is still a central idea in working with trauma today. Alongside his work on trauma, he was also interested in the impact of loss on the individual. He proposed that mourning involved a conflict between withdrawing and holding onto to the loved object (1917). Klein (1940) developed these ideas further and proposed that the ability to mourn everyday losses was part of normal child development, and how a child managed and internalised these losses could affect their ability to manage this later in their life.

In more recent years, there has been a great deal of work in child mental health on trauma and the impact of early care giving relationships, the majority with children who have suffered abuse and are in the care system. This work suggests that children demonstrate individual differences in the ways that they are affected by their experiences (Rutter, 1985). There are also differences between children and adults in relation to the impact of trauma and loss.

Children are thought to be at higher risk from the impact of trauma than adults due to a number of factors. One of which is their age and brain development. If children suffer trauma or loss in their early life, either trauma through their

relationships, (for example, being with a mother with severe depression or anxiety), and/or trauma through external circumstances, (such as, war, violence), then evidence shows that that it can affect them and their development: *"preverbal children, even in the first year of life, can establish and retain some form of internal representation of traumatic events over significant periods of time"* (Gaensbauer, 2002, pp. 259). One of the reasons for this could be because the majority of the foundations of brain development are laid by 2 years old (Schore, 1994). Neuroscience research supports psychoanalytic theory which believes the early relational experiences a child has are crucial to brain development and the child's ability to understand his own states of mind and internal experiences, as well as understanding his external life experiences. For children, these internal representations of trauma are more likely to be unconscious due to a child's limited ability to symbolise and verbalise their experiences and memories.

Children are also more vulnerable to the impact of trauma and adverse external events than adults because of their dependence on their caregivers. Through containment, children rely on their caregivers to help them recognise and make sense of their internal states and external events. The mother's state of mind and how 'contained' she feels herself can seriously affect the type of containment she provides. Henry (1974) described that children who have not had consistent experiences of containment, can develop internal objects who cannot sustain them through states of anxiety. She describes this as 'double deprivation', because children are both deprived of the mother who is unable to contain their experiences, but also that the children cannot contain their own anxiety, and their defences may lead them to deprive themselves of further help and support.

Added to this, a mother may also unconsciously project her own feelings and distress into her child, adding to the child's own anxiety (Briggs, 1997, Williams, 1997). If a child does not have enough consistent experiences of feeling contained by his caregivers (which will also depend on the child's own predisposition) then he is at risk of not being able to manage and cope with internal and external situations that cause anxiety. Defences against

overwhelming anxiety include splitting, projective identification, idealisation, denial, withdrawal, physical activity, omnipotence and repression. When defences are relied upon excessively and repeatedly, children are thought to be at risk of developing difficulties which manifest as symptoms in their behaviour, their mental state and their ability to relate and learn. This can often result in children being referred to services with presentations indicative of conditions such as ADHD, depression, anxiety and autism.

Therefore, what are the implications of trauma and loss on refugee children and their development? As I have suggested, as individuals, they all have different internal worlds and resources, and all have had different experiences of trauma and loss. Many of them may have had early experiences of 'good enough' care giving and so already have some good internal objects. As children though, they are all still at an age when they are dependent and reliant on adults to help them make sense of their internal and external experiences. However, their parents or caregivers may also be suffering from trauma, loss and/or mental health difficulties. In this sense, refugee children may be at higher risk of being deprived of an adult who is able to contain them and also, they are at risk of receiving the adult's own distress and states of mind, a reversal of the 'container/contained relationship' (Williams, 1997). In addition, they may also be vulnerable to the impact of transgenerational trauma which can affect children's attachments and mental health (Fraiberg et al, 1975, Fonangy et al, 1993, Sangalang and Vang, 2017).

This research aims to explore these areas further, by examining how the individual needs of accompanied refugee children can be understood through a child psychotherapy assessment. I will now describe the context of child psychotherapy assessment in more detail.

Child psychotherapy assessment

The idea that the interaction, between a child's external and internal experiences is a continuous dynamic, within the child's internal world, is something of particular interest to child psychoanalytic psychotherapists, whose training and skills are focused on this. A child psychotherapy assessment aims to observe and understand this interaction and oscillating states of mind, in order to identify the individual needs of the child (Boston, 1967, Wittenberg, 1982, Rustin, M.E., 1982). A unique aspect of child psychotherapy assessment and treatment is recognising and trying to understand the developing transference relationship and how this may reflect the child's internal world. It is believed that this can be observed through how the child relates to the therapist, crucially, close observation of how the therapist feels when with the child (countertransference).

Transference and countertransference

The idea that a patient may bring (or transfer) their past and present relationship experiences and feelings into their relationship with a therapist was first described by Freud (1905, 1912) and developed further by Klein (1935, 1952). The observation and interpretation of the transference has become a central feature in child psychotherapy treatment (Rosenbluth, 1970, Jackson, 1998). It is thought that through the observation of the transference relationship, the therapist may be able to understand the child's internal world and ways of relating, as well as any underlying anxieties.

Rosenbluth (1970) describes that throughout the session, the therapist asks him or herself, *"What is the child doing to me at the moment, feeling in relation to me now?"* (pp. 78). To answer this question, the therapist observes and tries to understand the 'total' or whole transference, meaning not only the child's behaviour, play and non-verbal communication but also the unconscious projections. The countertransference is the term given to the process whereby the therapist is able to take in and reflect on their experience of being with and of interacting with the child. The therapist pays close attention to both the positive

and negative aspects of the transference (Jackson, 1998) as this enables the therapist to understand something about the expectations the child has of this new person. Part of a clinical encounter may also be to think about what is the transference relationship the child and/or his parents have to the clinic, the building, the idea of therapy. In my experience, this is particularly relevant with refugee families whose external reality and recent traumatic experiences may have a profound effect on their transference to a new institution and a new group of professionals.

During child psychotherapy sessions, the therapist pays close attention to their own emotional responses to the child (countertransference) and where possible and appropriate puts some of their understanding into words. It is by observing the child and seeing how they respond to attempts to understand, that child psychotherapists begin to recognise and understand the transference relationship (Heimann, 1950, Hopkins, 1986).

Structure of a child psychotherapy assessment

The child psychotherapy assessment model that I used in this research is one that I was taught during my clinical training, which I will now describe. Issues of a standardised assessment method are discussed in the next chapter, the literature review.

A child psychotherapy assessment is usually comprised of 3 to 6 sessions, with the same therapist using the same room, ideally at the same time and weekly frequency. The therapist provides a box of carefully selected toys and drawing materials for the child to use and brings the toy box and materials to every session. Toys are usually age appropriate and include some or all of the following; a soft toy, a baby doll, a ball, animal figures (farm and wild animals), fences, dolls and a doll's house, plasticine, pens, pencil, scissors, glue, string etc.

The parent or caregiver waits for the child in the waiting room or another clinic room if they themselves are meeting with a clinician. The sessions last for 50 minutes and the therapist collects the child and brings them back to the waiting room, punctually at the agreed time. The child is told that they can ask the therapist if they need or want to leave the room to see their parent or go to the toilet etc. Everything which happens between being collected and being returned to the waiting room is thought about in relation to the principles of psychoanalytic work described above.

Once the child psychotherapy assessment is complete, the therapist usually meets with the parents/caregivers to discuss the outcome of the assessment and think about recommendations for treatment. They can also provide reports that can be shared with schools or other services, to help these services understand and recognise the child's emotional needs and ways of relating to adults and themselves.

Research question and overview of the thesis

I am interested in whether a typical way of assessing the internal worlds of children, a child psychotherapy assessment, is a helpful and relevant assessment method for children who are refugees and living with their parent(s). In this thesis, I will examine how this type of assessment can contribute to an understanding of each child's individual internal states and the impact that their external experiences have had on them. Through this, I hope to answer the central research question which is:

How can a child psychoanalytic psychotherapy assessment contribute to the understanding of the individual experiences of children who are refugees?

I aim to answer this question by undertaking a literature review and then presenting and discussing the analysis of 3 individual child psychotherapy assessments. These assessments were with refugee children who are living with their parent(s). The children were all latency aged (6 to 12 years old) during the assessments. I will describe the thematic analysis of the session notes of 4 assessment sessions for each child and then discuss these findings.

This research is based upon a small group of case studies, with accompanied children all latency aged and from a similar geographic region (Middle East). It aims to contribute to a further understanding of the needs of these children, with consideration of the implications of these findings for clinical practice and future research.

In this chapter I have outlined the background and rationale for the research; that there are increasing numbers of accompanied refugee children arriving in the UK, whose individual needs may be at risk of being overlooked because of an assumption that their needs are less than those of unaccompanied children. I have also discussed how their needs may also be misunderstood as relating purely to any trauma they may have experienced in their home country or on their journey to the UK. In my clinical experience, the impact of loss, day to day stress and their parent's state of mind, can be overlooked. I have described my work setting and role and my belief in the importance of being able to fully assess both the individual needs and the needs of the family as a whole. I have also described the theoretical framework of my work and training, in which this research is set, along with a description of a child psychotherapy assessment. Finally, I set out the research question and method of this thesis.

In the next chapter I will review the literature that relates to this question, including previous work on child psychotherapy research and assessments and research relating to assessments and clinical work with refugee children and young people. I will then describe the methodology that I used; a small study of assessments

with 3 latency aged refugee children. I will then examine the findings and discuss these in relation to the literature review and overarching issues for working with refugee children. I will then conclude this research with the implications of the findings for clinical work and policy when working and supporting refugee children and families.

Chapter 2: Literature Review

In the previous chapter, I set out the theoretical context of this research. In this chapter, the literature review, I will discuss the relevant previous and current research relating to child psychotherapy assessments with refugee children. This includes: an overview of child psychotherapy research, child psychotherapy assessments, child psychotherapy; trauma and loss, child psychotherapy assessment and treatment with refugee children and families, and other types of assessments with refugee children.

Method

A systematic literature search was carried out to identify relevant research related to this project. I selected the following keywords from the title; *refugee, children, child psychotherapy and assessment.* I used EBSCO to search the following databases; Psychoinfo, PEP archive, Psychology and Behavioural Sciences collection, eBook collection (EBSCO host), Psycharticles, PsycBooks, MEDLINE and CINAHL with full text. I chose these words as they are the most relevant to my research. As part of the literature search, I applied a search function (the symbol *) to find papers with words related to these keywords, for example refugee* , and this resulted in searches for similar words, including, 'asylum seeking', 'displaced.' I applied the following limiters to the search; Full Text; Scholarly (Peer Reviewed) Journals; Publication Type: Peer Reviewed Journal; Language: English; Population Group: Human; Intended Audience: Psychology: Professional & Research; PDF Full Text.

From this ECBOS database search, a number of papers were selected (using the keywords, and excluding duplicates) to review in further detail. In addition, I have also included papers relating to clinic based research and a number of books and papers identified through talking with colleagues or which were cited in other work. I will now describe the research in the 5 areas identified. I will then summarise my overall conclusions and recommendations from the literature review.

Overview of child psychotherapy research

Child psychotherapy research is still a relatively small and developing field, when compared to other scientific and health disciplines. Fonagy, (2003) strongly recommended that as a discipline, child psychotherapy needs urgent research focusing on three areas;

> *"First, we require evidence concerning the specific patient groups who uniquely benefit from our interventions, and related to this, assessment systems that help to identify these individuals… secondly, we need sensitive measurement systems to identify changes that may go beyond symptomatic improvement… and third, we need to develop new adaptations of psychoanalytic therapy.." (pp. 133).*

This was supported by findings from the first systematic review of child and adolescent psychoanalytic approaches. Kennedy (2004) recommended further research in child psychotherapy assessments as a way of providing a standardised and adapted assessment that could be used in a research context.

However, later work indicated that not all children who are referred for child psychotherapy treatment are actually seen for an assessment first (Kam and Midgley, 2006). They reported that from 220 new referrals for child psychotherapy, 46% were seen for child psychotherapy assessment, but did not report further on this. It would have been interesting to investigate this further, for example, if CAMHS clinicians viewed a child psychotherapy assessment as a helpful intervention in its own right or if there were some children that they considered not suitable for short-term assessment.

In an edited collection published in 2009, (Midgley et al (eds.)) described a number of key and important pieces of research in child psychotherapy and their applications. Within this, Urwin (2009) described the development of a qualitative measure to evaluate the effectiveness of child psychotherapy. She gave an example of the use of the Hopes and Expectations for Treatment Approach

(HETA) with a 7 year old boy, who was a refugee. The paper described the assessment process; one initial session with the parents, then 3 individual sessions with the child and a follow up with the parent. The paper's focus was on the use of the HETA but it was the only paper in the book that described work with a refugee child. There were other references to assessment, including a child psychotherapy assessment and treatment of a child with autism (Alvarez, 2009) and a specialised story stem assessment (Hodges et al, 2009).

A few years later, Midgley and Kennedy (2011) built upon the previous systematic review (Kennedy, 2004) and identified and examined 34 separate studies, including 9 randomised controlled trials. It still concluded that further research was needed, but that there was some evidence that psychoanalytic psychotherapy was effective for children and young people. It reported that the majority of the studies were undertaken in a, *"naturalistic setting"* (pp. 247), within the clinic, with patients, rather than recruited young people. They proposed that this was positive and the results were, *'cautiously generalisable to a 'real-world' context'* (pp. 247).

In a review of child mental health research, including child psychotherapy, Fonagy et al, (2015) examined specific mental health conditions for children and the evidence for treatment for each condition. In relation to assessments they reported that, *"there is consistent evidence that many child mental health problems are complex and their assessment requires specialist input."* (pp. 476). The work was not able to state which professions should be present for assessment. They also noted the high rates of co-morbidity and recommended a multi-disciplinary and flexible approach, with sufficient resources so young people should not have to wait too long. They said their work did not inform them yet which assessment and treatment packages were, *"consistently successful"* (pp. 477) as the research they examined often excluded co-morbidity. They also discussed the importance of safeguarding and risk assessment as part of assessment and treatment. The book did not mention refugee children, other than a review of some research for PTSD, in which it reviewed PTSD treatments broadly and not specifically for refugee children.

The most recent research into the efficacy of child psychotherapy is the recent IMPACT study (Goodyer et al, 2017), which compared the effectiveness of time limited psychoanalytic child psychotherapy (28 sessions) with cognitive behavioural therapy, CBT, and a psychosocial intervention, for depression in adolescents. The work followed on from previous research by Trowell et al, (2007) and Trowell et al (2009), which had reported that individual child psychotherapy was an effective treatment for adolescents suffering from depression. The IMPACT study was the first piece of RCT research to find that time limited child psychotherapy is as effective as CBT and a psychosocial intervention in treating depression in adolescents. The paper did not discuss if these results were applicable to younger children, and did not describe the assessment process because the participants had been randomly assigned to each group, rather than initially assessed.

The research I identified for child psychotherapy research in the general context, all recommended further research to be undertaken in a broad range of areas. It was notable that I could find few studies which specifically mentioned the assessment process as part of the decision making for further treatment; neither could I identify any specific work with refugees.

However, there are other types of research, for example, clinical case studies, that are proposed to be equally as valid as the work just reviewed. Rustin, M.J., (2009) argues that child psychotherapy has a long tradition of clinical research, in which observation and direct clinical work, has shaped ideas and developed our understanding of children's internal states and ways of relating. He described how this type of clinical research has led to developments in theory and practice. He proposed that this type of research is valid and has made a considerable contribution to the discipline, even though the current trend is for large scale RCT type research. Therefore, this literature review will include this type of research in the next three sections, which examine child psychotherapy work.

Child psychotherapy assessment

The literature search identified few papers that specifically examined child psychotherapy assessments. Petit and Midgley (2008) investigated three research questions relating to child psychotherapy assessment;

> *"Is there a standard model of child psychotherapy assessment within a Child and Adolescent Mental Health Setting? If not, what are the commonalities and differences in the Child Psychotherapists' approach to assessment?"*
> *"What is the relationships between assessment and diagnosis?"*
> *"Are different theoretical backgrounds reflected in the Child Psychotherapists' understanding of what is to be assessed?" (pp. 144).*

The research comprised of an audit of clinical work over 5 years of cases seen by child psychotherapists and a semi-structured interview with 5 child psychotherapists. The study reported that even though there was no standardised child psychotherapy assessment model, the procedure of assessments were very similar. They also found that 45% of child psychotherapy work is assessment work, including different types of assessments. The study was limited because it only involved child psychotherapists from one CAMHS team. It is not known if the views and understanding of these child psychotherapists were similar to those working in other teams, or in other areas of the country. It also did not report any demographic information about the patients being assessed so we do not know if they were working with a diverse and multi-cultural population. They recommended further work in the area of assessment and reported that it was an under-researched area.

This area of research was developed further by Mees (2016) who investigated the contribution a child psychotherapist made to generic CAMHS assessments. It examined 9 generic assessments that were undertaken by the researcher, a child psychotherapist, over a 6 month period, within a CAMHS service. It reported that child psychotherapists used child psychotherapy techniques of observation, countertransference and transference to help, *"in getting to the heart of the matter quickly"* (pp. 141). However, it did not describe the number of sessions or technique in much detail, but said they employed a flexible approach depending on each family. The research concluded that techniques used in child

psychotherapy assessments could be applied to generic family assessments in CAMHS.

The remaining research that was identified about child psychotherapy assessments were clinical papers about technique and applications of child psychotherapy assessments. These shall now be examined.

Papers describing and exploring child psychotherapy assessment, have been presented in a number of books written from clinical practice (Rustin, M.E., and Quagliata (eds.), 2004, Lanyado and Horne (eds.), 2009, and Horne and Lanyado, 2009). They describe the aims and process of child psychotherapy assessment as well as other types of assessments carried out by child psychotherapists with children presenting with a variety of difficulties, communication disorders, autism, eating disorders, family breakdown, under 5s consultations, risky adolescents, working with families and court work.

Green (2009), drawing on her experience and past work, wrote about assessments for individual psychoanalytic child psychotherapy. As with other papers, she also described the use of transference and countertransference. In addition, she emphasised issues to consider when assessing, which included, using a developmental framework, how 'stuck' the child is, their own understanding of themselves and nature of relationships, how in control are they are of their impulses, behaviour, what type of defences do they have against anxiety and how developed is their ego strength. However, the work did not talk about specific types of children, and did not make any reference to children who are refugees. It also did not describe the specific details of the assessment process, i.e. number of sessions, play material etc.

These issues were addressed by Walker (2009) who set out a very comprehensive account of child psychotherapy assessments, including contributions to generic assessments, description of state of mind assessments and assessment for individual child psychotherapy. In this paper, Walker drew on her clinical experience and training and described these assessments in detail, using clinical vignettes to evidence her use of close observation, transference

and countertransference. She also stated the importance of thinking about the child's different aspects of development, using Anna Freud's (1965) work and diagnostic profile. The paper recommended that state of mind assessment and assessment for child psychotherapy, should comprise of 3 sessions, using the same clinical room, toys and on the same day and time.

Gibbs (2009) discussed issues relating to race and culture when providing consultation, assessment and treatment. She described the complexities of cultural, internal and family experiences and how to think about these in the assessment process, relating to the transference, what the child and family's understanding and experience of the problem is and ways of coming to an understanding together. She recommended that the initial engagement was crucial and this could depend on the clinician's,*"concern, interest, respect and non-judgmental attitude and her ability to work with the family's structures"* (pp. 97). She also recommended that the clinician needed to be aware of their own feelings, thoughts and ideas about the culture, family dynamics and child development. The chapter did not describe if the assessment process needed to be different in terms of length of sessions, and did not discuss specifically about working with refugee children.

The majority of the papers written about assessment in the child psychotherapy literature related to specialised assessment, rather than generic individual assessments within CAMHS or private practice. I shall now examine this research, beginning with the work related to education and then child psychotherapy assessments for the court.

Dyke (1985) described assessments with children referred for child psychotherapy within a school for children with emotional and behavioural disturbance. She discussed how the assessment was an important tool to indicate if therapy could be helpful and made use of by the child and, also, for which children therapy would not be suitable. She reported that the assessment could help the clinician observe if the child was able to symbolise, rather than act concretely, and if the child had some ability to think about themselves. It could also indicate if there was evidence of the child having had some good

relationships in the past, if the child was looking for help and had the capacity to make use of the therapist. These were aspects that in her experience indicated that a child may be able to be helped in longer term child psychotherapy work. This paper also supported previous work on the importance and use of countertransference. However, the paper did not specifically describe the assessment process (number of sessions, materials, etc.).

The literature review found that many of the clinical papers on applied child psychotherapy assessments were related to child and family assessments for the court and local authorities. In a paper presented and published for a conference for judges and mental health professionals in the UK, Klauber (1997) set out the background of child psychotherapy and child psychotherapy assessments. The paper examined how child psychotherapy assessments could contribute to assessment for family courts. It described the use of observation, transference and countertransference and how this informed the assessment.

The details of this type of assessment were expanded upon in a later paper by Youell (2002). In this she wrote about her work as a child psychotherapist in a multidisciplinary team which undertook assessment to contribute to decision making for a local authority and the courts. The paper described in more detail, the individual child psychotherapy assessment and the use of close observation, particularly on how the child related to her own emotional response. The paper also described some of the structure to the assessment and the thinking behind it, for example, use of the same room each time, preferably a plain room with some toys, as so not to overwhelm the children and to be able to focus on the child's way of relating and play. The paper emphasised the importance of the use of observation of how the child relates and use of countertransference and transference. Both of these papers do not discuss in detail the length of assessment, perhaps indicating that assessments need to be flexible to meet the individual needs of each child when undertaking court assessment.

The length of assessment is discussed by Sternberg (2016) who described child psychotherapy assessments within a specialist national service in the UK for adults and young people who have committed or are at risk of committing violent

and/or sexual offences. The paper explained how the specialist assessments are requested by courts to help inform placement decisions. This paper discussed issues of technique in quite some detail, for example, knowing the child's history before the assessment, an awareness of what role the therapist was being invited into in the transference, the use of observation and interest in the symbolic meaning of the child's play. The assessment described here was different to other assessments in that it was completed in 1 session. Sternberg argued that this type of assessment involved all the techniques of a child psychotherapy assessment, but that clinicians undertaking such assessments need to be able to adapt these in specialist assessments.

The contribution of child psychotherapy assessments towards risk assessment was also written about by Allan (2016). In her paper, Allan examined the different types of work that child psychotherapists are involved with; consultation work, risk assessment, assessment for psychotherapy and individual psychotherapy. She described that the child psychotherapy assessments were with children and young people who have suffered as well as perpetrated abuse and violence. The paper did not describe the child psychotherapy assessment process, but it did talk about paying attention to the transference, and the importance of the network and stability for child and security in terms of managing the risk for the child.

The literature review identified that another important area of research in applied child psychotherapy assessment related to children in the care system.

Hindle (2007) asked if adapted child psychotherapy assessments could be useful in decision making about placing siblings together in care. The assessments compromised of separate meetings with social workers and foster parents at the beginning and end of assessment, and individual and joint sessions with siblings. She used some quantitative measures and adapted story stem assessments (Hodges and Steele, 2000). She reported that:

> *"Although the quantitative instruments provided a baseline for comparison they could not encompass the rich detail of interactions and intra-psychic processes gathered in the psychotherapeutic*

assessment sessions. Often hitherto unidentified issues came to the fore in the sequence of free play or in relation to the children's drawings… Most significantly the feelings elicited in me such as anxiety, confusion or fear were often not referred to by the children directly, but only accessible in their projected form through the countertransference - a powerful indicator of the children's subjective experience" (pp. 87).

Her research supported the importance of the clinician's observation of their countertransference, the child's play and ways the child relates to the therapist and others. She reported that in her work, there were repeated experiences of the discrepancy of what the network told each other about the children and the experience of being with them. She believed this arose from the anxiety the network felt about wanting to make the right decisions for children and the practical reality of resources, which inhibited them seeing and understanding the children's needs as siblings. Hindle's work echoed other papers in describing what techniques the child psychotherapy assessment comprised of, such as, the use of the same room, box of toys, time boundary and the clinician's use of transference, countertransference and observation. The assessment was adapted to include individual sessions with the children and also joint sessions as siblings. This paper did not describe work with refugee children but is very important in demonstrating how trauma and past experiences are not always put into words by children, and that child psychotherapy assessment techniques can provide an important way of understanding the needs of vulnerable children.

Research by Bradley (2013) examined if child psychotherapy assessments could identify the needs of children in care and contribute to the network's understanding and planning for these children. Using a 4 session model, she met with 4 latency aged children for assessment. Her research concluded that the child psychotherapy assessments were highly effective, *"in bringing a deeper and more complex understanding of the children in their outside lives and of their emotional worlds"* (pp. 230) and were different to assessments that focused on the children's external experiences. She advised that the technique for short-term assessment with children who have suffered trauma and loss should be:

"'More watching and feeling, much less talk'; minimal reference to traumatic experiences since this tends strongly to reinforce defences; keep in mind the constant risk of re-traumatising vulnerable children and acknowledge and repair this directly and in the moment if necessary; work with the ending in mind from the start, protect and preparing the child in relation to loss; keep in mind the mourning of good and bad objects and where possible address this in the transference, including ambivalence expressed to those who have failed and disappointed the child; make explicit reference to interconnectedness of the working relationships around the child" (pp. 54).

These recommendations are highly relevant for this research and applicable for assessment work with children who are refugees. This research method will be used in this project and will be described in the next chapter.

Another assessment method that has been used for children in care, or at risk of going into care, is the 'story stem assessment'. The story stem assessment was developed to help assess young children where there were concerns about maltreatment. Hodges et al (2009) described this form of assessment, which gives children different stories and asks for an ending. The history and research involving it was discussed. Compared to other adapted child psychotherapy assessments, it is different as it is based on a narrative based approach and used by other disciplines. The paper's focus was on suspected or known relational trauma, and a method of standardised assessment for this.

Overall, the research on child psychotherapy assessments and applied child psychotherapy assessments shows that perhaps this area is relatively under-researched, given that an assessment is often the first contact with the child. The clinical papers and research have demonstrated that the common features of child psychotherapy assessment are the use of close and detailed observation of the child's behaviour, play, way of relating to themselves, the adults with them, the clinician and the use of observation of the countertransference and

transference. There has been less literature identified to suggest that a child psychotherapy assessment has a standardised model in terms of number of sessions, length of sessions, whether parents or professionals are involved in consultation or appointments, the type of room and materials available and if quantitative measures are used in or alongside the assessment. Petit and Midgley (2008) showed that amongst child psychotherapists, there did seem to be shared understanding relating to some of these issues, which supports my own experience during my training and current clinical work. The review of the literature supports the recommendation that further research in child psychotherapy assessment is indicated (Kennedy, 2004, Petit and Midgley, 2008).

Child psychotherapy: trauma and loss

I now turn to the literature that relates to child psychotherapy work with trauma and loss, to identify if there are any references to working with children who are refugees or research whose findings could be applied to work with refugee children.

In an early paper, Boston (1967) drew upon her clinical experience to write about the ways in which a child's internal experiences of external events, including trauma, could affect them and how this differed between children. The paper described how child psychotherapy can help children to understand themselves and how they have experienced things internally (i.e. their constitution, what they bring to it). She evidenced her ideas with clinical material from her work with two boys and the different ways they related to their own experiences.

The idea that children react differently to traumatic events, due to their own internal experiences, was supported in later work by Hopkins (1986). In her paper, again, using clinical material and experience, she showed that children sometimes have conscious memories of the traumatic experiences, but often it is unconscious. This resulted in children presenting with and suffering from the emotional response and distress which the trauma had caused. The paper did not describe the assessments for either child or whether different techniques

were used. However, the paper described the use of observation, countertransference and transference as a way of gaining information about the child's internal and external experiences and relationships.

A child psychotherapy assessment with a child, who had suffered from trauma, was described in more detail by Emanuel (1996). This work focused on the trauma experienced by infants born addicted to heroin. Emanuel proposed that these infants suffered a double trauma; the impact of their own medical needs and, in addition, a lack of containment by their parents. These ideas were evidenced by wide reference to many clinical papers in the field of trauma and observation material and a case vignette of work with an 11 year old boy. The assessment was discussed in some detail and comprised of 3 assessment sessions, in which the child's play, behaviour, drawing and verbal communication was clearly observed and attended to sensitively. Emanuel explained that through the following 4 years of weekly child psychotherapy, the child experienced containment and increased ability in his own self-reflective function, through an *"emotionally responsive witness"* (pp. 238). However, the paper did not discuss if the theoretical and clinical implications were applicable and relevant for working with other types of trauma, namely, when working with refugee children.

It could be argued that this limitation is partly addressed by the work of Mendelsohn (1997). She described weekly child psychotherapy with a 4 year old child from refugee parents, who, over the course of treatment, suffered multiple and traumatic losses through the deaths of his mother, brother and foster mother, who all died from AIDS. The paper included some discussion of the child psychotherapy assessment with the child and his parents, but mainly examined the impact of the profound trauma and loss the child experienced and his somewhat remarkable resilience in the face of this during treatment. This resilience was suggested to relate to the child's own internal world and objects; that his early experiences from his caregivers had been internalised as a *"life-sustaining object"* (pp. 414). The author did not focus on other issues relating to being a refugee or discuss if there were other associated traumas.

In a later paper, Judd, (2001), wrote about the impact of loss and trauma on an adolescent who had to have his leg amputated due to bone cancer. He had also moved to the UK, from another country, with his family, when he was aged 6. The paper examined her work with him on a paediatric oncology ward in a hospital. The assessment comprised of some individual sessions in his hospital cubicle and additional meetings with parents and ward staff. She wrote movingly about his internal and external experiences of the loss of his leg, which left him in an overwhelmed state of emotional and physical pain. His loss and trauma was experienced as an intrusion, something forced upon him, without any choice and a sense of the 'best' being taken away. The resulting anger and grief was at times directed towards himself, with the feeling that he had lost his leg because of something he had done, but she also described how it was also directed towards his father.

The impact of trauma on parents was also discussed in a paper about intensive child psychotherapy with a 3 1/2 year old boy who experienced nearly dying aged 10 days old (Youell, 2001). The paper discussed how this trauma had affected the parent's way of relating to their son and their parenting, for example, expectations of behaviour and setting boundaries. It showed how the child related to his early traumatic experiences by using identification as a way of protecting himself from anxiety and fear. Youell reports that an important aspect of the therapy in the early stages was containment of the child's experiences:

> *"He needed me to be able to tune into his world but not be pulled into it. I had to see the ever-present danger from the outside but not have the same fearful reaction to it. I had to recognise that he became suddenly overwhelmed by feelings but not be overwhelmed myself. Above all, I had to make it clear that I was not swallowed up by the trauma" (pp. 315).*

The sense that trauma can both 'swallow up' the child, family and clinician, seems highly relevant to work with refugee families, who are often defined by the traumas they have experienced. The power and the intrusive nature of trauma has also be described in work with children who have been sexually abused

and/or abuse others. Horne (2009) discussed issues relevant to assessment and treatment, including the transference and expectations the children have of the therapists as adults, in an intimate space, and the powerful and disturbing thoughts and feelings that are experienced in the transference relationship and clinician's countertransference. She advised close supervision and an awareness of the impact on the clinician of working, containing, experiencing and making sense of such traumatic, undigested experiences. She recommended that assessment and treatment needs slow and careful work, at the child's pace and that their defences and ways of coping need to be respected without having any expectation of them to talk about their experiences, or tolerate the clinician verbalising them until they have developed their ego strength and therapeutic relationship. She also discussed the importance of the external framework for the child in terms of safety and stability. She gives clinical examples, including that of a 16 year old Kurdish refugee who came to the UK after suffering extreme violence and loss, and who projected his terror into women he touched sexually in the street. This is an example of how trauma and loss can lead to an extreme defence against overwhelming states of terror, helplessness and humiliation.

The subject of loss and trauma is explored further in a paper by Keenan, A., (2014), who examined the impact of loss on the development of an adolescent. The paper set out the theoretical background and literature on loss and mourning and the relevance of this for a young person whose mother had died when she was in early adolescence. The impact of loss, mourning and unresolved mourning, seems highly relevant for some children and families who are refugees, who may have lost close or/and extended family members, but also have suffered the loss of home, including their community and cultural environment. It demonstrates that loss of a caregiver has an impact throughout the child's life, and at different stages of development.

The impact of loss and trauma on parents and how this can affect their children is discussed further in a recent paper by Mooney (2016). In this, she examined weekly psychotherapy with a 6 year old girl whose parents had suffered trauma before her birth and during pregnancy, including the death of a previous baby in-utero at 30 weeks, and then mother suffered a stroke when their second child

was 10 days old, which resulted in 6 years of recovery and required her mother to take medication during her pregnancy with her daughter. The paper focused on treatment, and did not discuss in detail the assessment, other than clinical material of the first two sessions. The previous trauma was not shared with the clinician until 1 year into treatment, when themes emerged in the child's play. The paper is interesting as it discussed the impact of parental trauma on the development and experiences of the little girl and how through therapy she began to emerge from a chronically withdrawn state of mind.

The findings of this paper, taken with others (Youell, 2001, Judd, 2001, Keenan, A., 2014) suggest that long-term treatment may be required for some children and families who have suffered from trauma and loss and some trauma may not be apparent in the initial assessment.

Overall, the literature on child psychotherapy work with children who have suffered trauma and/or loss indicated that techniques used in child psychotherapy assessments (the use of close observation, the transference relationship and countertransference), can for some children contribute to understanding the child's internal states and how they have experienced and understood their own trauma and loss. Many papers discuss that the child's internal states and experiences need to be understood through observation of the clinician's countertransference and the child's behaviour, and be contained and understood by the therapist (Emanuel, 1996, Youell, 2001, Horne, 2009). This indicates that for children who have suffered trauma, the presence of an emotionally available and responsive adult is crucial in being able to understand their feelings and thoughts, and try to help put these into words. This suggests that containment through caregivers and within any therapeutic relationships is necessary and just as important, before a child can be expected to 'talk about' their experiences.

However, further research and clinical work is needed, as many of the papers did not describe the assessment process in detail when working with children who have suffered complex trauma and loss, such as, if extended assessments are indicated, or any issues with engagement due to impact of trauma, or impact of

parents and caregivers. In addition, many of the papers did not specify if their findings could be applied to children who are refugees.

Therefore, I shall now describe the findings from the literature relating to child psychotherapy work with children who are refugees.

Child psychotherapy work with refugee children

The literature search found few papers about assessment and treatment with children who are refugees when compared to other areas of child psychotherapy research. The exception is Sheila Melzak, who has written about her work with refugees who have experienced organised violence and war.

Melzak (1992) discussed a variety of ideas from her work, ranging from loss, trauma, and the effects of organised violence and the importance of paying attention to external and internal realities and how the child and young person experienced these. She gave as evidence clinical material from her work with an adolescent female, who had suffered multiple losses and experienced torture and trauma. Melzak described a framework she developed, *"within which to consider both the internal emotional strengths and vulnerabilities of each individual being assessed for treatment, as well as the specific external experiences and the links between the internal and external worlds."* (pp. 209). She did this by considering 5 points in depth: *"1) Various losses and difficulties in the mourning process, 2) accumulated and continuous trauma, 3) making the transition from one culture to another, and ways of facilitating this, 4) the cultural and developmental history and current phase of development, 5) growing up in a repressive regime"* (pp. 209).

Melzak went on to develop these ideas further in a later paper (Melzak, 1995). Here she explained that child psychotherapy work aimed to help children by enabling them to communicate their past and present experiences through non-verbal and verbal means. The paper described:

> *"A philosophy of assessment and therapeutic work with refugee children, which essentially acknowledges the context in which refugee children lived in the past and in which they live now. Their community, their home, their school, and the spaces in between these can provide an environment which is sensitive to the needs of refugee children. However, their needs can be invisible" (pp. 256).*

She recommended that clinicians should consider 8 key concepts when assessing and working with children who are refugees. These were described as: *"developmental issues, repression, violence, secrecy, scapegoat, loss, trauma and change"* (pp. 258). These concepts and questions seemed to be for the clinician to keep in mind to help them to assess the child's internal and external experiences and the impact of these on the child's development, understanding of themselves and others, and ways of relating. The paper raised many important issues that are highly relevant for clinicians working with children and families who are refugees although it would have been useful to have had more detail of the actual assessment process, for example, number of sessions, materials used, or if there were joint sessions with parents.

Further work on child psychotherapy treatment and theoretical background was described in a paper by Grünbaum (1997). The paper discusses her work with a 6 year old girl, whose mother and father had both suffered torture and then subsequent separation and death of the father, and then the impact on her of her mother's mental health. The child was seen for twice weekly child psychotherapy treatment, which involved close observation, attention to the transference relationship, and trying to understand the child's repetitive play. She concluded that child psychotherapy work gave the child their own space with a thoughtful, containing adult, which helped them to make sense of their past and present experiences. The paper did not describe if the child was seen for an assessment first, or began treatment straight away.

In a later paper, Sinason (2002) discussed her work with children, young people and families who have experienced extreme trauma. Within this she described an assessment session with a mother and daughter. She did not describe this

assessment in detail, other than it was a one session assessment for the local services, and it was for 90 minutes. From this clinical example, she discussed the impact of time on this family, in particular that they experienced the boundary of 90 minutes as something forced upon them by clinician. It was yet another thing that they had no say or control over. It highlights the importance of trying to recognise and understand how the child and family experience the institution and the clinician, and the impact of this on them.

The literature review found a further two papers by Melzak, one regarding psychodynamic and narrative group treatment for children and adolescents aged 16-21, for males and females (Schwartz and Melzak, 2005). This paper was interesting as it describes the importance and function of a group and the different ways of communicating for extremely vulnerable adolescents. In later work Melzak (2009), wrote about her thoughts and ideas about working with refugees from over 20 years of clinical experience, working with children, families and adolescents. The paper discussed issues relating to theory and treatment, including, loss, mourning and trauma. She describes the necessity of working holistically with the children and their families, recognising that they may have different types of needs, for example, housing, education and health. The paper emphasises the importance of working with some children and families for long term work, to enable them to feel held, contained, whilst their experiences can be understood and witnessed by the therapist, and from this, to enable the child to slowly take back their experiences.

A later paper written by a child psychotherapist about working with refugee children is Martin (2012). In this, he described his work with refugee children and families in a paediatric hospital setting. He discussed how psychosomatic symptoms had important links to trauma and the child's and families' way of understanding and processing the trauma. The paper did not describe the assessment process, but rather focused on the long term work with children and families, including an intensive case. However, it raised important issues relating to the parents' displacement of their trauma and fears into the child and their own ways of being unable to process and relate to his loss and experiences. This suggests that support for parents and their own work could be essential.

The idea of the displacement of trauma onto another is discussed further in a paper by Woods (2016) who describes intensive work with a 9 year old refugee child. This child suffered trauma from sexual abuse by his father, in addition to his experiences as a refugee. The paper's main focus is on the impact of the sexual abuse and his identification with the abuser, by sexually abusing other children. The paper discussed openly and clearly, the powerful and disturbing feelings experienced in the transference and countertransference, and the importance of supervision and parent work with the child's caregiver.

Overall, the clinical papers and research on child psychotherapy work with children and families who are refugees indicate that further work would be helpful. The work by Melzak is clearly based on a great deal of experience, working with very vulnerable children and families and raises a number of crucial issues to consider when working with refugees. However, there is a gap in the literature regarding child psychotherapy assessments, and whether they are a helpful way of assessing individual needs and if they need to be adapted in any way when working with this group of children.

Clinical work and academic research with refugee children: other modalities

I identified a number of papers and research studies that described assessments with refugee children from other modalities. These demonstrated that a range of methods have been used in assessments of refugee children for different reasons. I have divided these reasons into two broad areas; clinical work and academic research. I shall now critically examine the most relevant research and papers within each area, describing the methods of assessment used and implications for my own research.

Clinical work and research

The literature review identified a number of papers relating to assessments in clinical work with children and families who are refugees, i.e., direct work for

clinical and therapeutic reasons, rather than academic research. I have grouped these papers into three areas; crisis and emergency response, CAMHS and community based work and specialised assessments. I shall begin by examining the assessments currently used in crisis and emergency response work.

In a crisis situation, when there are large numbers of people, and different organisations trying to support them and identify needs, different types of mental health assessments are needed. One such assessment was proposed by Petevi et al (2001). They developed the 'Rapid Assessment of Mental Health Needs and Available Resources' (RAMH), a screening and assessment toolkit for adult refugees as a whole group. The toolkit is said to identify the different needs they have as a group, what they may have experienced, the immediate resources in the current environment and the longer term needs they may have. However, it did not have an assessment specifically for children, but tried to identify the children's needs through interviews with caregivers, or staff working with them.

Later work by Rothe (2008) addressed this. In his paper, he described a psychotherapy treatment model for refugee children. This was developed through his clinical experience and research in a refugee camp in Guantanamo with 32,408 Cuban refugees, 2,500 of whom were children and adolescents. He gave clinical examples of short-term psychiatric assessments in the camps, which took into account the child's *"ability to regulate their emotions.. ..undertake task orientation activities.. ..ability to sustain a positive self value.. ..and the ability to maintain rewarding interpersonal relationships and appropriate attachments.."* (pp. 632). The paper also gave examples of how drawing helped some children to verbalise their experiences and feelings.

In the same year, Jones (2008), drew upon 10 years of clinical work and research to describe how to respond to children's needs and set up services in areas in crisis. She reported that:

> *"It calls for greater attention to the child's perspective, their individuality, and the cultural, social and political context in which they live. It argues that those concerned with psychopathology of children*

in crisis should widen their frame of reference beyond narrowly defined traumatic reactions to included other mental health and psychosocial issues, including the current problems of everyday life" (pp. 291).

The paper argued that many children were often more concerned about their experiences in the here and now, rather than experiences of previous trauma.

The most recent papers on assessments for use in crisis situations are two letters to the editors of the journal, *European Child and Adolescent Psychiatry*. Hebebrand et al (2016) wrote to call on the international community of mental health professionals to work together to address the current refugee situation. They recommended that when undertaking assessments with refugees, child mental health professionals need to consider the pre-migration experiences of the refugees, the experiences during transit and then their experiences on arrival in the host country. In line with Jones (2008), they emphasised taking into account the holistic needs, and point out that initially physical health issues dominate, due to exhaustion, poor nutrition, untreated infections, all of which need appropriate treatment, as well as attention to their mental health and well-being.

In the second paper, Gadeberg and Norredam, (2016) proposed for a working group to be established to address urgent needs for refugee children through validated assessment tools. They report that the:

"Systematic literature search (unpublished data) shows that a huge lack of screening tools for especially young refugees below the age of six exists. It is therefore of great importance that the working group considers alternative ways to identify trauma and mental health issues among this population, e.g, by use of doll plays, drawings etc.." (pp. 930).

The papers and research regarding assessments with refugee children in crisis situations emphasise the importance of being able to identify needs quickly and address the whole situation the child and family are in, for example, living

arrangements, physical health etc. but also how to identify the individuals in most urgent need of help.

I shall now examine the research and clinical papers relating to clinical work with refugee children who have received support through CAMHS and community based work and see if assessments in other modalities are established in this group.

I identified four papers that described clinic based work with children and families who were refugees. In an important paper about issues of denial and silence, Almqvist and Broberg (1997) described how children can re-enact trauma through their play and that the impact of trauma on children is often denied by their parents. The treatment was described as child psychotherapy and was undertaken by psychologists in Sweden. They discussed the 'Erica Play Technique', which involved observation of the child's play and trying to understand its meaning, which they reported, then allows the children to verbalise what has happened. It raised the issue of how some parents are unable to acknowledge and respond to their child's experiences, whilst suffering from their own experiences and the support that these parents need.

The importance of working with families was highlighted in a paper by Fox (2002). She discussed her work as a psychologist in a specialist refugee team within a CAMHS clinic in the UK. The paper described the use of observation, transference and countertransference and psychoanalytically informed psychotherapy work. She examined how the child and parent's internal states and objects impact on how they understand, relate and live with their external experiences. The paper did not describe the assessment process in any detail.

In another paper based on clinical work and research literature, Elliot (2007), gave an overview of the issues relevant when working with refugees. It did not make any specific recommendations regarding child psychotherapy assessment. It did recommend that, *"initially a comprehensive assessment is required in order to identify the nature and range of presenting issues"* (pp. 138). The paper gave a good overview of generic assessment and identifying needs, and the

importance of paying attention to both past and present issues, and to have an approach which is flexible, holistic and culturally aware.

The following year, Ehensaft (2008), described long-term once weekly work in the US, with 17 year old adolescent refugee who had experienced torture. Ehensaft is a psychologist working as a psychoanalytic psychotherapist. She examined her dual role of attending to external reality, in writing a report for an asylum claim as well as the young person's internal state. She stresses the importance of the time it takes to put experiences into words and for the clinician to, *"concentrate first on recognising and withstanding the wordless, chaotic terror in which abused children live"* (pp. 128).

The literature search identified 6 papers that describe community based CAMHS work, mostly in schools. Fox (1995) described issues facing refugee children in school (external and internal) and also the issues for teachers trying to teach and support them. She discussed some CAMHS interventions with school staff including training and a work discussion group for teachers. The paper emphasised the importance of school and the child-teacher relationship for the children. She encouraged teachers to use observation and to think about how they are feeling in order to connect with and support the children, whilst maintaining their role as teacher and their confidence in this, in the face of such distress. The paper did not make any reference to child psychotherapy assessment.

Blackwell and Melzak, (2000), also offered clear guidance for school staff working with refugee children. They examined how school staff can be supported to understand the child's needs and contain them in school, with practical advice about how to emotionally support the children and the importance of consistency and boundaries.

Work in the same year, focused on a CAMHS intervention in school. O'Shea et al, (2000) described a small pilot study in an inner London primary school (ages 7-11 years old). Teachers referred refugee pupils, after identifying their level of need using a quantitative measure, the strengths and difficulties questionnaire,

(SDQ), with 14 out of the 90 refugee children referred to a CAMHS worker in school who undertook assessment and treatment within school. The paper did not describe the assessment process in any detail, but it seemed to include clinical interviews and quantitative measures. It gave case vignettes to describe family interventions. It reported positive outcomes in engagement from parents due to being seen in school, and that parents were often keen and able to relate to services where they were working directly to support their child's education. The paper noted that the majority of the 14 children identified by the teachers showed signs of inattention and over-activity, which suggested that perhaps the measures, did not identify the more withdrawn children who may have been internalising their difficulties.

A follow up study to the work of O'Shea (2000) was reported by Durà-Vilà et al, (2012). They examined a community based CAMHS service (located in a primary school, secondary school and voluntary homeless family service) to see if there were differences between the children referred. The research involved 102 children and young people who had been referred. The intervention consisted of semi-structured interviews with parents and the child, consultations with school staff, quantitative measures (SDQ, and referral form information). It reported that 20% of participants did not have any face to face sessions, and the CAMHS work was consultation to teachers or to their family. Children who had been in the country more than 2 years, were more likely to be offered individual treatment; more newly arrived families received more consultation. It did not report further on the assessment process or what types of individual sessions were offered. There were not any child psychotherapists working in the team.

The importance of community based CAMHS work in engagement is supported by Hughes (2014). In this clinical paper, she described a group intervention for mothers from Afghanistan, who were referred by the school their children attended, with concerns about the mothers' well-being. The paper describes that these mothers would have been unlikely to attend a CAMHS clinic, due to stigma and a difference in cultural understanding about mental health. The women spoke about a concept of 'tashwish', a Pashto word, which seemed similar to depression. Hughes recognised that the women wanted to speak about this and

their own experiences in the group, before they began the 'Tree of Life' narrative, strength-based intervention. She noted that the mothers reported feeling better, stronger and more able to cope with their previous experiences, day to day life and look after their children, as an outcome of this adapted group work. The paper went on to describe that the 'Tree of Life' approach was used in school with children from different communities within London. It reported that the children were often struggling with issues relating to the present, rather than purely trauma relating to past experiences, for example, the impact of racism, poverty, learning a new language, living within a new culture, bullying in school and anxiety about their future.

The literature review identified that the final area of clinical assessment work with young people who are refugees was specialist assessments for legal services and the Home Office.

A clinical paper by Tufnell (2003), described her clinical experience working within a specialist traumatic stress clinic in London, as a psychiatrist assessing children to provide information for their application to stay in the UK. She used clinical material from one case in detail to describe the assessment process. The assessment began with a request from the child's solicitors, in which they provide reports covering the child's medical and educational needs. A planning meeting was then arranged with the family to think about the assessment process and the impact of this on the child and carers. Tufnell described that the assessment then followed *"a more or less conventional format"* (pp. 437), of meeting and talking with the families and young people. The paper highlighted the importance of using detailed observations for children who are non-verbal or very young, including looking at, for example, interactions, behaviour, within the context of assessment with the family. The assessments were flexible in the number of sessions offered, and decisions about this were made based on clinical need.

Research relating to clinical work with refugees suggests that further work in assessment and treatment is required. Few papers identified how individual assessment can contribute to a holistic and family assessment. However, the papers raised important issues regarding engagement, the impact of experiences

on parents, issues of denial, secrecy and how education and school can contribute to supporting and understanding the needs of refugee children.

Academic Research

The literature review identified some academic research that was very relevant to the question of which assessments and treatment should be used and how useful they are for children who are refugees.

A systematic review by Ehnholt and Yule (2006) reported that there is a poor evidence base for research on assessment and treatment with refugee children. They found that most assessment is semi-structured clinical interviewing with self-report measures and quantitative questionnaires. They did not report any assessment using observation. They advised meeting with the children individually as well as with their family but warned clinicians that formal interview assessment may remind families of past interrogations and/or trauma. They reported that quantitative measures may not be valid due to being standardised on US and UK children. They found scarce research on treatment for children under 8 years old. The review did not mention child psychotherapy or any research that used the clinician's own emotional response as a tool in the assessment.

This work was developed by Montgomery (2011), who reviewed 4 key pieces of research. She examined assessments with refugee children aged 3-13 years old, who were living with at least 1 parent, and whose parent(s) suffered from torture. They were all families from the Middle East, who were claiming asylum in Denmark. The research recommended that assessment and treatment of individuals should take place alongside family and parental assessment and support. The outcome of this research demonstrated the importance of assessing both children and families because they have different reactions and responses to trauma and PTSD could be too simplistic as a focus.

Ziaian et al (2012) also reported that PTSD may be over-represented in research and clinics. In this study, they examined if depression was not being recognised

amongst refugee children. They undertook assessments with refugee children in Australia, in which questionnaires were sent to their parents and teachers. The research reported that there was distress amongst the children, but again, identifying this relied on reports from their parents and teachers, and there was no direct observation or assessment with individual children. It recommended further research to help identify and distinguish the impact of pre-migration trauma compared with post-migration stress on children who are refugees.

Later research, De Haene et al (2013), examined refugee children's attachment security to see if it was affected by the experiences that they and their parents had been through. They measured their attachment using:

> *"The Attachment Story Completion Task, ASCT, Verschueren et al, 1996, a migration specific adaptation of a validated doll-play procedure for pre-school and school-age children… ..respondents are asked to complete attachment-specific story beginnings (i.e. stems) using a doll family." (pp. 414).*

The research recommended that further assessment research was needed, which should include an assessment of parental states of mind and consideration about the risk of evoking traumatic memories when children are assessed using the migration-specific story stems.

Another area of academic research that this review identified is the research relating to unaccompanied minors. From this area, I have selected the research most relevant to this research to examine further.

These children are thought to be the most vulnerable, having often made long journeys and then arrived into their host country on their own. This assumption is only partly supported by the work of Michelson and Sclare (2009). Their study was the first research into the differences between unaccompanied and accompanied children presenting in CAMHS in the UK. They reported that there were some differences between unaccompanied children and children with caregivers relating to; access to CAMHS, socio-demographic factors, their mental

health needs, and service provision. Unaccompanied children often presented with symptoms of PTSD and had had more traumatic events before they arrived, but the groups showed similar levels of post migration stress and presenting issues. Accompanied children had a higher level of risk of conduct disorder when compared to unaccompanied children. However, the research did not mention anything about assessments or recommendations for assessment for both groups.

The issue of assessment and treatment for unaccompanied minors was examined by Groark et al (2010). Their work aimed to identify and understand the needs of this group further, using quantitative measures and a qualitative semi-structured interview with 6 young asylum seekers in the UK. They reported that establishing a sense of a secure base for these children was crucial.

Being able to establish a secure base for all refugee children and families involves being allowed to stay in the host country until they chose or are able to return home. However, in the UK, this involves a lengthy process with the Home Office, full of uncertainty for many young people and families. The impact of previous experiences and trauma can impact on unaccompanied children's ability to tell their story for asylum claims (Given-Wilson et al, 2016). This research reviewed the literature looking at unaccompanied adolescent's asylum claims. It reported how unaccompanied adolescents could struggle to tell the story of what happened to them due to trauma, cognitive levels and memory. It showed that the ability to verbalise experiences is not just age related, but it is also affected by trauma and who they tell their story to. It did not comment if this finding is applicable to younger children, but it would seem reasonable to assume that due to their age, they would be even less able to verbalise their experiences and understanding of what has happened to them. The capacity to verbalise experiences and reflect upon them may be crucial to working through trauma. This could be a protective factor for children and families who are refugees. Academic research in this area of resilience shall now be examined.

The literature review found a number of academic studies that aimed to investigate why some refugee children and families were either more at risk or were protected from developing mental health issues related to their experiences.

In an early study, Miller (1996), used semi-structured interviews and adapted quantitative measures (the child behaviour checklist and the women's health questionnaire) to explore the children's understanding of their experiences and examine if they had any mental health symptoms. The study did not use any observation directly. It did not explicitly describe if the interviews were done individually but it did show an interest and awareness of the importance of a child's internal understanding of events and themselves, whilst within a large refugee community camp. The study reported relatively low levels of mental health issues for the children and linked this to maternal well-being and the children remaining with their caregivers, whilst in their own community, even if in a camp, as well as having no direct experience of violence.

The importance of family as a protective factor was also reported by Ajdukovic and Ajdukovic (1998), who undertook 3 psychosocial assessments over 3 years with mothers and their children living in a large refugee centre in Croatia. Their assessments comprised of quantitative measures initially only with the mothers. They decided to assess the children in the 3rd year of assessment, *"because of the realisation that in some families the mothers themselves were overwhelmed by problems and did not have the capacity to recognise and assess their children's difficulties"* (pp. 190). The study found that the children were at risk in their development, though many showed remarkable resilience and had many ways of coping with the chronic stresses associated with being refugees. They reported that the children at most risk seemed to be the children who had traumatic experiences before they were displaced, or those without their parents, or with parents who were not coping very well or living in large refugee centres. In terms of the assessment with the children, they found that, *"younger children were not able to give reliable accounts of their feelings in displacement, while older children were sometimes unaware of all the aspects of their behaviour and reactions, or were trying not to burden their parents with additional problems"* (pp.

193). This suggests that narrative assessments for some children may be limited in being able to identify difficulties.

In the same year, research by Hjern et al (1998), also examined the risk and protective factors for latency aged refugee children from Chile and the Middle East, living in Sweden. Their research involved interviews with the families and questionnaires about organised violence, mental health, family stress and social situation in exile. They reported that:

> *"Signs of poor mental health were alarmingly common among the refugee children and did not improve over time during the first 17-19 months in exile. Long term effects of political violence in the home country and stress in family sphere in exile were singled out as major determinants of poor mental health" (pp. 24).*

It was not clear if the children were seen individually or with their families when they were interviewed, which may have affected their responses, as reported in reported in the previous study by Ajdukovic and Ajdukovic, (1998).

In the most recent and comprehensive research in this area, Fazel et al (2012), undertook a systematic review of the literature which aimed to identify and summarise the risk and protective factors for refugee children (aged up to 18 years old). They reported that the risk factors for mental health issues in refugee children are; *"exposure to pre-migration violence, female sex (mainly for internalising or emotional problems), unaccompanied, perceived discrimination, exposure to post migration violence, several changes of residence in host country, parental exposure to violence, poor financial support, single parent, parental psychiatric problems"* (pp. 277). Protective factors were identified as, *"high parental support and family cohesion, self-reported support from friends, self-reported positive school experiences and same ethnic-origin foster care"* (pp. 277). However, the majority of the studies included in this review were with adolescents or older latency aged children, so the understanding of the risk and protective factors for much younger, pre-verbal children is limited. The study

recommended further research in understanding the needs of children and families who are refugees.

The literature review also found that there has been research that used assessments with refugee children and families to see if there were any differences in the ways that their mental health needs were identified.

Montgomery (2008) examined if there was a difference between parent and child reporting of external and internalising conditions. The study looked at the responses of 122 adolescents from the Middle East, who were interviewed separately from their parents, using quantitative measures. She reported that the young people generally reported a higher level of symptoms than their parents reported of them. These differences were larger for externalising behaviour for males and larger for females for internalising behaviour. The research recommended that information used in the assessment of refugee children should be from multiple informants, not just parents. She noted that parents' understanding of their child's difficulties might be affected by their own perception of the problem and their own health needs;

> *"Parents might project their own mental health problems onto their children, and parents with somatic illnesses might neglect mental health problems in their children. These influences seem to be gendered, since the father's health situation can influence not only the father's, but also the mother's assessments of their children" (pp. 60-61).*

However, a limitation of this study is that it did not include younger children, less than 11 years old, so it is not clear if this outcome is applicable for the younger age group.

This issue is addressed in Goldin et al (2008) whose research compared clinician assessment with parent, child and teacher reports for 48 refugee children from Bosnia (aged 7 to 20 years). They reported that clinicians assessed that 48% of the children had mental health issues. The parent reports correlated highly with

primary aged children, and less so with the adolescents `and teachers under-reported internalising behaviours. This research used a mixture of quantitative measures and qualitative semi-structured psychiatric individual interviews with the children. They questioned whether the high correlation between parent report and primary aged children could be in part due to the fact that the children were initially interviewed with their family, during which the parents' views tended to dominate. In considering the children who were at risk of mental health issues, they reported that the children:

> *"Fall roughly into two categories; those whose distress appears to be visible to their adult world; those who bear a "secret" load of inner pain and turmoil. Interviewing the child both alone and in interaction with parents and siblings appears of prime importance in identifying both categories…. [and that an assessment] must balance a threefold challenge - that of giving credence to the child's experience, meaning to the child's distress, hope and empowerment to the child's future endeavours" (pp. 214).*

The area of work was expanded upon by research by Jarkman Bjorn et al (2011). In this study they compared a semi-structure interview with parents with child assessment using the 'Erica play-diagnosis (projective test). Their results emphasised, *"the importance of getting the diagnostic information from the child in order to understand each child's psychological condition."* (pp. 517). The paper discussed why the results may have been so different from parents and children. It refers to issues of denial from both parents and children as a way to try to protect family members. It also discusses the limited verbal ability and understanding of young children, which would affect an assessment that depends on verbal input, but may also affect what the child is able to tell to the adults about their thoughts and feelings.

The academic research regarding assessments with refugee children show that again, there is not one standardised assessment technique and instead a wide range of quantitative, qualitative and some projective assessments are used. They all recommend further research in different areas of work with refugee

children, from identifying needs, understanding the impact of their experiences and how best to support these children and their families. A number of them emphasised the importance of seeing the child individually as well as with their families, in order to gain a greater understanding of the child and family and use of an assessment that does not solely rely on verbal report.

Summary

In this literature review I have identified and examined research, clinical papers, book chapters relating to 5 areas; an overview of child psychotherapy research, child psychotherapy assessments, child psychotherapy; loss and trauma, child psychotherapy work with refugees and finally, clinical work and academic work of other modalities. In each area, the research has made a number of highly valuable contributions to our understanding of child psychotherapy work, assessments, and working with vulnerable children and some of the complex needs that refugee children have. The themes from each area will be discussed in later chapters in relation to the findings from this research.

However, overall, this literature review concludes that there is also a lack of research in the types of assessments that are indicated for young refugee children, whilst in transit, on arrival and when living in their host country. There is also some gap in research in the child psychotherapy discipline about whether a child psychotherapy assessment can be helpful in identifying the needs of young refugee children. I hope that this small research project can contribute in some way towards the research regarding clinical work with refugee children.

Chapter 3) Research methods

As I have previously described in the introduction to the thesis, this research aims to investigate if a typical way of assessing the internal worlds of children, a child psychotherapy assessment, is a helpful and relevant assessment method for children who are refugees and living with their parent(s). In doing this particular piece of research, I hope to examine how a child psychotherapy assessment may be able contribute to an initial understanding of each child's individual internal states and the impact that their external experiences may have had on them. In this chapter I will describe the research methodology I used to investigate this, and the reasons behind this choice of method. I will then set out the design of the research and from there, describe the data collection process and discuss the chosen data analysis method which was thematic analysis. Finally, I will conclude with reflections on the validity of the chosen design, method and analysis.

Research question

McLeod (2001) describes how research arises from, *"a wish to be able to demonstrate that already known propositions are true (verification) and a wish to generate new propositions about the world (discovery)" (pp. 13).* This can be said to be true of this research. My research question is:

> *How can a child psychoanalytic psychotherapy assessment contribute to the understanding of the individual experiences of children who are refugees?*

With this question, I aimed to examine how a child psychotherapy assessment can be helpful (therefore, verification of clinical practice in this field) but also I aimed to examine if there were differences and/or commonalities to specifically working with refugee latency aged accompanied children (discovery). As I

described in the introductory chapter, this research question has arisen from my clinical work with refugee children, within a theoretical framework of child psychotherapy and psychoanalysis.

Qualitative research

This research design and analysis has been conducted using qualitative research methods. I chose a qualitative method because the theoretical focus of this research is conscious and unconscious processes, understood through subjective experience and observation, rather than objective, quantifiable measures. Qualitative research is most suited to this as it:

> *"Always involves some kind of direct encounter with 'the world', whether it takes the form of ongoing daily life or interactions with a selected group. Qualitative researchers are also routinely concerned not only with objectively measurable 'facts' or 'events', but also with the ways that people construct, interpret and give meanings to these experiences. Qualitative approaches typically include attention to dynamic processes rather than (or in addition to) static categories, and they aim to discover or develop new concepts rather than imposing preconceived categories on the people and the events they observe" (Gerson and Horowitz, 2002, pp. 199).*

As I described previously in the previous chapter, research with refugee children has examined many different areas, both from a clinical perspective and also from an academic, theoretical interest. These studies used a variety of different types of qualitative methods (interviews, observations, structured and semi-structured interviews) and some used quantitative measures (formal questionnaires). Many relied on parent report, rather than observations and direct work with the children. Overall, I did not identify a specific design or methodology that was solely recommended for research with refugee children and that could help investigate my research question in depth.

In general, very little qualitative health research has been conducted with children (Singh and Keenan, S. 2010). They report that the majority of qualitative health research has been with nursery aged children or adolescents, about their understanding of their illnesses, their treatment and implications for issues such as non-compliance with medication. They believe that qualitative health research is very important because it gives a voice to, and understanding of children who are, *"in marginal and/or vulnerable populations because these groups are rarely given a voice in their experience of services and treatments"* (pp. 701). I would argue that children who are refugees are certainly within a marginal and vulnerable group.

Therefore, what research methods have been used before in psychoanalysis and child psychotherapy research? I will now discuss these and the implications for the design of my research.

M.J. Rustin who has written widely about research in child psychotherapy and psychoanalysis, states that, *"research, in the sense of the systematic acquisition and logical accumulation of empirical knowledge, has always been essential to the development of psychoanalysis as a field of practice*" (Rustin, M.J., 2003, pp. 138). Some child psychotherapy research has involved quantitative methodologies, (Fonagy and Moran, 2009) but the tradition and much of the present research has used qualitative methods because they are believed to be able to explore the meaning and understanding of the data in much more depth.

Rustin, M.J., (2003, 2009) argues that the case study method, used by Freud, and the majority of psychoanalysts and child psychotherapists to understand their patients and generate new ideas, is a valid and important research method. Rustin, M.J., (2003) proposes that the case study method provides a space, in which creativity and freedom can flourish and so allows new ideas to develop and build upon and challenge existing ones.

Rustin, M.J., (2003) describes how with this method, all of this occurs within the boundaries of the session and consulting room. He discusses how a crucial aspect of this type of research is that psychoanalysts and child psychotherapists

use themselves as research tools. They use their observation skills and reflective states of mind to observe closely the conscious and unconscious communication in the room, and use detailed notes, observation, reflection, re-working, supervision and research with other patients; all of which they use together to develop their understanding of their patients and emotional processes as a whole. He further emphasises the importance and validity of this approach to research, as well as recommending the development of more formalised empirical methods. He proposes that the two should continue side by side, as two methodologies, and not to compete with each other. This is supported by Kegerreis (2016), but she also recommends that additional work is needed to develop research and methodology in child psychotherapy.

The link between the research paradigm for psychoanalysis and child psychotherapy and the choices between current and future methodologies has been discussed by Hollway (2004). She describes that,

> *"The qualitative paradigm, while based on a recognition of the centrality of meaning-making to human activity, rejects the psychoanalytically based idea of internal mental states and the ways they can be communicated outside language. Based on these critiques, I have focused on what kind of ontological and epistemological principles would be appropriate for practices and research informed by psychoanalytic principles. I have emphasised psychoanalytic understanding about knowledge and the mind of the knower as a research instrument. I have argued that extrapolation from case studies can be regarded as an adequate basis for more widely applicable knowledge" (pp. 40).*

Midgley (2004, 2006) discusses these methodological issues further. In his 2004 paper, he describes the range and risks of child psychotherapy research when methodologies focus solely on either case studies or larger evidence based research, such as randomised control trials (RCTs). He argues for a breadth of research methodology, and describes three types of relevant and valid qualitative types of research, "*the 'first circle': relevant but non-psychotherapy research" (*pp.

97), *"the 'second circle': accounts of therapy research"* (pp. 99), and, *"the 'third circle': therapy process research"* (pp. 101).

The research method of this study is within the 'third circle.' I chose this because I am interested in examining my own clinical practice further by understanding the individual needs of the children that I work with. I believe that the most appropriate method for me to do this, is a methodology that aims to capture and research the 'real' experience of the child and myself in the therapy room. Kazdin (2002) argues that much of the previous research in therapy with children does not replicate and test actual clinical experience, i.e, children are recruited, not clinically referred, often they present with less complexity, and they usually don't receive the same clinic treatment, for example, length of treatment. Therefore, I was keen to use a method that not only would capture the same type of child psychotherapy assessment that I use routinely, but also with children that I would see in normal clinical practice.

Overall, it seems that research in child psychotherapy and psychoanalysis are now incorporating research methodologies that both value the importance of the use of case studies, but in addition, examine the material from these cases using qualitative analysis methods to explore the material in a systematic and in-depth manner. Qualitative data analysis methods used in child psychotherapy and psychology research include grounded theory (Glaser and Strauss, 1967), interpretative phenomenological analysis, IPA (Smith et al, 1999), and thematic analysis (Braun and Clarke, 2006).

However, these methods of research and data analysis need to continue to remain open, and not be systematic in a rigid or closed way. As Rustin, M.J., (2003) recommends, as with clinical practice, in research, the researcher has to approach the material with an open and reflective state;

> *"If 'openness' to the clinical experience is the essential root of understanding in psychoanalysis, then too prescriptive an idea of what is to be looked for, of where discoveries are presumed to be waiting, could bring harm as well benefit to the activity of generating new*

knowledge. Bion's famous prescription to 'eschew memory and desire' has relevance not just to the apprehension of the reality of the individual patients, but also the need to 'forget' what is more generally known, in order to be exposed to the possibility of experiencing a genuinely new idea" (Rustin, M.J., 2003, pp. 142).

Therefore, the methodology that I have chosen and used in this research, will use case studies to examine my direct clinical work, and use thematic analysis of the raw data from detailed session notes, that include observations of the child's behaviour, play and also my observations and reflections of my own countertransference. I have chosen this type of methodology because the clinical work and research is set within a theoretical context of the unconscious; and so is best observed through non-verbal communication, including countertransference and the use of the researcher as a research tool (Rustin, M.J., 2003, 2009, Hollway and Jefferson, 2013, and Holmes, 2014) rather than purely verbal accounts. I shall now describe in detail, the design of the research, followed by a description of the data collection and the method of data analysis.

Design of the research

Singh and Keenan, S. (2010) proposed that research with children should first involve a small pilot study, to test out the method and understand how the children will react to the research. This research has been designed and conducted specifically with a small sample (3 participants) and will be evaluated to see if this is a method that was both valid and appropriate to answer my research question.

Within the small sample, I chose to use more than one case study because I am interested in whether a child psychotherapy assessment can help understand the individual experiences of different children. Therefore, I chose to compare multiple case studies for differences, as well as commonalities.

This form of assessment was developed by Bradley (2013) who designed a method which used a short term assessment (4 sessions) to help identify the

ways that children in care understood and related to their experiences, as described in the previous chapter.

In this research, I used a similar methodology. I met with the children individually, for 4 assessment sessions (50 minutes duration). I had planned for these sessions to be one week apart. After each session, I wrote detailed observation notes of each session, using skills that are taught and developed as part of standard pre-clinical and clinical child psychotherapy training. These notes were then analysed using qualitative thematic analysis. I met the children's parent(s) before the assessment to discuss the assessment and the process and then again after the assessment. The outcome of the assessment and recommendations were then discussed with the child (if appropriate), their parent(s) and the professional network.

These types of child psychotherapy assessments are routinely used in clinical child psychotherapy practice to identify how a child relates to adults, their emotional state and identify specific emotional, behavioural and relationship needs. This information is then used to help the child's family, the school and other professionals understand the child and identify how they are able to support the child.

Description of a child psychotherapy assessment

I have described previously, there is a shared understanding amongst child psychotherapists about what constitutes a child psychotherapy assessment (Petit and Midgley, 2008), rather than a formal diagnostic description of a standardised assessment. I have described the methodology of a child psychotherapy assessment, previously in the introduction.

In this research, there were some slight changes to this methodology. I believed that it was crucial with this population, refugees, that they had another clinician involved with their care, either who was undertaking a longer, generic assessment or ongoing work with the family and children. Therefore, the child psychotherapy assessment would be an addition to the therapeutic work that the

children and family were already receiving. I was also aware of the potential impact of short-term assessment on this population and emphasised to the children that I would only be working with them for four sessions, and I carefully attended to this both within myself, and with the children themselves throughout the assessment as recommended by Bradley (2013).

Description and technique of written session notes

Writing detailed observation notes of everything that occurs within a session, is a skill developed during the pre-clinical and clinical training in child psychotherapy. As part of the pre-clinical training, weekly observations are undertaken of infants for 2 years, and young children for 1 year, as well as writing accounts of the different types of work done with children. These notes are then presented in small seminar groups with experienced child psychotherapists, and the group examines the material to try to understand the meaning and significance of the conscious and unconscious communication and behaviour of the child. These observations include observations of the child's play, words, mannerisms, ways of relating, as well as, our own thoughts, feelings and associations, as a means of trying to understand the countertransference and so, the transference relationship. During the clinical training and after qualifying, child psychotherapists continue to use this technique to write detailed notes for supervision, as a way of understanding the child and the work in greater depth and detail.

Rustin, M.J., (2006, 2009) and Midgley, (2004) propose that our training and experience in infant and young child observation enable us to recall and record the session material with a high level of detail and that these notes are an important research tool. They emphasise that child psychotherapists and psychoanalysts have a long tradition of using observation and notes for clinical research. In more recent times, observation notes have been recognised even further as a valid research method and applied in many different areas of child psychotherapy research (Sternberg, 2005, Adamo and Rustin, M.E., (eds), 2014). There has also been growing interest amongst social researchers in the use and validity of observation and recording of countertransference (Walkerdine

et al, 2002, Hollway and Jefferson, 2013, Holmes, 2014). They propose that detailed observation of behaviour, as well as thoughts, feelings, associations, all add to the depth of the data collected and recorded and these subjective states should be recognised and understood as a potential research tool, rather than attempting to repress or deny the subjective experience of the researcher.

This has led to further interest in the clinical session notes that are written routinely in child psychotherapy. Research has been conducted that has analysed these notes using qualitative research analysis methods such as grounded theory (Sternberg, 2005, Wakelyn, 2011, Keenan, A., 2014).

In this research I decided to use the written observation notes from each session with each child, as the data set to be collected and analysed. I decided not to use a tape or video recorder because I wanted to replicate the real life clinical experience for both the child and myself.

I had planned that after each session, I would write detailed notes of everything that had occurred within the session. Beginning from when I collected the child in the waiting room, until when the child and I returned to the waiting room at the end of the session. However, due to my clinical and working commitments, I was only able to write all of the notes for one of the participants directly after the session. For the other two participants, the majority of the notes were written after a few hours. However, all of the notes, for all of the participants were written on the same day as the session.

Data collection

All the data was collected from children referred and seen within one setting, a specialist refugee service within CAMHS.

Work setting

The Refugee Service is within a NHS clinic, which is in a large city in the UK. The building itself is quite large, and does look like an official building or institution.

Inside, the child and family department comprises of a colourful main waiting room, and clinical rooms. The clinical rooms are decorated in neutral colours, and have plain walls, carpets, wooden doors and a large window. Each room has a sofa, two armchairs, one large table and one small child's table, with a chair each to match and a bin. In the room, I had placed a box of toys (see appendices for a list of the full contents), a doll's house, a pillow and a blanket, which are all items which I use as standard practice in child psychotherapy assessments with latency aged children.

Ethics

Ethical approval for a prospective research study was sought from a NHS ethics committee (LREC). This was then ratified by UEL's Research Ethics Committee (see appendices).

The assessment method was very similar to standard child psychotherapy assessments, which are part of the ordinary assessment and treatment offered to children by child psychotherapists within the Refugee Service. However, as with all assessments with this group of vulnerable children, I paid careful consideration to the impact of short term assessment, in particular with regard to issues of the use of the transference, differences in culture, levels of trauma, previous relationship to institutions and other issues affecting families and children who are Refugees, for example, legal status in the UK, physical health.

I also paid careful attention and consideration to issues of power, authority, class and culture and gender. I agree with Singh and Keenan, S. (2010) who believe that power and difference between researchers and participants should be acknowledged and reflected upon. I was aware that as a British, professional, white, woman, I have my own beliefs, and that I would also be viewed and experienced in ways that I was both conscious and unconscious of. The issue that I am most conscious of when working with refugees is that I represent and work in an institution. The families may believe that myself and the institution has the power to affect them in both positive and negative ways, depending on their previous experiences of institutions, in their own countries and their journey to

and life in the UK, (for example, worries about confidentiality in regards to the Home Office and their application to remain in the UK, or housing or education). Though I always address this carefully and sensitively with families, it is something that I am aware is a power difference in the clinical work, and therefore also in this research.

The other issue that I am aware of is that I am living in safety, in my own country, with my family and friends, in a stable housing and work situation. I am also living within a different culture and community to the children and families who are refugees, which again, I am aware of, but unconsciously this will also have an impact on my work and the families.

Confidentiality

All identifiable information has been changed in the process notes, analysis and the thesis.

However, the thesis has used detailed clinical material to illustrate the findings and discussion. In addition, I have not been able to change the family context completely without affecting the analysis and discussion of the findings.

Therefore, to ensure complete confidentiality to the children and families, I will apply for a Confidential Status Request (through UEL) so that the thesis cannot be accessed online, and a paper copy will only be available with permission. If appropriate, I aim to publish the findings of this research in a later paper, in which I would not use detailed clinical material and I would amalgamate the details of the participants to fully protect the anonymity of all of the children and families.

Consent

Consent was sought by a member of the multi-disciplinary team not involved in the research. Depending on their age and capacity (Gillick competency) to consent, consent to participate was gained from the child and their caregivers. Detailed information sheets were provided in English and an interpreter was also

offered if needed, so that parent(s) were able to access full information about the research.

I had planned that if a child or their family declined to participate or changed their mind during the course of the assessment, that it would not affect the assessment or their future treatment in any way. This was carefully explained to the child and family by the clinician and was also in the information sheets.

Information sheets were also made available to the children if their parent(s) wanted. These were different to the adult information sheets and were in age appropriate language and terminology. The parent/caregiver and the child were given time to decide (1 week) and to ask further questions before asking for informed, written consent. For all three participants, the parents chose to give informed consent on behalf of their children. For each of the children, I asked for their assent (rather than written consent) (Singh and Keenan, S., 2010), and I asked the children that I would like to meet them on their own to understand them better and if they agreed to this? All of the children said yes, though of course, it is important to acknowledge that they said this in the knowledge that their parents had agreed to this. I did let them know that if they did not want to, then we could continue to meet with me and their parents or with the other clinician (examples of the information sheets and consent form are in appendices).

Participants

Three participants, all aged 9 years old, 1 female and 2 males, were recruited from within the Refugee Service. Participants were born outside the UK and were from three different countries from the same geographical region. All three had arrived with both parents, though 1 of the boys now only lived with his mother as his parents had subsequently separated. All were attending primary school. The families of all three had different status to stay in the UK, from waiting for asylum to be granted, 5 years leave to remain and indefinite leave to remain. All of the participants had a case consultant clinician within the service, who was separate to this research and who worked with the family and held clinical responsibility during the research. All of the children seemed to have a sufficient understanding

of English and did not want an interpreter. All of the parents were offered an interpreter but only one parent felt they needed and wanted an interpreter present for their meetings with myself and the CAMHS clinician.

The inclusion criteria for participants were as follows:
Children had to be referred from within the team or from external referrers (GP, Social Services, School).
All children had to be registered with a GP.
Children had to be within the age range of 6 to 12 years old.
Children had to have been born outside the UK and are currently living within the UK.
Children had to be living with at least one parent or caregiver with parental responsibility or guardianship.
Children and families were not excluded if they required interpreters.
Children and families were not excluded if they did not have leave to remain in the UK

The exclusion criteria for participants were as follows:
Age
Children born in the UK
Unaccompanied children
Children for whom there were ongoing safeguarding and/or risk issues.

Recruitment

When I designed this research, I hoped to recruit 4 to 6 participants, but unfortunately, recruitment was more difficult than I had anticipated. During this time, the service received a high number of referrals for unaccompanied children and accompanied children for whom there were complex safeguarding issues or accompanied children who were second generation refugees.

Method of data analysis

As I have described, the data collected in this research were the individual session notes for each child, from each of the 4 assessment sessions.

There are various types of methods for analysing qualitative data (Silverman, 2000), including interpretative phenomenological analysis, IPA, (Smith et al, 1999), grounded theory (Glaser and Strauss, 1967) and thematic analysis (Braun and Clarke, 2006). IPA is commonly used in psychology research and has been described as being a good method when the data sets involve people's own accounts and perceptions, that have been collected through semi-structured interviews or narratives. I chose not to use this method because my data set would include observations and reflections, as well as verbal material. I was concerned that if I only used a method that could analyse verbal material then it would limit what I could capture and understand in the material, as much of the material may be non-verbal communication and behaviour. This issue is discussed in more detail by Midgley (2004).

Grounded theory, developed by (Glaser and Strauss, 1967), has been used as a data analysis method in recent child psychotherapy research (Rustin, M.J., 2016). The technique aims to identify theory from the data by an inductive method, which is a close and systematic examination of the data set. Despite its use in previous child psychotherapy research, I have not chosen to use grounded theory for the data analysis in this research. I have chosen to use a thematic analysis approach which is proposed to offer more flexibility, not be bound to a particular theory and be more accessible to less experienced researchers (Braun and Clarke, 2006).

I chose a data-driven method of thematic analysis, in which I analysed the data using the raw material, and identified themes within each subsample and then compared the themes across the samples (Boyatzis, 1998, Braun and Clarke, 2006). Thematic analysis is thought to be helpful to identify and understand both the 'manifest-content' and the 'latent-content' of the material at the same time (Boyatzis, 1998), *"manifest-content can be considered the analysis of the visible or apparent content of something…latent-content analysis is looking at the underlying aspects of the phenomenon under observation"* (pp. 16).

I shall now describe the methodology of the data analysis, using thematic analysis, in more detail.

The data set comprised of 12 data items (for each of the 3 participants, I had 4 sets of notes from each of the assessment sessions). The participants were seen over 3 time periods (due to recruitment) and the entire data set was collected over 21 months. I decided to wait and analyse the data set in one time period, so that I could ensure that I used exactly the same methodology for each participant. I then examined the session notes in chronological order for each of the participants.

To begin with, I read, re-read and re-read the material many times, to initially try to get a sense of the themes and content of each session (Boyatzis, 1998, Braun and Clarke, 2006). At this stage, I did not ignore any ideas or comments that I had; I made an initial note of things that came to my mind as I read the material. Because the data set was relatively small, I decided not to limit my analysis to any certain sessions, or parts of the sessions. I aimed to try to examine and analyse the whole of each session, for each individual participant and be able to make links within the sessions for each of the participants, as well examining ideas within the participants as a group. In this way, the analysis was inductive, as I examined and coded, *"the data without trying to fit it into a pre-existing coding framework.. in this sense, this form of thematic analysis is data-driven"* (Braun and Clarke, 2006, pp. 83).

After this initial phase, I then began to generate initial codes for the data. I did this by working, *"systematically through the entire data set, giving full and equal attention to each data item and identify interesting aspects in the data items that may form the basis of repeated patterns (themes) across the data set"* (Braun and Clarke, 2006, pp. 89). I separated the transcript into descriptive codes (for example, 'action', 'observation', 'speech by me' etc) and then described what these related to (for example, 'boundary', 'relating to me', 'relating to family' etc). I then analysed these individually and began searching for themes by reading the material again, with my codes and analysis, examining if they were linked to each

other or other material. From these codes and analysis, I then identified main themes and organised them in ways that related to the structure of a child psychotherapy assessment. This enabled me to investigate and analyse the content for each child and theme in further depth, whilst still allowing me to be able to compare the themes for each child. Within these central themes, I was then able to organise the material further into sub-themes. An example of the analysis of a session can be found in the appendices.

Definition of main themes and sub themes

I shall now define the main themes and the sub-themes which I identified in the data analysis. The three main themes relate to the key principles of a child psychotherapy assessment, which are; 1) how the child and family relate to the structure of the assessment, 2) how the child relates to me and the institution 3) how the child relates to their own self and 4) how the child relates to their external experiences.

Theme 1: How the child and family relate to the structure of the assessment

One of the three main themes was how each child related to me and the structure of the child psychotherapy assessment.

Sub theme - Beginnings

In the data analysis, a sub theme of 'beginnings' emerged. I defined the beginning of each session as the time the session was due to start and analysed the data in relation to everything that happened at that time. This included if the children were brought on time, their behaviour in the waiting room with their caregivers and other people, their reaction to seeing me, the walk to the therapy room, their initial behaviour, speech and manner when they first got in to the room.

Sub theme - Endings

As with the beginning of each session, the data analysis also revealed that the end of each session was another sub-theme. In the data analysis, I defined the end of each session and the data associated with it as; when it was time to pack up, the preparation for the end of the session, the return to the waiting room and then the goodbye with the child and child meeting their caregivers and then leaving the waiting room.

Theme 2: How the child relates to me and the institution

Sub theme - Transference and re-enactment

The data analysis also revealed a sub theme of 'transference and re-enactment.' This sub theme emerged through the data about how the child related to me. In child psychotherapy assessments, the way a child relates to you is thought to be an indication of their previous and ongoing, internal and external relationships and experiences, i.e., what they 'transfer' on to the therapist, and what can get 're-enacted,' can help the therapist understand what the child's experiences and expectations are, and have been of adults and themselves.

Sub theme - Behaviour

During the data analysis, the final sub theme within this main theme was identified as 'behaviour.' This was data that related to the child's behaviour, including their behaviour with me, with the materials provided and their behaviour in the room and in general.

Theme 3: How the child relates to their own self

The second main theme that emerged from the data analysis was how each child seemed to understand and relate to their own selves. Analysis of the data identified three sub themes within this:

Sub theme - Identity

A sub theme that emerged was one of 'identity.' Data from each child psychotherapy assessment session gave me information about how each child viewed themselves, and how they wanted to be seen by me.

Sub theme - Denial

The data analysis produced an interesting sub theme of 'denial', about how each of the children related to their own needs and how they understood and denied these needs.

Sub theme - Deprivation and loss

The third sub theme within the main theme of how a child relates to themselves was a sub theme of 'deprivation and loss'. The data analysis showed how the children understood themselves and responded, in relation to any losses experienced.

Theme 4: How the child relates to their external experiences

The final main theme that I identified in the data analysis was how each child related to their own external experiences, including previous experiences and ongoing experiences in their external world. Within this theme, there were three sub themes:

Sub theme - Parents and family

This sub theme concerns how each child understood and related to their parents, family and how their parents related to them and the child psychotherapy assessment.

Sub theme - Housing and school

Another sub theme which I identified was the external issues of housing and school for each child.

Sub theme - Refugee issues

The final sub theme which I identified was how each child related to their refugee experiences.

Validity

In this chapter, I have set out the design and methodology of the data collection and analysis. I have described my reasons for choosing the design and methodology and why I believe it enabled me to investigate my research question. However, the design and methodology is not without limitations, which could affect the validity of the findings of this research. I will discuss some of these issues now.

One of the main criticisms of qualitative research has been that it could be influenced by the subjectivity of researcher and what they project onto the material (Boyatzis, 1998). This is certainly a risk to this research, especially as I was a sole researcher, and had been responsible for the idea and undertaking of the research. I had sought and used supervision to help me design the methodology, but I was the only person who both collected and analysed the data.

However, McLeod (2001) emphasised the importance of critical reflexivity acknowledging that, *"qualitative research is a personal activity, involving a personal struggle to challenge assumptions and achieve understanding, and usually also involving entering meaningful relationships with people who are the research 'informants' or 'participants"* (pp. 195). McLeod proposes that subjectivity can contribute to the research, if the researcher is aware and employs 'critical reflexivity' of their practice and work. This idea is very similar to a central technique of child psychotherapy, in which, we are constantly reflecting on our own feelings and the child's states. Though of course, it is important to acknowledge, that even with our own personal psychoanalysis, there will be areas that we are not aware of and therefore, supervision and speaking with

colleagues and remaining open to meanings, help ensure these 'blind spots' can be acknowledged and thought about.

One of the key research tools in this design was the observation and recording of my own thoughts and feelings in the individual sessions with the children. The use of countertransference as a research tool has been debated (Rustin, M.J., 2011). Some researchers (Hollway and Jefferson, 2000, Walkerdine et al, 2002) believe that an openness, awareness and acknowledgement of subjectivity can contribute to the research, through trying to understand the transference and countertransference as a therapist would with a patient.

Whether the therapist as a researcher is a reliable and therefore valid research tool, has also been discussed in regard to the use of case studies. Midgley (2006) discusses the use of the single case study and describes three main criticisms that this method faces. Firstly he address, *"the data problem"* (pp. 126) and asks are therapist's own notes a reliable and valid source of data? This is an important consideration. In this research, I did not audio record or video record my data. I felt that both audio and video would be too intrusive and would not add any detail as I was interested in the way the child related to me and what feelings were evoked in me. I felt I would miss this if used methods that I do not routinely use in clinical practice. Also, previous work has reported that session notes are as similar to audio notes, with, *"no major discrepancies"* when compared with each other (Trowell et al, 2003, pp.158).

The second issue that Midgley (2006) discusses is, *"the data analysis problem"* (pp. 126). He recommends that research should use, *"systematic ways of analysing the clinical data"* (pp. 132). As I have described, I chose to use thematic analysis as a way of systematically analysing my data. However, I am aware that this was the first time that I have undertaken such a data analysis and the first time that I have used thematic analysis. Although I used the clear guidelines set out by Braun and Clarke (2006), the findings may still be limited in regards to this.

The third issue relating to validity that Midgley describes is, *"the generalisability problem"* (pp. 136). He asks if findings from single case studies can be applied to whole populations. I addressed this in a small way by using three case studies, of same age, and of both genders. For ethical reasons, I did not select the participants for the research, other than the inclusion and exclusion criteria. This research was interested in both the individual differences and commonalities between the children, although the children were all from different countries within the same geographic region.

As I have just discussed, this research does have some limitations relating to the methodology I chose. However, whilst these limitations may have effect the validity and generalisability of the findings, I also believe that the methodology has a number of strengths that make it a relevant piece of research to investigate my research question. Its design is based on a 'real life' experience of a child psychotherapy assessment with refugee children, and so I propose that this is a valid method to use to try to understand the individual needs of refugee children and if or how these needs can be identified in child psychotherapy practice.

In this chapter, I have described the research methodology that I chose and used in this research. I have discussed the reasons behind the choices I made regarding research design, methodology and data analysis. I have also discussed some of the issues relevant to the validity and generalisability of the findings. In the next chapter, I will present and discuss in detail, the main findings of this research.

Chapter 4) Research findings

In this chapter, I will describe the main findings from the thematic analysis of the individual child psychotherapy assessment. I will describe each child psychotherapy assessment separately and I will explore how the themes and their sub themes manifested for each child (I have defined and described these themes and their sub themes in the previous chapter). To conclude this chapter, I will compare and discuss these findings as a group, highlighting the differences and commonalities in how the themes and sub themes manifested across the three participants.

I have chosen to present the findings as three case examples because I wanted to ensure that each child could be clearly described and understood as an individual. I was concerned that for this research, presenting the findings as different groups of themes may have risk losing sight of each individual child, as well as being difficult for the reader. I will now describe the 3 individual assessments, including information about the background and reason for referral, as well as the themes identified from the individual session.

Description of the individual child psychotherapy assessments

Participant 1: Ebi, "It's ok, the table at home is wobbly and I am good at drawing."

Referral:

Ebi was referred for a child psychotherapy assessment by the Educational Psychologist in the Refugee team, to contribute towards the generic CAMHS assessment she was undertaking with the family. Ebi was referred by his GP, due to his parents' concerns about his challenging behaviour at home, his emotional difficulties and his unexplained physical complaints (stomachaches, headaches).

Background:

Ebi was 9 years old at the time of the child psychotherapy assessment. He was an only child and lived with both his parents in a large city in the UK. The family were from a country in the Middle East and had fled 3 years previously, when Ebi was 6 years old. They did not speak about their journey to the UK. Their extended family still lived in their home country and they only had contact through phone and the internet. The family were waiting for 'leave to remain' from the UK Home Office and as such, they were living in temporary NASS (National Asylum Support Service) accommodation with another family and had been moved numerous times, which had resulted in Ebi moving schools frequently.

Ebi's mother suffered from depression, migraines and was on medication prescribed through the local adult community mental health team. Ebi's father presented as under significant strain and anxiety. Ebi's mother did not speak much English and was socially isolated. Ebi's father spoke good English but was also relatively socially isolated.

In their home country, Ebi's parents worked in professional roles. They had had close contact and support from their extended family. Ebi's parents reported that Ebi was born at full term, after a healthy pregnancy and that he had been a healthy baby with normal development. Ebi was attending a primary school and was reported to be doing well and school staff had no concerns about his behaviour or emotional state.

Ebi's parents gave consent for Ebi to be seen for an individual child psychotherapy assessment and for this to be included in this research. They requested that this was completed during the summer holidays from school so that he would not miss lessons. I met with Ebi and his parents for an initial meeting with the Educational Psychologist and we arranged the dates for the 4 individual appointments and the follow up review appointment with Ebi's parents, once I had completed the child psychotherapy assessment. In this first meeting, Ebi seemed shy and quiet but interested when I spoke about wanting to try to

understand how to help him and his parents. He agreed to meet with me on his own.

Summary of assessment

Ebi's mother and father brought him to the first appointment and then his father brought him to the remaining three appointments. The first three appointments were a week apart and the final appointment a fortnight later due to my annual leave. All of the appointments were attended late, his father had seemed supportive of the assessment, but overwhelmed with other issues.

Ebi presented as highly anxious and inhibited in the assessment, which affected his ability to speak and play. Initially it seemed as if this related to being separated from his parents but also being on his own with me in the therapy room. I experienced powerful feelings in my countertransference of wanting to do more, provide more, in response to feelings of deprivation and loss. Over the course of the assessment, he became more relaxed with me, but still with high levels of anxiety and inhibition in his play and verbal interactions. He seemed to use denial and self-sufficiency as a defence against his anxiety. He did not actively seek my attention, instead, he focussed on drawing two 'aliens' and initiated and completed two types of 'sorting tasks' (arranging furniture in the doll's house and tidying up the toy box) in the sessions. The main sub theme of his sessions was the impact on him of his parents' state of mind and difficulties relating to being refugees in the UK. I felt that he could have benefitted from individual work at a later stage, once his parents had received mental health and social support in their own right, which would then result in them being in a better position to support individual work for Ebi.

Theme 1- How the child and family relate to the structure of assessment

Sub theme - Beginnings

The assessment and data analysis revealed that for the Ebi, the sub theme of 'beginnings' manifested as lateness. He was brought significantly late for every

appointment. For the first session, I had re-arranged the time at the parents request and so I was surprised that they were late, with no notice:

> *Session 1: Ebi attended with both parents, they were 15 minutes late, and despite me offering a later appointment from the 9.30am I had originally offered. Ebi was stood near the bookcase in the waiting room, his parents were stood near the other chairs, near the window. I said hello to them all, smiled at Ebi, his father apologised for being late, saying, "we are a late family."*

The vague and unclear explanation for them being late continued in the next session and it led to a feeling of deprivation and provoked strong feelings in me of wanting to do much more for him. I was also aware of being left with strong feelings frustration and that the assessment was not valued:

> *Session 2: Ebi attended with his dad, they were 25 minutes late. I had just called to see what had happened and his father said they had just arrived. I was aware of feeling annoyed, that there seemed a lack of respect for appointment with no phone call to say that they were running late. I went to the waiting room and then they arrived. I said hello to them and smiled at Ebi. His father apologised for being late, he said something about they are always late and then that Ebi had felt very tired this morning, he was late getting up.*

I was also aware each week of Ebi's father appearing and reporting being under great strain and stress. I did not know if the lateness was related to this or due to other issues. Unfortunately, my colleague who had referred the family was not able to see them during some of the assessment as she was away. I was aware of feeling concerned about Ebi's parents and wondered if bringing him was very difficult or provocative for them without their own support:

> *Session 3: Ebi attended with his dad, they were 20 minutes late and Ebi came to the door of the waiting room when they heard me coming. His dad looked tired, Ebi looked a bit brighter, his father had his arm*

around Ebi. I said it was good to see them and I asked how they were? I was hoping for an explanation about why they were late. His father said ok, but he had woken up with a pain in his neck, very stiff, couldn't move it. He did seem in pain. I said I was sorry to hear that, Ebi's father nodded. He took his arm away from Ebi and I said we would be meeting in the same room, that we had half an hour.

Ebi's own response to their lateness was difficult to observe. In the first two sessions, I wondered if he was relieved and whether he had had a more active role in making them late to avoid the anxiety he felt in the session. In the last two sessions, when he seemed more relaxed with me, it felt as if he denied that it had any impact, or that he minded. In all of the sessions, it seemed for both Ebi and his father, that I was the one who was left feeling the frustration and the confusion about the loss of his time. This denial was also present in another sub theme that emerged, relating to endings and goodbyes, which will now be discussed.

Sub theme - Endings

The sub theme of 'endings' did not manifest as strongly with Ebi, as with the other children, (which will be described later). However, an avoidance of a goodbye was still present and I think meaningful for him. I observed that by the final session, he had become more relaxed with me and able to request something and that he had a sense of something valuable which had been offered:

Session 4: Ebi looked at his folded paper and asked could he take this home? He wanted to finish it. He asked again, and seemed to want to take something with him, but I also wondered if it was a card for his parents, perhaps his mother. I asked what he wanted to do, could he make one at home? He shook his head, "it's a card." I let him take it and wondered why. There was a sense of him wanting to take something (though again it felt unsubstantial) and wanting to do something for his parents. It was time to finish, we walked back to waiting room, Ebi's father thanked me, and confirmed they would

attend the parent review meeting on Friday. I said goodbye and Ebi was looking at bookcase and did not look at me.

It felt as if at the goodbye, Ebi needed to focus on something, the bookcase, as a distraction and to avoid saying goodbye to me. Perhaps he also wanted to take something home with him, the card, as a response to saying goodbye after the deprivation of not having all of his time in the session. Ebi's avoidance and denial of his feelings and anxieties did not mean that the sessions were devoid of feelings. In contrast, I was often left with powerful, vivid feelings and thoughts, which I observed closely in my countertransference as part of the assessment. I thought about these feelings and how they could help me try to understand how Ebi related to me in the transference relationship; what type of person he expected me to be and experienced me as. This sub theme shall now be examined.

Theme 2: How the child relates to me and the institution

Sub theme - Transference and re-enactment

For Ebi, the sub theme of 'transference and re-enactment' manifested as interrogation. Ebi appeared highly anxious in the first assessment session, and at first I thought this related to being apart from his parents and being with someone new:

Session 1: Ebi seemed to sit a bit more easy on the sofa, but still seemed nervous and quiet. I was aware of feeling anxious that the beginning had been a bit rushed and whether I should have asked his parents to stay. I felt aware of wanting to reassure him and to tell him that we could go and see his parents if he wanted. I held onto this thought for a minute and he began to look around the room and at the toys or door, it was hard to tell which, they were both in the same

direction. His lips moved and it seemed as if he was counting in his head, or saying something to himself and glanced at the door and then back to the toys.

He did not respond when I addressed his fears in the first meeting; something which I am well accustomed to in the ways I relate to children in their first sessions. It was unusual how anxious he was and I became aware that I was drawn into a very active role, asking him questions about his fears:

Session 1: I asked again about other times when he got worried or scared and he looked back at me but didn't answer. I said maybe there were other times, but he wasn't sure if he wanted to tell me about it yet. He nodded. I said I wondered why? He looked away. I said maybe because I was still a very new person? He nodded. I asked if he felt scared when he talked about things that worried him? He looked confused, and I explained that for some children, even talking about what worried them, made them feel worried. He shook his head, said "no." I asked about when he feels worried, what happens? Does he feel it in his tummy, his body, thoughts in his mind? He shrugged and said, "I just feel it." He squeezed the water bottle and I felt aware of my questions. I said maybe I was asking him too many questions. He looked at me without saying anything. I said I was thinking that meeting me on his own was new for him and maybe he was feeling very unsure about it and wondering what it was about and who I was and what he was supposed to do.

I had expected that Ebi would feel a bit more relaxed in the second session. I thought I had worked hard to address his worries in a careful way and that he had seen the toys and would know what to expect in the next session. On reflection, this seems very naive; that in this moment, I assumed that being a 'nice' person, who addressed his fears, provided toys and had an interest and desire to help him, would be sufficient in reducing his anxieties. However, in the second session, I was just as active in asking direct questions, and I was left with a strong feeling of 'interrogating' Ebi:

Session 2: Ebi looked back at his water bottle and I said maybe it still felt confusing to know who I was and what coming here was about… …and having to come here this morning and now here I was asking him really difficult questions! He looked at me and nodded. I said maybe he really didn't want to come this morning and he had felt really annoyed at having to come here! He nodded a little, then quickly looked back at the water bottle and seemed to murmur to himself. I said maybe he felt worried when he felt annoyed or angry? He looked up, shook his head. I said I was thinking about when he gets annoyed and angry, what happens? Does he go very quiet? He shook his head... ..I felt a bit at a loss how to proceed, aware that I was asking a lot of questions, and it felt a bit like an interrogation.

After observing my own feelings and thinking about them, I was more aware and concerned about this role that I had been pulled into; of interrogating Ebi. I wanted to think and understand more about this and so I spoke to my colleague who was working with the family. I asked if the parents had had any previous experience of torture and interrogation and she said no. I was left feeling disturbed, concerned and confused about the high levels of anxiety that Ebi was displaying with me and the feelings being projected into me. I wondered if I was being given an experience of how he understood his current experiences in the UK, with parents who were highly stressed and whether having so many changes in his life had left him feeling confused and disturbed.

However, much later, after the assessment was completed, I spoke again to a different colleague who was working with the parents for parent work (one of the recommendations from my assessment). The clinician informed me that both parents had had periods of imprisonment and torture in their home country, which they had only now been able to speak about. He thought that there were still other traumatic experiences that they had had, that they could not speak about, perhaps both in treatment sessions and between themselves.

It seems likely that Ebi's anxiety in the room with me was in part related to his own fears and experiences, and also my own anxiety at the first assessment of this research. However, also, perhaps the experience of him being seen on his own, and taken into a room, had brought back traumatic memories for his parents, that were then unconsciously projected into him. This may have resulted in their trauma being transferred and partly re-enacted in the child psychotherapy assessment. Perhaps in response to this, Ebi not only appeared anxious in sessions, but also understandably, on his 'best behaviour.' The sub theme of behaviour and how it manifested in Ebi, shall now be described.

Sub theme - Behaviour

For Ebi, the sub theme of 'behaviour' manifested as being on his best behaviour with me. Throughout the assessment and data analysis, it felt striking to me that my experience of Ebi did not match the child that his parents had described to my colleague during the generic assessment that he was angry, rude, disobedient, particularly towards his mother, but also to his father at times. In contrast, during the assessment, he appeared on his 'best behaviour' with me:

> *Session 1: Ebi took the bright green plasticine strip and looked at it, then folded it together, squashed it together… …He slowly rolled it out, seemingly softening it up, but I also had a sense he wasn't quite sure what he wanted to do with it, he was trying it out. I commented on it being stiff and needing warming up and softening, he nodded. Again I wondered to myself if he wanted to play with it, or if he felt he was expected to, was he being a 'good boy?' He then seemed to roll it with a bit more of a sense of purpose or agency and squashed it into a oval shape. He glanced over at me, which felt as if he was looking to see what I was doing. I commented that perhaps he was wondering about what I was doing, maybe he had not met someone who was quiet at times, and maybe I was different to his teachers or other adults. He nodded firmly.*

The way the child relates to the therapist is one of the central aspects to a child psychotherapy assessment. Ebi seemed confused about who I was and how to relate to me. It seemed in his mind that I was someone he had to be careful, cautious and good with, perhaps similar to his teacher in school. In turn, this then meant it was difficult to know how Ebi then understood himself. Was he on his best behaviour because of his anxiety about me and the assessment or was this also how he understood himself? Did he see himself as a 'good boy' and so keen to show me this? How he understood and related to his own self is the third main theme that emerged in the data analysis and how this manifested in the sub themes for Ebi shall now be examined.

Theme 3 - How the child relates to their own self

Sub theme - Identity

The data analysis and assessment showed that for Ebi, the sub theme of 'identity' manifested as feeling 'alien'. As I have described, Ebi was highly inhibited with me in the assessment sessions. I initially understood this to be related to his anxiety, but in the first session, he was also able to tentatively use the plasticine to perhaps express how he experienced me and/or his own self:

Session 1: Ebi put the green oval lump of plasticine on the table and carefully peeled off the other plasticine strips which were different colours. He attached 4 of them to each corner, so it looked like a body with arms and legs. He didn't do anything to the strips, other than push them on, it still felt quite passive and inhibited. He then took a pen and pressed the end into the body to make 4 little holes. I commented on he had had an idea, what had he made? He looked at me seriously, and said, "an alien." I silently wondered if I was the alien or whether all of his experiences felt very alien to him. I asked more about the alien. Ebi said, "he is a policeman alien." He then tried to lift him up and the legs fell off. He didn't show much response or disappointment. It felt

as if the alien wasn't really that important for him, or he wasn't keen to talk more about him, but there was also a flicker of disappointment.

His lack of response had made me wonder if the alien was significant for him but this figure then reappeared throughout all of the sessions and he drew two pictures of the same alien. He was not able to verbalise any of his thoughts or feelings about the alien. I had to initially rely on my observation and countertransference:

Session 2: I said we didn't have much time left, but were there other things that he wanted to do? He looked at the box, and said "my alien picture." I said he remembered doing that last week, it was in the box… …He silently drew and I thought about the alien and how out of touch, out of my depth and anxious I felt and how alien I must seem to him, how hard it was to make a real connection and my anxiety about separating him too soon from his parents.

I wondered if my countertransference was also an indication of his own anxiety and disconnection. By the final session, he seemed more comfortable with me and the alien had become a happier and more relaxed alien:

Session 4: I think I asked him about if he remembered he would be coming today, how he felt about coming and seeing me? Was I someone scary? "No, someone to help,'" he said firmly. As I talked about his picture he took a pen and drew a smiley face on the ninja alien picture and asked if he could take his pictures home.

I thought that the alien was both a representation of how he understood his own identity and his experiences in the UK. But also, an indication of how he experienced me and I was also the 'alien.' Both these states seemed to create confusion for Ebi about what demands he could allow himself to make of me. This

was another sub theme that emerged in the assessment and data analysis; he did not relate to himself as a child who needed or could make any demands from me. This shall now be described.

Sub theme - Denial

The sub theme of 'denial' emerged in the assessment and data analysis. With Ebi, this manifested as a denial of his own needs. This led to remarkable levels of self sufficiency and resourcefulness:

> *Session 3: Ebi finished colouring in the alien, and as with the pens, he seamlessly took out more paper and chose another colour pen. He took out the toy mobile phone, looked at it, and used it to draw straight lines. I wondered why he didn't ask me, or look to see if the ruler was in the box. He then took out a piece of plastic doll's house furniture and he used the toy chest of drawers to draw smaller straight lines… …I was also thinking about his own resourcefulness, finding something that did the job, something that he could provide for himself, without making any demands on me, or perhaps also rejecting or mistrustful of what I could offer.*

I thought his self sufficiency seemed to be closely linked to a denial of his own needs and frustrations, which again emerged repeatedly in the sessions and data analysis:

> *Session 4: He carefully selected pens, pencils, took out the long ruler, looked at the ball and cursorily looked at some of the other toys, but quickly went back to the paper and ruler and drew some lines. I noticed that the table was wobbly and I felt the pull of wanting to get up and sort it out straight away but I stopped myself, and wondered what he would do. He continued as if he hadn't noticed it, or was ignoring it.. …The table wobbled a little bit again, (not hugely) but I commented on*

it, saying the table was wobbly. Ebi nodded. I asked if he wanted me to try to fix it. He shook his head and said, "no," without looking at me, concentrating on drawing his straight lines. After a few more minutes, I asked if it was hard to draw lines on a wobbly table? Ebi nodded. I said I was wondering why he didn't want my help to try to fix the table and stop it wobbling. Ebi said, "it's ok, the table at home is wobbly and I am good at drawing." He said this without looking at me. I commented on the wobbly table at home and the other things that I knew needed fixing at home. Ebi nodded. I said last time we had met it had been the door. Ebi nodded said, "its fixed now but…" I asked what he thought about that? He said, "my dad said it is fixed but he thinks it will just break again." I asked Ebi what he thought? He said firmly, "I think it will break again." He continued with his picture as he said this, he didn't make any eye contact with me, and it seemed as if he had given himself a task to do, by himself, not needing anything from me, and without expecting that I would want to know about his picture, or share the experience with him. I wondered whether this task was to help with anxiety or more related to his expectations and experiences of adults.

This denial of his own needs and the impact on him, seemed to be a defence against any disappointment, or frustration that he may have felt towards me and my power to be able to provide things, or to fix things or to be able to be interested in his creativity and thoughts. As well as a denial of his own needs, Ebi also denied the impact of any deprivation or loss on himself. This was another sub theme that emerged in the assessment and data analysis, which I shall now describe.

Sub theme - Deprivation and loss

The sub theme of ‘deprivation and loss’ for Ebi, manifested as projection of deprivation and loss. During the assessment, I was aware of the deprivation and loss of time in the sessions, due to Ebi arriving so late. It provoked a very strong response in me of wanting to give more and do more, particularly of time in the first session:

> *Session 1: I also felt aware of the time, that we only had 5 minutes left and I felt strongly pulled into wanting to offer more time, to extend the session, it seemed as if he was finally starting to relax a little, and that it seemed too soon to finish, too soon to say it was time to finish and too soon to have to make the long journey back to their house. This dilemma became even stronger, when Ebi finished his sorting out the furniture in the doll’s house and reached into the box and took out a piece of purple paper and sat down, to draw. I said it would be nearly time for us to finish, we had 5 minutes left before it would be time to say goodbye and then I would see him again next week. Ebi didn’t seem to pay attention and he was carefully drawing a circle, drawing around the roll of sellotape with a pencil.*

During the assessment, it felt as if I was the only one feeling such powerful feelings about this loss and it seemed as if it didn’t really matter for Ebi or the family. However, the data analysis revealed that for Ebi, his response to his deprivation and loss seemed to be to minimise or deny the impact on himself. I became more aware of what was being projected into me by both Ebi and his family. I was aware that I was the one who was left feeling confused and unsure of myself and wondering if I was doing something cruel or ordinary:

> *Session 2: I was also aware of the dilemma of wanting to give him more time, he seemed increasingly relaxed drawing his alien and I was aware of feeling cruel and withholding at having to say it was time to finish. I felt anxious and cross at myself for feeling confused about research vs normal clinical practice and remembered that in normal clinical practice, I wouldn’t give more time and I felt a growing awareness of how the sympathy I felt for the family, masked their*

disrespect, neglect and devaluing of what I could offer and what Ebi needed.

This led to a tremendous pull in my countertransference of wanting to do more and more and more, perhaps in compensation for the experience of deprivation, loss and frustration. It was so strong with Ebi, I had to closely observe my countertransference and frequently had to stop and think, before rushing into action. The way that this sub theme manifested recurred frequently in the data analysis, throughout all of the sessions. It did not just relate to wanting to give more time, but a countertransference of wanting to give more of everything, that any frustration could be felt as an unbearable deprivation:

Session 3: After a few minutes [of Ebi colouring in the alien], I became aware that the red pen seemed to be running out and I was aware of wanting to immediately offer to go and get another one, that it just felt as if finally he was feeling a bit more settled and now the pen wasn't even working and that I couldn't even provide that for him; the basics. I thought about this, and I was curious to see how he would react and I was aware of this strong feeling in me of wanting to provide, to make everything ok, to make him feel comfortable with me.

I understood my countertransference of wanting to provide and be a 'good therapist' to be a result of Ebi's denial and minimising of his own losses and deprivation and perhaps his expectations of adults. For Ebi, this was likely to be linked to the losses he experienced in his internal, but also his external experiences; his extended family, his home and his experiences as a refugee. This is the third main theme identified in the data analysis and the sub themes within this shall now be examined.

Theme 4 - How the child relates to their external experiences

Sub theme - Parents and family

The data analysis and assessment showed that for Ebi, the sub theme of 'parents and family' manifested as parental mental health. I observed Ebi's parents to be very anxious and protective of him and they clearly loved him dearly and wanted the best for him. I was aware that Ebi's mother was receiving treatment from the community adult mental health team for depression.

However, throughout the course of the assessment, I became increasingly concerned about Ebi's father's mental health and state of mind and I knew he was not receiving any adult mental health work. From analysing the material, at the beginning of each session, he appeared under increasing strain and stress due to housing issues, not being able to work and concern for his wife and son. By the end of the assessment, he seemed to be struggling with having so much to look after. Ebi often responded to his father's distress and strain by turning away, distracting himself and not making any demands from him, as he did with me in the sessions:

> *Session 4: I said hello to Ebi and his father. His father looked tired and stressed. Ebi smiled at me shyly and then looked away and turned to the fish tank when his father asked how I was and asked if it would be possible to use my phone, saying something about he couldn't find his phone, maybe he had left it in the shop or at home. I said of course, and asked the receptionist if we could use the reception phone.. ..and he dialled his number. Ebi continued to look at the fish and I felt aware of this being yet another thing getting in the way of starting the session, and I was concerned at his father's state of mind. Ebi's father said there was no answer, perhaps he had left it in the shop.. ..I said that we would meet now and his father encouraged Ebi to go, "saying see you soon," and then after a moment, "'take care." I felt sad as his father said that, it seemed so unsubstantial, so poignant, that his father said those words, rather than being able to give him a different experience or something to that effect.*
>
> As the assessment came to an end, I became aware and concerned that Ebi's own reported difficulties may be affected by his father's own

distress. Ebi's father was very active in seeking support for his son and his wife, but he was not able to recognise and acknowledge his own mental health needs. Ebi's father was also very active in asking for support for practical issues, relating to housing and legal documents, which were a constant source of anxiety, anger and frustration for him and further impacted on his emotional well-being. Issues relating to housing and school were another sub theme identified in the data analysis and shall be discussed now.

Sub theme - Housing and school

The data analysis and assessment showed that for Ebi, the sub theme of 'housing and school' manifested as 'denial and avoidance' of any worries. In contrast with his father, only on one occasion did Ebi tell me about their housing situation. The family had been sharing a house with another family for the past three years. The analysis of the data showed how I found myself being the active one and asking him questions about this, perhaps linked to the feeling of wanting to do more:

> *Session 2: I asked about other times he felt annoyed and angry; does it ever happen at home and school? He said, "at home with Tom [child from the other family they share the house with] when he is horrible to me." I asked what happened then? He said, "we fight," and looked back down at his water bottle and his lips moved again.*

Ebi did not speak any further about how he understood or experienced living in the UK with another family, and living apart from his extended family. He did show an interest in the doll's house, which perhaps indicates he was unable to verbalise some of his thoughts and feelings about their housing situation. This will be discussed in the next sub-theme.

The analysis of the data revealed that he also did not speak to me about his experiences in school or in any detail about his experiences at home or in the community. I am not sure if this was due to his general anxiety and inhibition with

me in the sessions, or whether it also related to how he defended himself from his own frustrations, disappointments and losses; he denied and minimised them and/or perhaps did not have any expectations that an adult could do anything to help him with them. This sub theme is of course closely linked to the next sub theme, of how he related to his own experiences of being a refugee. This shall now be described.

Sub theme - Refugee issues

The data analysis and assessment revealed that for Ebi, the sub theme of 'refugee issues' manifested as loss of home. Ebi came to the UK three years ago, when he was 6 years old. During the assessment he did not speak to me directly about what he understood about why he and his parents had come to the UK. He was very aware of his parents' wish for a permanent home in the UK; both a physical home in their own house, but also that they were waiting for the Home Office to grant them permanent leave to remain. Ebi did not directly talk to me about his experiences of loss of his home and his feelings about this and their current housing situation. However the feeling of the loss of home was observed in his play and my countertransference:

> *Session 1: Ebi then spent the next 5-10 minutes, slowly and thoughtfully arranging all the furniture in the house, deciding where each piece should go and which room was what. He did it with no reference to me, other than on one occasion he asked me where the dressing table with the mirror should go, "in the bathroom?" He seemed more relaxed in this 'arranging and sorting' task. At times he seemed to murmur to himself, without making much sound, moving his lips, but with some words audible, but I did not understand him as they seemed to be in his home language. I felt very aware of the housing difficulties in the real world for him, and I felt sad as I saw him arranging the furniture and thought about the difference between the 'affluent type of house' that the doll's house represented (large mansion house) and their current house, which they share with another refugee family.*

As I watched him, I was also aware of how smartly he was dressed, how well physically looked after he seemed and how different his life might have been in his home country, as the only son of a professional family.

Apart from the sub theme of 'alien', Ebi did not explicitly speak or act out in play, anything further about how he understood and related to his own refugee issues. Perhaps this signified that for him, the impact of being a refugee was felt more through his parents' experiences, rather than his own conscious understanding, or perhaps he did not yet feel comfortable to share these thoughts with me.

Discussion of findings for Ebi:

From analysing the data from Ebi's assessment, it is clear that the impact of his parents' mental health and their ongoing and past experiences was major sub theme in the assessment, and which contributed to a number of other sub themes identified. The data analysis also demonstrated how important my observation and countertransference was in this particular assessment.

Overall, I was most concerned about the impact on Ebi of his parents' state of mind; that he was at risk of a lack of containment and also receiving the projection of their distress; the reversal of the 'container/contained' relationship (Williams, 1997). The somatisation of his distress was understandably causing his parents a great deal of worry, but I was concerned that he may have been carrying distress for the whole family, in an unconscious state, which can occur in refugee families (Martin, 2012). I was also concerned that his somatic symptoms were also a manifestation of his own internal emotional experiences. He was not a child who was able to express his thoughts and feelings with words, in the assessment, much of his communication was non-verbal and also, I think, unconscious. He was a child who I had vivid and powerful feelings with in my

countertransference, and would need a great deal of emotional availability and support from his parents to help make sense of these experiences for him.

Ebi's parents also reported struggling with his behaviour at home, his anger towards his parents, particularly his mother. During this assessment, I was acutely aware of the frustration and anger that I felt when Ebi was brought late, as well as the tension I observed between the parents when I first met them. Ebi's mother spoke of her anger at her husband's political activities in their home country, which had resulted in them having to leave the country. Ebi's father seemed very angry and frustrated by how he was treated as a refugee in the UK; he was unable to work, he felt disrespected and was living in sub-standard accommodation, with very little control over his and his family's life. My colleague and I both tried to help them in many practical ways with these significant external issues, with letters, reports and phone calls to the housing association and the Home Office. However, I also felt very strongly that the anger which I observed in the parents and experienced in my countertransference with them, also needed to be understood as a communication about the parents' own internal states as well as my own (Winnicott, 1949, Miller, 2008). I thought that it was crucial that this anger could be contained robustly through further clinical work with the parents, to try to stabilise the family situation and atmosphere at home.

Therefore I made the following clinical recommendations from this assessment:

1) Further mental health support for Ebi's parents and for them to receive both individual work and work as parents.

2) Consideration for further individual work or family work at a later stage when Ebi's parents' own mental health was more stable and able to support either individual child psychotherapy or family sessions.

However, after analysing the clinical material, I am also more aware now of the sub theme of deprivation and sub theme of denial. The assessment and data

analysis demonstrate that at the time of assessment, Ebi was a child who related to and defended against his feelings of loss and deprivation by denial and projection. This in turn led him to depend on his own resources, without expecting or asking for further help from adults. At times this self-sufficiency led to resourcefulness and resilience, but for Ebi, I think there was also a danger that it could lead to further deprivation if the adults were not able to recognise and respond to his emotional needs. Or in contrast, the adults could respond with 'over-action'; of rushing to do more, provide more and more and more, rather than being able to recognise and contain the underlying frustration and loss.

With either response, I would be concerned that Ebi could then be further deprived of adult support and help. This could lead to Ebi becoming more stuck and reliant on his own resources and not expect adults to be able to provide anything meaningful for him and so he may not be able to seek or use help from adults, and be risk of 'double deprivation' (Henry, 1974).

However, at some times during the assessment, I felt he was able to begin to make some use of me as a consistent, though perhaps benign adult, and so not stuck in a 'doubly deprived' state. On further reflection now, I have a question in my mind about whether Ebi's own needs were neglected in the outcome of this assessment. Was I premature to recommend parental support in the first instance, without offering something alongside Ebi? Should I have arranged some individual work in his own right, that perhaps could have been set up knowing the difficulties the parents would face to bring him, but working with this, rather than also perhaps avoiding this difficulty and denying Ebi his own individual support, whilst he and his family were under such strain? The risk of the clinician and network depriving children and families further, resulting in 'triple deprivation' has been described previously in work with 'looked-after' children (Emanuel, 2002). I am left with a concern that this may also be true for Ebi and his family.

Participant 2: Samer, "Do they make all the toys in China because they are too busy with wars here to make toys?"

Referral:

Samer was referred for a child psychotherapy assessment by a Specialist CAMHS Practitioner and a Child Psychotherapist in training, to contribute towards the generic CAMHS assessment they were undertaking with the family. Samer and his family were referred by their GP because Samer's mother was concerned about his behaviour at home and with his peers. She reported that he was often aggressive and would hit and bite other children, and have tantrums. She was very worried that he had a mental health condition and reported that many members of his paternal family had mental health issues.

Background:

At the time of the assessment Samer was 9 years old. He lived with his mother and 3 older siblings (1 brother aged 14 years, 2 sisters, aged 15 and 11 years old) in a large city in the UK. The family were from a country in the Middle East. The family had fled their home country 15 years previously, due to political persecution. Samer's father had been imprisoned and Samer's mother had witnessed her own father being killed in front of her. The family lived as refugees in another country in Europe before coming to the UK in 2007, when Samer was 1 years old. Samer's mother did not speak about either journey. In their home country they had close support from their extended family. Samer's father worked in a professional role and his mother worked as a housewife.

Samer's parents separated when he was 2 years old and his father returned to their home country. When Samer was 7 years old, the family had to return to their home country because his maternal grandmother was terminally ill and his mother had to care for her. Samer and his siblings lived with their father during this time and returned to the UK after 12 months. Samer's father still lived in their

home country and had regular contact with the family throughout and visited them in the UK.

Samer's mother reported that Samer was born at full term, after a healthy pregnancy and that he was a healthy baby, though his behaviour had been challenging since he was a toddler. When he was 4 years old he had an operation to remove his tonsils and adenoids, but other than that, he had good health and normal development.

When the family came to the Refugee service for assessment, there were significant difficulties with their housing and financial situation, which was having an impact on all the children and their mother. Samer's eldest sibling was reported to be self-harming and was also seen for an individual assessment during the time that Samer was assessed by myself.

Samer was reported to be working below the National Curriculum levels in school, which his teacher thought was due to him missing a significant amount of school when the family had to return to their home country. He had also recently changed primary school as his mother thought that a new school would help him.

Samer's mother gave consent for Samer to be seen for an individual child psychotherapy assessment and for this to be included in this research. I met with Samer and his mother and two of his siblings for an initial meeting with Specialist CAMHS Practitioner and we arranged the dates for the 4 individual appointments and the follow up review appointment with Samer's mother, once I had completed the child psychotherapy assessment. The initial assessment was dominated by a chaotic atmosphere, in which the children quickly seemed to get bored and as a result tried to annoy and compete with each other for our and their mother's attention.

<u>Summary of assessment:</u>

Samer's mother brought Samer to all the planned appointments (once a week for 4 weeks), on time and she seemed supportive of the assessment. She received

consistent support and appointments from the CAMHS Practitioner throughout the assessment.

Samer did not appear anxious at meeting me and seemed to expect that I and the assessment would be a good, if, benign experience for him. He did some drawing, and was initially confused by me being playful with him, but was able to make good use of what I could offer and later in the sessions, enjoyed playing games with me, and was highly competitive. His denial of anxiety, and his competitiveness and omnipotence were strong features in the assessment, as was a lack of internalised 'paternal function' and an infantile sense of insatiability. As with the other children, there was also knowledge of danger and external world events, for example, ISIS, terrorism and war.

Theme 1 - How the child and family relate to the structure of assessment

Sub theme - Beginnings

The data analysis revealed that for Samer, the sub theme of 'beginnings' manifested as separation anxiety from his mother at the beginning of each session. I had not been expecting this as when I had met him before the assessment, he had seemed interested in me and the sessions and keen to be seen on his own without his mother. In the first appointment, it initially seemed as if he was confident and secure in saying goodbye to his mother and coming with me on his own, but the data analysis showed that perhaps this masked an underlying anxiety:

> *Session 1: They attended on time, Samer was in the waiting room, he was sat opposite from his mother and sister, looking at me expectantly… ..I added that we would meet in a separate room but I could bring him to see his mother at any point if needed. Samer smiled, looked at me expectantly rather than anxiously and he seemed interested in where he was going, rather than anxious to say*

goodbye… …I got a sense of him being quite self-sufficient and relaxed at being away from his mum. He then quickly looked up and said, "the ceiling looks like it's going to come down at any minute!" I felt surprised at this sudden anxiety. I looked at the tile which he was pointing at, and compared to some of the other ceiling tiles, it looked more solid. I asked which one and he pointed again, saying, "at any minute!!"

The analysis of the data showed that Samer initially denied feeling anxious at being apart from his mother and family, but then he seemed to experience a sudden intrusion of anxiety about feeling unsafe; that the ceiling could suddenly collapse at any minute. This sense of intrusion was present in a later session, when it was time to begin the session with me and say goodbye to his mother:

Session 3: Samer arrived on time and was in waiting room with sister, interpreter and his mother… ..Samer said something to his mother in [their language]. She replied and I wanted to ask the interpreter what he had said but I didn't, as it felt a bit intrusive. Samer left the room with me and said, "bye" to his mother and as we walked down the corridor, I asked what he had said to his mother, he said 'bye.' I said it meant before that, I couldn't understand him and he said, "oh, I asked her what the time was." I felt a bit intrusive asking, but I was aware of feeling left out and not being able to understand.

I wondered if my anxiety about being intrusive, but also my sense of not being able to understand was also something he may have felt in relation to me on separation from his mother. However, by the final session, the beginning of the session, and Samer's separation from his mother, had become more straightforward and acknowledged by both of them:

Session 4: Samer attended on time, he was sat next to mother in waiting room… I said to Samer and his mother, that we would start

and my colleague (parent worker) will be along shortly… .. Samer waved goodbye to his mother, who waved back.

The data analysis was helpful to show how Samer responded to his mother and his own feelings, when it was time to separate from her and begin his session with me. It showed how his emotional responses developed over the course of the assessment and how he responded to them. The data analysis was also very interesting to examine how he then responded when he was re-united with his mother at the end of each session, and this sub theme will now be examined.

Sub theme - Endings

During the data analysis, I identified a sub theme of 'endings' and for Samer, this manifested as an avoidance of goodbye. At the end of the sessions, Samer would often ignore me or not be able to acknowledge saying goodbye:

Session 2: We went in the waiting room and his mother smiled warmly at him and I said goodbye, see you next week. Samer didn't say goodbye or look at me as I left the room.

Initially, I was not sure if this avoidance was related to the separation with me and the session coming to an end, or whether it related more to seeing his mother again. However, by session 3 and 4, the clinical material and analysis of the data showed how strong Samer's response was when he was re-united with his mother:

Session 3: I said goodbye, and said I would see him next week for final session. Again, Samer didn't look at me as we said goodbye, he was absorbed in talking to his mother.

Session 4: From the door of the waiting room, Samer then kept a watch out for his mother. He called out to her as she came down the corridor and he ran up to her, looking in the plastic bags she had, and the interpreter commented, "all children go straight for the bags." He made no eye contact with me as we said goodbye, he was focussed on his mother and her bags.

It was interesting to see in the data, that even the interpreter noticed and commented on his reaction to his mother, which is quite unusual for an interpreter to do. I wonder if this was an indication of the strength of Samer's reaction to his mother or if something was also provoked within the interpreter. The data analysis demonstrated that within me, a 'paternal function' was often provoked and this shall now be described in relation to the transference.

Theme 2: How the child relates to me and the institution

Sub theme - Transference and re-enactment

The data analysis identified a sub theme which related to how Samer related to me and the institution was of confusion. It showed how he was a child who was perhaps trying to be in charge of his own rules by creating confusion in the other person. In response, I often acted in a 'paternal role', for example, setting boundaries, rules and drawing his attention to the reality of what was happening, someone who could make sense of what he was doing and the confusion he created:

Session 2: Samer sat down and there followed a very confusing sequence, in which he wanted to play with me, but he kept changing the rules and the expectations and there was an assumption that I would go along with it, and that I would not question his change of rules, or additions… ..I spoke about how confusing it was, there were so many different rules and they kept changing, he shook his head,

said it wasn't confusing and he explained it again to me, and he then changed again… ..I asked how do we know what points we had? He said, "I know," and he got out pen and paper and wrote them down [something we had done together in the previous session]. I said that is much clearer about how many points we had. We continued playing, and I needed to keep on trying to draw him back to the rules that he had said, and there were times, when he tried to cover things up and make out that I was just not understanding him. I spoke to him directly about this, saying we were playing a game in which he was in charge of the rules and changed them, and some of the rules were actually cheating. He denied it, then smiled and said, "no, if you get another point, you can make up a rule. What's the score? You have been on 14 for ages!"

His wish to confuse me, to be better than me and triumph over me appeared many times in the assessment and will be explored in later sub-themes. This did seem to leave him confused in relation to both himself and me, but what also emerged in the data analysis was how he experienced confusion in relation to the whole institution and building. During the assessment, it was striking how confused Samer would become about the room we used. Initially, I thought this confusion was linked to Samer's denial that anything was different about meeting me and the previous family meetings with his mother and his siblings:

Session 1: I opened the door and Samer went in happily, saying, "it's the same room." He was looking around it as I sat down, he sat on the sofa. He said it was, "the same room" and he looked around. He said, "look same sofa, same door, that's the same." He was pointing to the table, chair, sofa, saying, "that's the same." And then, pointing at the window, the walls, "it's the same!" I said it certainly looked very similar, was there nothing that's different?! He smiled, looked again, and said, "that's different" and pointed to the little table, and said, "there is a number on the chair, what number is it? 2? [room number], or is it a 7?" I said it was a 2, and he said, "so we are in room 2?" I said yes, he said, "the wall is a

bit different, in the other room there is a mark on the wall here, not here and the ceiling is different."

Never the less, Samer showed that he was able to use my mind and thoughts to help him orientate himself and make sense of where he was and where he wasn't. With this, he showed a remarkable attention and memory to the detail of the previous room he had been in multiple times with his mother, which was on the other side of the building. For example, his memory of where the marks were on the wall or the difference in ceiling tiles, seemed to contrast to his feeling that everything was the same. However, his ability to remember and hold onto this knowledge was not as strong as I expected. His confusion of place emerged again in the assessment and corresponding data analysis for all of the other sessions:

Session 2: He went to walk past the room, and I said, "here we are," and opened the door. I felt surprised that he didn't remember as he was so attentive to detail in the last session. He went in and said, "that is confusing, all the doors are the same," and looking around the room said, "they all look the same as well."

Session 3: Samer ran ahead as we turned the corner, looking for the room and I felt certain that he would remember, given how carefully he had noticed every detail about the room in previous sessions. We were in room 2 but he ran past it. I called him, "it is here" and he came back saying, "but we are in room 7?" We went in the room, and he said "but we were in 7 last week? But this room looks the same, or a bit different, that's really confusing." I said he was so certain that he had remembered right but this was our room, 2 and he looked around and noticed the torn room number sign on the chair. I found myself saying, perhaps because that looks like 7? But I knew that he had been very confident that he knew he was in room 2 last week and that I was just reassuring him and he nodded, but he said, "that is confusing". I said I wondered if it often felt confusing expecting to be somewhere and being somewhere else? Samer looked at me and said, "all these rooms are the same!"

Session 4: He ran a little ahead of me, looked at the room numbers and turned and said, "this one?" I said yes, he was right and I felt pleased that he had remembered and recognised it. We went in and he said it was, "still a bit confusing, I thought it was 7." Samer pointed at the chair with the torn sticker, that said room 2, but where it was torn it looked as if it was room 7. I nodded and said the sticker did look like 7 but he had remembered. He looked around the room, as if to check, then went straight to the box, and I said he wanted to make sure it was the same room.

Samer's insistence that the rooms were the same did not seem to only relate to the fact that the rooms did in reality look similar. His sensitivity and memory about the fine details and differences between the rooms seemed in direct contrast to his denial that they were different.

At the time of the assessment I was not sure if this related to his own need to deny any differences (both in relation to his difference with adults as well as external reality) or if he was also expecting me to be someone who would try to trick or confuse him. I also wondered whether there was something else that was being re-enacted for him. Samer and his family had lived in different places, in 3 different countries. When Samer was 7 years old he had gone back to the family's home country and lived with his father for 12 months, whilst his mother looked after her own mother in the same country. With the evidence now from the data analysis, I wonder if Samer's own denial of any difference in where he is, relates to this; his previous experiences of living in countries that are very different, both in terms of culture, and safety, but also the difference in caregiver. Perhaps his denial of these differences served to defend himself from acknowledging any anxiety and confusion he felt about this. This may have been protective at the time, but it may have led to a confusion in being able to orientate and make sense of his surroundings and who is with him and if they can be trusted.

Sub theme - Behaviour

The final sub theme within the main theme of how Samer related to me and the institution was his behaviour during the assessment. The analysis of the data revealed that for Samer, this manifested as him being on his best behaviour with me, perhaps as he would if he was in school, being watched by the teachers:

> *Session 1: Samer picked up and examined some of the other toys and settled on some paper, pencils and the ruler and took them to the sofa and started drawing, with his side to me, so I couldn't really see. He seemed to be drawing an outline of a house and he commented that the view was different from this window and was that a camera outside? I looked at where he pointed and it was a street light, I asked him about this, he seemed to think it was a camera for the road and said a few times, but it looks like an illusion, looks as if it is facing in, but it's not. I wondered if he was feeling a bit watched. I said I wondered how he felt about being here in the room with me, he shrugged, said, "fine, am on my own with a teacher in school as well." I asked him about this and he said he thought it was because of his handwriting. He certainly seemed a bright boy and I wondered about his behaviour at school, knowing that his mother described quite extreme behaviour at home.*

I was also aware during the assessment, that he was behaving differently to how his mother described him at home:

> *Session 3: I asked about what happened when he went 'mad,' he said "I don't know, I just feel mad." I said I hadn't seen that here, he shook his head. I said maybe he was on his best behaviour with me; he nodded and said, "yes." Samer said something about, "getting a letter home from school." I said maybe he was worried what I thought or*

what I would tell his mother? He did not respond, other than saying he wasn't mad, but wasn't sure, "one month I am ok, the next month mad."

Later in the session it seemed as if Samer had more control over his behaviour than perhaps he wanted his mother to know:

Session 3: I said that when I had met him with my colleague and his mother and sisters, he had said he thought that he was mad, was that something he was scared about? He shook his head, "no, not really." I asked if people said that or if they thought that? Samer said, "sometimes if I make my face go mad, and they think I am mad or scary." Samer demonstrated this with his face and laughed, saying that he did that to Ben in school and it made him cry.

However, perhaps Samer's behaviour and internal states were not as straightforward as his best behaviour indicated. The data analysis also revealed that in relation to himself, Samer had ways of seeing himself, that could leave him vulnerable with regards to his relationships with adults and seeking help. This second theme, of how the child relates to their own self, and the sub themes within it, shall now be described.

Theme 3 - How the child relates to their own self

Sub theme - Identity

The assessment and subsequent data analysis revealed a sub theme of 'identity', which manifested in Samer as omnipotence. Samer identified and related to himself as someone who could do anything and he wanted to prove this to all those around him. His exaggerated belief in his own potency and power was evident from the first session:

Session 1: Samer said he had finished and he came back over to the box and took out the plasticine saying he would make something. He took off the wrapper. He said it was very hard and tried to karate chop it, which seemed to hurt. He rubbed his hand, saying he wanted to take the layers [of plasticine] off but if he did it might ruin it. It was too hard. He softened a bit in his hand and looked at me and I asked if he wanted some help? I said I wondered if there was anything in his box that could help him? I was thinking of the ruler, but I forgot it was on the sofa. He found the scissors and said this might do it, but they just sunk into the soft plasticine, he tried again, but said again, if he did it too hard, he might ruin it. He put it on the table and I picked it up and tried to get the layers off and succeeded. I realised that I had not asked him if he wanted me to do this explicitly and I wondered how he would react to an adult helping him. He said it was easier for me because I had nails (not very long) and if he grew his nails, "they would be the size of the sofa, too big!" I said, that would be very big!! He nodded, said again that I could do it because I had nails.

As this first example demonstrated, when his omnipotence was confronted with help from me, it seemed to increase his sense of envy and competition with me and his need to prove to himself and me, how powerful he was. He seemed to find it hard to imagine that I was an adult who had something to offer him. The data analysis revealed this competition was present very strongly in the next and subsequent sessions:

Session 2: Samer tried again to catch the ball one handed and got the next two points, saying to me, "you are not going to win!" I said he was very confident about that. He said, "I have never lost at any game!" I exclaimed, "what never, ever?" He said, "never, I always win." I said what about at school? He said, "I always win." I said, "at home?" He immediately replied, "I always win." I said I wondered what would happen if he lost at a game, how would he feel? He smiled patronisingly at me, "I will never lose." I felt interested to see what would happen if I won the next point but I couldn't observe this as he

started throwing it in directions so I had no chance of getting it. I said I thought he was really worried that I might be able to win, or get some points, he shook his head, telling me, "you catch the ball wrong, you catch it like this," gesturing with two hands together, "but I do it like this," two hands together by coming from sides, not underneath like mine. He threw again, saying that was what the other big boy at school did, and he always won against him. He threw again, after looking at the wall, and I said out loud, "you are plotting how to throw it so I won't be able to get it" and he laughed and nodded, and threw it. I said I thought he was worried that I would get some points, he was having to make sure I didn't get points. He denied this, saying the boy at school, "was taller but it didn't help him." I asked if he thought I was taller? He said, "not really, well maybe, but I am still going to win!" I said I wondered why he was very competitive, why he wanted to win and be better than me with this game?

Samer's competitiveness seemed to be driven from his belief that he was the same as me, an adult. He believed that there was no difference between himself and me, and if there was any difference, it was that he was stronger, better and more powerful than me. This denial of being little and different seemed to relate to his denial of any anxiety regarding himself but also me as an adult. His denial of anxiety was another sub theme that emerged in the data analysis and assessment and this shall now be examined.

Sub theme - Denial

The data analysis and assessment revealed that for Samer, the sub theme of 'denial' manifested as denial of his own anxieties. As I have already described, Samer's use of denial was a recurrent aspect of some of the sub themes, for example; denial of separation anxiety from his mother, denial of difference between himself and an adult and denial of difference between therapy rooms. This denial seemed to be a defence against any feelings of anxiety. Another manifestation of his denial of his anxiety which manifested in the assessment was

a denial of his rivalry with his siblings and disappointment with what adults could provide:

> *Session 1: Samer looked in the box and he took out the phone and said, "oh, this cell phone is fake." He shook it a little, and turned it over. I commented on whether he was disappointed it wasn't a real one. He shook his head and said, "I am going to get an I phone 7 when I am 10." I asked how he felt about that? He said, "it is better to wait and get the best, will be the newest version." I felt surprised at this mature attitude and seemingly not feeling left out or wanting to catch up with his siblings.*

Samer also denied any rivalry with other children in the clinic and he denied he had any anxiety that they may want or take the toys and materials that I had provided for him in the assessment:

> *Session 2: Samer went to the box and he got out the plasticine that he had stuck back together at end of last session and said, "I wonder if it's still too hard like last week?" He took it out and said, "still hard, wonder if I can make it even harder so no one can pick it up from table." He pressed down, with all his weight, but he could still lift it off the table. I said last week he had wanted to make sure that no other children could play with it. He shook his head and denied this, and quickly put it back in the box and took out the phone, examined it and suddenly said, "why is there all that noise?" He seemed to be referring to someone walking in the corridor, he got up to see who it was and I think tell them off, but he stopped himself and said "there is an emergency!! Dial 911."*

When Samer denied his anxiety about the other children taking the plasticine, he immediately seemed to experience a sudden intrusion of anxiety. As I have already described, this also happened when he had denied feeling anxious about being apart from his mother.

I thought that when Samer denied that he had his own needs and anxieties, he also was denying that he had any need for adults. This meant that he denied that he was a child who had any need of adult help or comfort. His denial of his own needs and his denial of his worry that other children could take things from him, then seemed to contribute to a feeling of deprivation and wanting more. This is the next sub theme that emerged and this will now be examined.

Sub theme - Deprivation and loss

The data analysis revealed that a sub theme of feeling deprived and fear of loss was strong for Samer. In Samer, this manifested as feeling insatiable and wanting to get inside, with a limited internalised paternal figure to stop him. Samer was able to act out and communicate these feelings in play and with words:

> *Session 2: Samer dialled the phone and I pretended to answer it. This week he responded, saying, "police?" I said, "yes, police, what is the emergency?" He giggled and said, "I have run out of chips!! Quick, get me chips." I played along, "is this an emergency?" He said, "yes, I want chips now!!" I said "you can't wait; you need police to bring you chips?" He replied, "yes, now!!" He laughed and put the phone down. He rang back, saying he was going to 'prank call' me. He pretended to ring, "hello?" I said, "hello?" He said, "I am a policeman and I am in your apartment and someone has broken in and stolen all your chips and the burglar is here now and eating all of them!" He made eating noises, and said, "and guess what the burglar is me!!" I said, "what!! You are in my apartment and have broken in, and are eating all my chips?!" He laughed, saying "yes, and there are other people here." He took out of the toy box, a pig, a horse, a small pig, a motorbike and the teddy bear, and he said, "they are all eating your chips!! And leaving the empty packets all over the floor!" He put the phone down and dialled again, saying "Tescos, KFC, McDonalds, Pizza Hut, send me all your food now! I want pizzas, burgers, chips, now! Send me all*

your food from the whole world!!" I said he wanted everything, all the food in the entire world and he wanted it now!! Samer nodded.

Samer was able to express his feeling of deprivation and wanting more and his fear of people taking things from him, into words and play, rather than having to project it into me, or relate to me in the transference; i.e., I was not left feeling in my countertransference that I was with a deprived, hungry child. However, I did feel that I was with a child who at times wanted to devour his mother, a child who in these moments, felt he had little paternal function (either internal or external) to stop him:

Session 2: Samer then played out a sequence with the little pig and the teddy bear. The teddy bear was the dad and the little pig wanted all the chips and his dad called the police (me) saying, "give me chips for him, otherwise he has said that he will eat everything!" I asked the daddy teddy bear if he had chips? Samer [daddy teddy bear] said, "no, only an emergency bag, and if I give him that, it will all be gone and he said he will eat everything up; he will eat the horse, the pig!" I said the little pig was threatening him and he couldn't say no. Samer [daddy teddy bear] replied, "he said he will eat me!" I said that was the emergency, not the chips! I said it was an emergency that the little pig was telling his dad that he wanted more chips or he would eat him. Samer put the phone down and the little pig jumped on the motorbike and went zoom. I said the little pig has run away! He nodded, "to find chips!" I said I wondered why the little pig wanted so many chips, that he had to threaten his dad and felt that it was never enough?

Samer's fear that he could lose everything, or that everything could be taken away from him, seemed to leave him with an overwhelming insatiability; that he never had enough and that there was no adult who could help him or stop him. The assessment and data analysis showed that in his play, he responded to this anxiety by threatening the adult who was not providing him with everything he felt he needed. This was something that also happened in reality at home, and his mother reported to my colleague, that she would often have to cook him different

food compared to his siblings, and provide him with whatever he wanted. Whether this internal state related to a perceived or real deprivation of his father and/or absence of paternal function, is not clear. I did not meet or speak to Samer's father during the assessment, but through examining the material, I am struck by the sense of an absent or weak paternal figure both within Samer, but also within his mother. I wonder if for Samer this related to a delay in working through oedipal anxieties, perhaps due to the family situation at the time when he was much younger, and/or his own difficulties with this.

However, what was not present in my mind during the assessment, and that I have only thought about as a result of the data analysis, is the trauma his mother suffered before he was born, of seeing her own father killed in front of her. I wonder now if this trauma affected her own internalised paternal figure; that whether the trauma of witnessing her own father being killed, also killed off or weakened her own internal paternal function. These issues will be discussed in more detail later.

Theme 4 - How the child relates to their external experiences

Sub theme - Parents and family

The data analysis revealed that the sub theme of 'parents and family' manifested in Samer as an infantile response to his mother. As I have already described, during the assessment, Samer would act as if he didn't mind being apart from his mother. However, the data analysis showed that he did relate to his mother in a very early infantile way. In each session he mentioned being able to smell her when he was expecting to see her:

> *Session 2: It was then time to finish. Samer packed away and we went back to waiting room. As we got closer to the room, Samer said, "I can smell my mum." I felt surprised at his infantile response.*

Session 3: It was time to finish, and we tidied away and we walked back to waiting room. Samer's mother was still with the parent worker. Samer waited patiently for her, telling me that he could, "smell and hear her."

Session 4: We walked back to the waiting room, with Samer sniffing the air again..

I was aware that Samer's mother suffered from depression and that until the referral to CAMHS, she had not sought any help in her own right. At the time of the assessment, I was not sure if Samer's infantile response to his mother was due to a perceived absence in the mother-baby state of mind (as is sometimes a consequence of depression). Samer was only 1 years old when the family moved to the UK as refugees from another host country. I do not know about his parents' state of mind at the time, but I imagine that they may have been preoccupied and anxious with the move. I also wondered if Samer's way of relating to me, which was very rivalrous and competitive, was also in part due to his mother's depression and passivity and his competition with his father and siblings.

However, on reflection now, I wonder if it was also a result of their separation when they returned to their home country. For Samer, this loss of his mother or not having enough of his mother could be due to his real external experience. The assessment also revealed that Samer's own internal state and way of relating to himself, was with an identity of feeling deprived and insatiable.

Therefore, it could be argued that whatever Samer's actual real external experiences were with his mother, he may always have felt it was not enough. Given the evidence of this sub theme and how for Samer this manifested in such an infantile response to his mother, I wonder if his internal feeling of insatiability related to very early experiences with his parents. These early experiences may then have been compounded by the later separation with his mother when they had to return to their home country. Whether these feeling relate to Samer's own internal states or his actual real external experiences, he reacts in the same way as I have described previously; with denial of any anxiety. This way of managing

his anxiety was also identified in the next sub theme to be examined; housing and school.

Sub theme - Housing and school

Before the assessment, I was aware that Samer's mother had spoken at length to my colleague about her concerns that they would be evicted from their house due to rent arrears that had built up when they had to return to their home country. The children were all aware of this and had spoken to my colleague about their concerns, but Samer did not speak to me directly about it in the assessment and it did not manifest in his play or within the transference.

He did speak about his experiences at school, although, this was when I asked him. For Samer, this sub theme, manifested as denial of any concerns at school with peers:

> *Session 3: [Samer had been talking about WWF wrestling] I asked if he liked wrestling and he nodded, and fighting? Samer said, "not really, people keep asking me to fight them at playtime, then when I say yes, they change their minds. There was a boy at my other school who kept wanting to fight me and said things to upset me." I asked about school now and he said, "ok, boring though." I asked about the other children, "they are ok, one boy who says he wants to fight me but doesn't." I asked about playtime and games with other children and rules. He said, "is ok, there are games and I make the rules, or I referee." Samer didn't seem aware or report any peer difficulties with competition, dominance etc..*

Samer also seemed to minimise any difficulties he may have with the work and the demands on him in the academic environment of school:

> *Session 4: Samer said school was, "boring." I asked if the work was too easy for him. He said, "sometimes." He then said that, "I finish really quickly and have to just sit there." I said maybe we needed to think with his school about that. He seemed to sense what I was about to say and he quickly said, "sometimes it is too hard, like maths, some sums are really hard so I give up." I got a sense of him preferring to take the easy way out.*

Samer's wish to avoid being given harder work, may relate to him being a child who did not like to work hard, but I wondered if this also masked an underlying anxiety about his ability and his capacity to tolerate frustration and 'not knowing.' These are all crucial aspects of a child's ability to learn (Youell, 2006). From the data analysis, it seems likely that if Samer did have any anxieties about his ability to learn and do well in school, then he would probably deny these anxieties and not seek help from adults. However, this way of relating to himself and his external experiences was not present in how he related to his own experiences of being a refugee, in which some areas, he sought my help to understand. This is the final sub theme, and it shall now be examined.

Sub theme - Refugee issues

During the assessment, Samer did not talk directly about his own experiences as a refugee. For Samer, the sub theme of 'refugee issues' manifested as a desire to understand events in the world. The assessment and data analysis revealed him to be a child who showed an interest and ability to think about world events with me, and how they related to him, as a Muslim living in the UK. He did this is in both a manner appropriate to his age, but also at times, he seemed to want to understand these events as an adult would:

Session 4: Samer took out the phone again and examined it, sniffed it, saying that it smelt like a pencil sharpener. I said, "plastic?" He replied, "no, pencils." Samer said, "why is it made in China? Why are all toys made in China?" I said that was a good question, what did he think? He said, "do they make all the toys in China because they are too busy with wars here to make toys?" I felt really sad at this. I said did he think there were a lot of wars here? He said, "yes, too busy to make toys, too busy dropping bombs and on Syria now." I felt surprised at his level of knowledge about current affairs, (David Cameron, the Prime Minister, had been on TV last night talking in parliament about his belief to bomb Syria). I asked Samer if he had watched this on the news? Samer replied, "no, I never watch the news, I saw it on You Tube." I felt sad again and I asked what else he watched on You Tube? (I was wondering to myself what he had been exposed to online). I felt relieved when he said, "cartoons." He said he would, "call China." He used the phone to call China and when I answered he said, "do you make all the toys because everyone else is at war?" I said we did make a lot of toys, and yes, there are a lot of wars. He put the phone down and went over to the window, and looked at how to open it, saying it was like the window at school. I asked more about the wars. Samer said, "everyone is at war, Paris is at war, maybe [here] will be at war." He came back to the sofa, "it's like world war, ISIS say they are Muslims but they are different, they kill people, different to real Muslims, they just say they are, but they aren't really Muslims, there is war everywhere." I asked if he was worried about war and [here]? He said, "no, [here] is ok." I asked about his family, was he worried about them? In their country? He said, "no, they are in [home country], they are ok."

Samer denied that he felt anxious about war coming to where he lived in the UK and he denied any concern about his father and extended family who still lived in their home country (which still experienced frequent bombings and attacks). At the time of the assessment, I wondered if the impact of being a refugee for Samer

was more affected by the impact of his parents' experiences, rather than his own direct experiences.

However, as the analysis of the data has shown, Samer frequently used denial as a way of avoiding his own anxiety and fear, and he preferred to identify with adults and felt he was an adult. On reflection now, I wonder if I underestimated his anxiety and fear about war and if he was safe, and if I missed an opportunity to help him think about his fears about this with an adult alongside him?

Discussion of findings for Samer:

From analysing the data from Samer's assessment, it is clear that the impact of his denial of his own anxiety and corresponding needs was a major sub theme in the assessment, and contributed to a number of other sub themes identified. The absence of a strong internalised paternal figure and overall parental function was also a main feature of Samer's assessment. The assessment and data analysis revealed that he was a child who identified and related to himself as an omnipotent adult-child, which made him feel big and strong when he felt anxious, but also him left feeling that he was too powerful, with no adult to stop him. In spite of this, he was a child who in the assessment, responded well to every day boundaries and expectations when I introduced them. Despite some of his difficulties in relating to me as a trustworthy and solid figure, the assessment demonstrated that he could make use of an adult mind and thinking.

The clinical recommendations from this assessment were:

1) Further parent work and/or individual work to help his mother understand Samer's need for clear boundaries and expectations and for her to feel more confident in her role as an adult and his parent.

2) Consideration for further family work with Samer, his mother and his siblings to think about how they support each other as a family.

However, after analysing the clinical material, I am also more aware now of the sub theme of denial. The assessment and data analysis demonstrate that at the time of assessment, Samer was a child who related to and defended against his feelings of anxiety by denial. This in turn led him to exaggerate his own skills and resources, without asking for further help from adults. I think there would be a risk of this resulting in further deprivation if the adults were not able to recognise and respond to his emotional needs. Therefore, Samer would then be further deprived of adult support and help.

This denial of his own needs may relate to his expectations and experiences of adults; both his parents had suffered significant losses and trauma. The assessment showed that Samer was not a child whose primary trauma came from his own refugee experiences, but perhaps he has been affected by his parent's experiences and losses. In relation to his mother, perhaps her own trauma, loss and depression impacted on her ability to set ordinary boundaries, (Youell, 2001). She was also very anxious that Samer was mentally ill as his father was, and this also seemed to get in the way of her seeing him as a little boy, rather than an ill partner or little king. I think it was the combination of an absent father in Samer's external world, with a limited internal father in Samer and most important, within his mother, that affected Samer. This assessment has shown that the internal absences were very significant for Samer, and that his difficulties and behaviour were unlikely to be due only to his parents' separation and father living away from home.

Participant 3 - Rania, "I ask them every day, when can we go home? And they say when the war finishes."

Referral

Rania was referred for a child psychotherapy assessment by the Refugee service at point of referral into the team. Rania was referred by her GP, with concerns about PTSD, after her father reported that he was worried about her behaviour at home and nightmares. A psychiatrist saw the family for generic assessment whilst the child psychotherapy assessment took place.

Background

At the time of the assessment, Rania was 9 years old. She lived in a large city in the UK, with both her parents and two younger brothers (Ibrahim, who was 5 years old and Hassan, who was 2.5 years old). The family was from a country in the Middle East and had fled 3 years previously, when Rania was 6 years old, because of ongoing civil war. Their city was encircled by fighting, during which time they witnessed attacks on the city and Rania saw her father being shot in his leg. They managed to leave after 8 months. They did not speak about their journey to the UK. Rania's father and mother both worked in professional roles in their home country. Their youngest son was born in the UK, and has complex and severe physical disability. The family was given leave to remain in the UK until 2017. They were appealing this for permanent leave to remain. They were in permanent housing.

Rania's father reported that Rania was born at full term, after a healthy pregnancy and that she was a healthy baby and had normal development. Rania was attending primary school and she was reported to be doing well and school staff had no concerns about her behaviour or emotional state.

Rania's father gave consent for Rania to be seen for an individual child psychotherapy assessment and for this to be included in this research. I met with

Rania and her father and her 5 year old brother Ibrahim for an initial meeting with the psychiatrist and we arranged the dates for the 4 individual appointments and the follow up review appointment with Rania's parents, once I had completed the child psychotherapy assessment. Rania and her brother Ibrahim seemed interested in me and the toys during the initial appointment and comfortable with their father.

Summary of the assessment:

Rania's father brought Rania to all the appointments on time. However, he was not able to bring Rania on consecutive weeks; there were two weeks between the first and second appointment, 3 weeks between the second and third appointment and 12 weeks between the third and the final appointment. The breaks between the first and second appointments were due to other commitments he had, and then there was a break for Christmas between the second and third appointment. During the third and final appointments, two offered sessions were not attended, without any message.

Rania did not appear anxious at meeting me and being in the clinic. She seemed to experience the assessment and my attention, as something very special, just for her. She enjoyed looking at the toys in the box and playing with the doll's house. The main sub themes of the assessment were predominately of loss and fear of further deprivation associated with this. The losses were wide ranging; loss of home and country, loss of her parents' attention (especially mother) and corresponding rivalry with her siblings and rivalry with other children. As with the other participants, there was also material relating to identity, being on best behaviour and avoidance of goodbyes.

Theme 1 - How the child and family relate to the structure of the assessment

Sub theme - Beginnings

The assessment and data analysis showed that for Rania, the sub theme of 'beginnings', manifested as being supported by her father at the beginning of each session. Her father brought her to all of the appointments. He had explained that her mother could not bring her as she had to stay at home and look after Hassan, their youngest son. Rania's father brought her on time for every session. He played an important role in helping her say goodbye to him and he worked with me to help her begin her session:

> *Session 1: Rania was sat opposite her father as I went into the waiting room, I said hello and she smiled shyly at me. I explained that we would meet on our own and her dad would wait here for her. I looked around the room and saw that her brother Ibrahim [5 year old brother] was already playing with some other children in the waiting room. I said Ibrahim would wait here with her dad and we would come back in 50 minutes. Rania nodded and her father smiled at her and told her to take her school bag off, which she did, and she gave it to him and we said goodbye.*

Rania did not appear to be anxious about being apart from her father in this first session on her own. In the next session, Rania's father supported her in the same manner and on that occasion, he also met with my colleague during the appointment. Rania was able to use words to ask where he would be and seemed reassured when I showed her which room he would be in. She also seemed comfortable in waiting room with her father and brother Ibrahim. However, her father cancelled and re-arranged the third assessment session and the data analysis showed that this did have an impact and seemed disorientating for her:

> *Session 3: Rania attended on time after the cancellation last week. I wondered if they would come and I felt pleased to see them when the call came from reception. I went into the waiting room and I saw her father and said hello. Rania and her brother Ibrahim were at the other side of the waiting room, and it took a while to see them amongst the other children and parents, they were looking at the toys and books…*

..Rania's father asked her if she wanted to leave her big school bag, which was on her back, and he helped her take it off and he held onto it for her. Rania and I walked to the room and she said, "when I came in, I saw the sign for reception and I knew where to go!" Rania seemed pleased at this. I commented that she knew where to go and she was coming back to see me. We arrived at the room and I opened the door, expecting her to know which one, but she didn't seem to remember.

Unexpectedly, there was then a 12 week absence before the final session, and I did not receive any messages from the family. I called them and wrote to them on two occasions, and then offered a final assessment appointment, which they attended. In this appointment, I noticed a change in Rania and I felt concerned about them. However, the data analysis also showed that her father still facilitated the beginning of the session:

Session 4: Rania and her father attended on time, I went into the waiting room, which was quiet, there was just one other parent. I said hello and Rania's father smiled at me. Rania turned around, she had been looking at the books, and smiled shyly at me. I said it had been a long time since she had been here and she nodded. Her father nodded and he said sorry but offered no explanation and I was left not knowing why they had not come and wondering if their son was ok or if something else had happened, or if they had not wanted to attend. I asked how they were and Rania's father nodded and said ok, and Rania smiled again. I said that it was good to see them and today would be my final meeting with Rania, and then I would arrange an appointment to see Rania's parents with my colleague, so we could all think as adults how they were and if needed any more support. Rania's father nodded and he helped Rania take off her woolly hat and scarf, which she wanted to hold. I noticed that her coat seemed a bit scruffier, with a few stains and she had a spot on her upper lip and remains of her breakfast around her mouth. This was in contrast to how well and smart she had looked on previous appointments. She had already turned away from her father, and holding her hat and

scarf, wearing her coat, she walked towards the door of the waiting room and waved at her father. I said we would be back in 50 minutes. We walked down the corridor and she knew where to go, but was unsure which room we were in.

During the 12 week gap, I was aware of feeling concerned about the family because I had no communication from them. My colleague had also been absent for a time but then had also tried to contact them on her return. It felt as if they had suddenly disappeared and I shall discuss this in more detail in another sub theme of transference and re-enactment. It also seemed in contrast to how supportive Rania's father had been towards the assessment. He was also supportive and able to facilitate the end of each session, when it was time to say goodbye. This shall now be examined.

Sub theme - Endings

During the data analysis, I identified a sub theme of 'endings' and for Rania, this manifested as an avoidance of goodbyes. Rania seemed to find the end of each session disappointing and often wanted to finish what she was doing and then would walk slowly back to the waiting room:

Session 1: We packed up [the toys] and walked slowly back to waiting room. Rania's father asked to re-arrange the time of the next appointment as he had a course he had to attend. Ibrahim asked if it was his turn? [to see me, I unable to recall how father responded]. Both children looked at fish tank whilst patiently waiting for their father. We said goodbye, Rania had her back away from me getting some water, her father called her to say goodbye and she waved.

As in this example, Rania's father was able to help her with acknowledging and saying goodbye at the end of each session:

Session 2: It was time to finish and we tidied up and walked back to waiting room and waited for a few moments for her father who was with my colleague. Rania looked at the princess crown on Christmas tree and seemed pleased to see it. She seemed pleased to see her father when he came in. We agreed to meet after the Christmas holidays and we said goodbye. Rania was still absorbed in the tree when I said goodbye and her father prompted her to say goodbye, which she did.

During the assessment, I had wondered what the Christmas tree and the princess crown had meant to Rania, and whether she had become absorbed in it because it was significant for her in relation to Christmas and the cultural difference in this. However, after completing the data analysis, I now wonder if it also served as something concrete to focus on whilst waiting for her father and the end of the session, before a holiday break. Her avoidance of directly saying goodbye to me without her father's support was present in the next two sessions and felt particularly poignant for me in the final session:

Session 4: It was time to pack up and finish and we tidied the things away. I asked if she wanted me to look after the card for her mother or take it home, and she said take it home. We walked back to the waiting room and she said, "it smells nice, like flowers." Her father smiled at her when we returned and I explained again that I would say goodbye to Rania today and we would contact him and his wife for an appointment with my colleague. He nodded. I said Rania had made a card for her mother and he smiled. I said goodbye to Rania but she had turned away from me, and was getting a drink of water. She waved goodbye, but with her back to me and without looking at me. I felt sad to say goodbye.

I felt aware of feeling sad at saying goodbye to Rania, and at the time, I wondered if this was a reflection of her own feelings as well as my own. At the time, I felt as if I was not sure if parents would return. My experience of the family was that Rania's parents provided good care for her and her brothers. They clearly loved

her deeply and wanted the best for her, but they were also parents who were coping with looking after a young child with a severe physical disability, in addition, they were living here in the UK as refugees, with the corresponding loss of their family and home. However, her parents did attend the review meeting, which I shall discuss later. The impact of issues relating to Rania's experiences as a refugee which were re-enacted in the assessment will now be discussed within the next sub theme.

Theme 2 - How the child relates to me and the institution

Sub theme - Transference and re-enactment

For Rania, the data analysis showed that the sub theme of 'transference and re-enactment', manifested as an intrusion of refugee issues. During the assessment, Rania would often talk about her thoughts and feelings about her experiences as a refugee and these verbal thoughts shall be examined in more detail later. However, what also arose through the data analysis was how her experiences were re-enacted within the assessment, through non-verbal communication and play and within my countertransference. In the first session, this intrusion seemed to relate to what she may have witnessed when she was in her home country:

> *Session 1: Rania drew a huge heart and started carefully colouring it in. I commented on it being a big heart. Rania said, "it isn't what hearts really look like, they look like this." She drew a biological heart shape and I had a disturbing thought if she had seen a heart in real life and what she may have seen [in her home country]. I asked how she knew this and I felt relieved when she said her teacher had said that to someone in her class.*

During the assessment I was aware that this intrusion of anxiety may relate to my own fears about what Rania may have experienced and that this meant that I may have missed what else she was communicating. This recurred again in the second session as an intrusive fear of fathers being taken away:

Session 2: Rania immediately took out the dolls and opened the doll's house.. ..She quickly grouped the two families, "these are the same, their mum is in the kitchen, this girl has a room all for herself and the boys are all upstairs." Rania then looked at the other dolls and said, "maybe the girls should all share a bedroom together." Then she put both mother dolls in the kitchen. I asked if these are two families in one house, or two families in two houses? Rania said one house, they are all friends. I asked where are the fathers? Rania said, "they aren't here, they've been taken away." My thoughts immediately went to her father and fear of being taken away. I asked where they had gone. Rania said, "maybe the other children had taken them, no daddy dolls in the box." [Though there were 'daddy' dolls in the box, but she had used them to represent the all the 'boys']. I realised I had jumped to conclusion about the expression "taken away" and wondered why I had asked such a direct question. I asked about the other children. She said "the other children who use the [therapy] room."

I found it interesting that my own fears were perhaps becoming confused with what else was preoccupying Rania, which was that other children could take the 'daddy dolls' out of the box. Rania's fear that other children could take things from the box emerged throughout the assessment and data analysis and will be discussed in a later sub theme.

The data analysis revealed another example of perhaps how Rania's experiences as a refugee were being re-enacted in the assessment, which was a confusion of place:

Session 3: Rania came back to the table and sat down and I sat down. I suddenly wondered if I had sat in this seat last time as I was sitting on the sofa and I wondered if this was where I had been sitting last time, or if I was on the other chair, I felt confused and not in my right place.

This experience of not being in my usual place, or in the wrong place, was unusual for me, as normally, I am very clear where I sit. At the time, I noticed it but did not know what it may mean. However, in analysing the data, it seemed to be another example of how for Rania's experiences as a refugee, may have been re-enacted and transferred in the assessment. Refugees often have to move from place to place, both in their journey from their home country, but also within their new country. For Rania, this may have related to her own confusion of leaving her own home and coming to the UK.

Data from the final session also provides evidence for this. It was striking that there was such a long gap between the third and final session. I was left with a strong feeling that the family had suddenly disappeared, with no warning and no messages from them. This is a common experience for refugees, whether they have been forced to flee suddenly, or in secret for their own safety. When Rania returned for the final session, both Rania and I were left not knowing what had happened:

> *Session 4: Rania tried to take the plasticine out of the wrapper and said, "it is hard now and it smells different." I said it wasn't the same coming back today; it had been a long time and things felt a bit different, some things were the same, but some things felt different [though the contents of the box and room was the same]. She nodded and carefully pulled off some purple and pink plasticine and instead of making the blanket bigger; she added it to the sides of the bed/rug, seemingly to make it more secure. I said perhaps it was very confusing to be back here today because the last time we had met, we had said we would meet again in a week, and now it was 12 weeks and maybe it was confusing what had happened. Rania nodded, and she said something that I can't remember, but I remember there was a strong sense of things being left unfinished.*

These recurring examples of how Rania's experiences as a refugee may have been re-enacted within the assessment are interesting because she was also a child who was able to verbalise her thoughts and feelings about her experiences.

I wonder now, if the experiences that were re-enacted were perhaps related more to thoughts and feelings that she was not able to verbalise so clearly. Rania was only 6 years old when she left her home country and arrived in the UK, and so many of her experiences may have not been understood verbally and consciously.

Since this time, Rania has also had further experiences, which have also impacted on her understanding of herself, her family and her behaviour. Throughout the assessment, it was striking how well behaved Rania was with me, and this is the next sub theme which will now be examined.

Sub theme - Behaviour

The final sub theme within the main theme of how Rania related to me and the assessment is her behaviour during the assessment. For Rania, this manifested as her being on her best behaviour with me, perhaps due to feeling very special about receiving my uninterrupted attention, time and the materials that I provided for her:

> *Session 1: Rania carefully cut it out and stuck it down on the paper, again commenting that she needed to be careful with the scissors and asking me if I had bought the glue new? There was a sense of her being on her best behaviour and feeling very special with all the things that I had provided. She said she wished she had a box like this at home with all of these things.*

However, she did allow herself to let me know that she wanted more time at the end of the session and she wanted to finish the card she was making. The data analysis showed that even this bid was made under the guise of best behaviour:

> *Session 1: I said it was nearly time to finish, we had 5 minutes left, then we would tidy up. She nodded and drew and then cut out rainbow shapes. It was time to pack away and I said this to her and she said,*

"when my teacher says that in school, I keep going to finish." Rania did the same with me, she wanted to finish sticking the card, then writing on her friend's name and pushing the time boundary in a 'very nice, little girl' way.

This sense of her being on her best behaviour, was in contrast to how her father reported that she behaved at home. He was increasingly worried about her and said she was disobedient with her parents and aggressive towards her brother Ibrahim:

Session 3: Rania's father got up and came over to me.. ..her father pointed to a small scratch on Ibrahim's face, saying that Rania had done it, she had pushed him and he fell, and he was now teasing Rania. It was difficult to fully understand him, and he didn't seem to understand when I said it sounded difficult and were both children fighting more? I said that I would let my colleague know and we could also talk about it more when we meet for our meeting in two weeks time.

I spoke to my colleague about these concerns and we thought about how Rania and her brother Ibrahim may be affected by their past experiences, but also by the ongoing experience of their youngest brother Hassan having such profound disabilities, who needed a great deal of care from their parents and other adults.

Rania continued to be on her 'best behaviour' throughout the assessment. However, she was able to let me know how much she wanted to take some of the toys home, despite her sense of my 'rules':

Session 3: Rania looked at the plasticine and asked if she could open it? It felt as if she was wondering what rules were here. I thought with her about this and she agreed. I asked her what she thought the rules were here and she said "not take things out of box, not take paper or plasticine home…" ..Rania went back to look at her picture and did a picture for her new friend Sara and then stuck it on to the picture,

building it up and adding to it. She asked if she could take it home? I said we could think more about that next week; it was time to pack up now. Rania didn't say anything or show any disappointment.

I was interested in whether Rania's best behaviour was related only to me and the assessment and how she wanted to be seen by me, or whether she also understood and identified herself as a 'good girl.' This will now be discussed in the next sub theme of 'identity.'

Theme 3 - How the child relates to their own self

Sub theme - Identity

The data analysis revealed that the second main theme of the assessment related to how Rania understood and related to herself. The first sub theme that emerged within this was 'identity'. For Rania, this manifested as an identity of growing up and being a good girl.

In the first and final sessions, she showed an interest in playing with the farm animals, and was very excited to find all the baby animals. At first, I wondered if she identified with these baby animals:

Session 1: Rania then looked through the box again and said, "oh they have a farm!" She took out the fences and individually took out the animals. She commented on the baby animals, "is this a baby cow? And another!" She put them both in a fenced area. She took out a donkey and horse, asking me if the donkey, "is it a baby horse?" She looked at it and said, "no, it's a donkey," and I felt impressed at her language. She said, "look," and pointed at the mane. She took out all the other animals. She was interested in the baby pig who was pink and black, she examined him, then looked at the bigger pig and back at the baby pig, saying, "has it been coloured in? Was it pink and now

it's black?" The comment made me think of her identity and her skin colour.

However, the data analysis showed that this play probably related more to her trying to understand her own development and age, which seemed confusing for her at times:

Session 2: Rania said she couldn't talk properly because her tooth had come out and she showed me the gap in her front tooth… ..I asked what she thought about her teeth falling out? She shrugged and said, "all my friends want their teeth to fall out but I don't like it, babies have this!" She opened her mouth and pointed at her gums. I asked what she understood about why teeth fall out? She shook her head, I said maybe she could ask her mum and dad and was she worried about it? She nodded and said she can't speak very well.

As I described previously, in the sub theme of behaviour, Rania often appeared on her best behaviour with me and I think this not only related to wanting me to see her as a good girl, but also to her own sense of herself as being grown up:

Session 3: In the room, she went straight to the box and then the doll's house. She asked where she should put her water (cup of water from waiting room) as she didn't want to spill it. I thought she looked very grown up and composed. I said that was a good idea, where would somewhere safe be for it? We looked around and she saw the other table, then the window sill, and said she would put it there, she said, "it's so tall, the cup, lots of water."

The data analysis showed how Rania's understanding of her own identity as a good, grown up girl, was likely to be linked to her complex feelings towards her brothers and her denial of some of her own feelings that she projected into her brother Ibrahim. This is the next sub theme and this will be described now.

Sub theme - Denial

The sub theme of ‘denial’ manifested in Rania as a denial of her own negative feelings, particularly greed. Rania was able to verbalise her wish to take things home from the assessment, but she denied how strong this was and seemed to project her negative feelings of wanting to take, into her brother Ibrahim. She related to herself as a ‘good’ girl, compared to her ‘naughty’ brother Ibrahim:

> *Session 1: Rania asked when she could take the picture home? I said when we said goodbye, not today, we would meet for 3 more times, then say goodbye and she could take the picture home then if she wanted. She nodded. She then said that her brother Ibrahim takes chocolates from the teacher and takes things from her mum's basket and she didn't know what to do. She said her teacher and her mum knew, but he always did it and when she told him not to, he runs away from her and takes off the wrapper and eats the chocolate. I said her brother took things that he wanted, maybe she wanted to do that sometimes? She denied this and said she would now make a rainbow.*

The data analysis showed that it was mostly her brother Ibrahim who Rania experienced as taking everything from her. She seemed much more unsure about whether she was allowed to have her own desires and needs in relation to her brother Hassan, who was 2.5 years old and had profound physical disabilities:

> *Session 2: Rania said again that Hassan really likes her favourite teddy bear and he has lots of people coming to the house to help him and he has a special chair to sit in to make his legs straight and he has to have this in bed, she drew the chair and blocks that her brother had. She said she talks to him. I commented on him needing a lot of extra help, she nodded. She said her favourite bear helps her go to sleep but one night he had it and she took it from him! There was a moment of triumph, and then she said she gave him his teddy bear, an elephant. I commented saying, actually, she needed her own favourite bear, that was hers and her brother had his own teddy bear but maybe*

she wasn't sure if she should take it from him? Even though it was so important for her? Rania nodded and said she had put the elephant under his arm and he had not woken up.

By the final session, it felt more possible to speak directly to Rania about the impact on her of having to share everything with her brothers. I observed in her play, why she may have felt she needed to deny the strength of her negative feelings towards Hassan and keep these feelings separate:

Session 4: She was putting the animals in pairs, and she was pleased to find a horse family; a mummy, a daddy, and a baby. I was thinking about her having to share with her brothers. I said this to her, that it was hard for her; she missed her home country, but she also had to share with her brothers! She nodded. She picked up the crocodile and looked at it and looked for another fence, but she had used the 6 fences to make a square pen for the pigs, and a triangle on top of the square for the horse family. She took out the roll of sellotape and used it as a pen for the crocodile. The other animals were lined up in pairs, apart from the elephant. I said she wanted all the animals separate and she nodded. I asked why and she said, "they will eat each other!" I said she wanted to look after them and make sure nothing bad happened to them. She nodded.

Rania's denial of her negative feelings, as represented by the crocodile, may have felt even more necessary for her, because of her refugee experiences and fears of loss of her family and loss in general. Her denial of her own strong wishes and negative feelings towards her youngest brother Hassan may have felt protective against an anxiety of further loss, whether loss of actual family members, but also loss of care and support from her family. For Rania, her sense of loss and what she no longer had was evident throughout the assessment and data analysis. This will be discussed now.

Sub theme - Deprivation and loss

As I have just described, Rania was a child who coped with her complex feelings towards her brothers and sense of wanting more, by splitting her feelings and projecting the negative aspects (greed, taking things) into her brother Ibrahim, to protect her brother Hassan, who she may have felt unable to have angry and envious feelings towards because he was disabled and needed much of her parents' attention and care.

The data analysis and assessment indicated that Rania's denial of her own greed may be a result of her profound sense of deprivation and loss. What also came across strongly in the assessment, and evidenced in the data analysis, was that this also related to loss and fear of further loss of a maternal figure. This was demonstrated very poignantly in the first session:

> *Session 1: Rania drew a teddy bear and said, "I have lots of bears at home but I have lost my favourite one, at the dinosaur museum.. ..When I got home I couldn't find her anywhere!" Rania said, "I looked all over the house! I took all my teddy bears of the shelf but couldn't find her anywhere." I said that was sad. She nodded. I asked what did she think had happened to her bear? She thought and said, "maybe someone found her and thought she was rubbish or maybe someone took her or maybe someone found her took her to a room with all the other lost teddy bears." I nodded. Rania said, "I have lots of bears, but I really liked that one, she had a rainbow on her stomach." I felt sad hearing this.*

The data analysis suggests that Rania was also fearful of further loss from damage from other children. In every session an anxiety arose about if other children had been in the box and taking things, or ruining her work. The sense of a paternal figure that could protect her was there, but Rania seemed to fear that this figure could not protect her box and her work from damage or things being taken:

Session 2: Rania was pleased to see the picture she had done, saying, "it is still here, it hasn't been scribbled on!" I asked if she had been expecting it to have gone or be ruined? She nodded and said, "I thought other children would have come in and taken it or drawn on it." She looked at me carefully and asked "where is your coat? Do you have an office where you keep your coat?" I said I did. She immediately said, "is that where you keep the box?" I nodded. She smiled and seemed relieved, then she frowned, and said, "but children could still get in there and put the wrong things in the box!"

As I described in the previous sub theme, Rania was a child who often complained about her brother Ibrahim taking her things and her parents not doing anything to stop this. But also, there was a sense that she was also a child who wanted more and more, and wanted to take things, perhaps in relation to her internal and external experiences of loss. However, she was able to begin to verbalise this towards the end of the assessment:

Session 3: We packed up together and Rania wrapped the plasticine figure of the sleeping girl up in a piece of paper and we found a safe corner for her in the box then carefully put her pictures on top, and then the teddy bear. Rania said, "if I took him home, I would call him Golden Bear and I would let him sleep with me and my other bears, he is so soft." She was stroking his fur. I said she was telling me she would really like to take him home. She nodded.

I understood Golden Bear to be a concrete expression of her desire to replace her lost Rainbow Bear; and that her experience of me and the assessment, had been something that had made her feel special. I think Rania had enjoyed and needed time on her own with an adult who could give her undivided attention and understanding, as a mother would. I also wondered if she wanted to be the special and 'golden' child for me, I was aware that she certainly elicited a maternal response in me. I often felt as if I wanted to look after her and interestingly in the first session, this occurred alongside a feeling of tiredness:

Session 1: Rania looked at the box and asked, "are there dolls?" I nodded and she opened the box and seemed pleased to see the dolls. I asked if she wanted me to move the doll's house closer, and we moved it onto the smaller table, so that I could see what she was doing. I sat down, and I was suddenly aware of feeling very tired and having to make a lot of effort to concentrate on her.

At the time of the assessment, I was interested to see if this feeling of tiredness was connected with Rania and the assessment, or something that belonged to me. It felt an unusual tiredness, stronger and significant enough for me to notice it within myself. In the session, my maternal feelings recurred:

Session 2: In the room, Rania went straight to the box, but then looked up and shivered a little, saying, "it's cold." The room was cold, and I said I was sorry, but yes, it is cold, she could keep her coat on if she was cold. Rania nodded and tried to open the box. I immediately went to help her, then stopped myself, aware of having offered without her asking or necessarily wanting help. I asked her if she wanted help and she nodded and we opened the box together. She immediately took out the dolls and opened the doll's house and said, "the mum is on the toilet again", and pulled down the mother doll's trousers and placed her in the bathroom, sitting down.

At the time, I was surprised at this play; that the mother was placed on the toilet. I was not sure if there was something intrusive about it but also a sense of a tired mother being busy and not having any private space of her own. In the assessment and subsequent data analysis, I wondered whether Rania felt an absence in feeling that her mother had enough energy and time to keep her in mind. In the final session Rania seemed to want to do something nice for her mother, in which my own thoughts, I had initially wondered if it was related to me:

Session 4: Rania then took some paper and pens out and started making a card. I wondered if it would be for me as there was a sense of tidying up and getting ready to say goodbye. Rania drew a big

rainbow and asked if I knew what it was? I guessed a rainbow and she said, "it was easy to guess!" She then wrote her mum's name on the card. She added a sun above the rainbow and lots of kisses under her mother's name. I had a thought about whether this was a card to cheer her mother up.

I wondered if Rania's concern for her mother was due to her current experience of a busy, tired, worried mother, which seemed in contrast to the sense of the 'rainbow bear' type mother, which perhaps she had had when she was much younger. I wonder if this sense of loss of an early maternal figure, was due to the normal childhood experience of loss of the intense mother-baby relationship, that was then compounded by the subsequent birth of two brothers, and at a time, when the whole family had to flee their country. This may have resulted in Rania feeling that she needed her mother and her father even more than usual. The way that Rania understood and related to her family and her external experiences, is the final sub theme. This will now be described.

Theme 4 - How the child relates to their external experiences

Sub theme - Parents and family

For Rania, the sub theme of 'parents and family' manifested as Rania feeling safe and supported by her family. Her parents' capacity to look after her and support her seemed good. The data analysis revealed that Rania seemed to have internalised a feeling of safety within her family as she described movingly in a dream she told me:

Session 2: Rania asked, "do you want to hear my dream about my bird?" I said did she want to tell me? She nodded and said, "my bird asked me to take her out of the cage so I could stroke her head. I opened the cage and she came on my hand and let me stroke her. She said she liked it when I stroked her and I kept doing it and then she said she could fly but then she changed her mind and asked me

to put her back in the cage, but she jumped up to the top bit and next to the opening and wanted me to keep stroking her head." I felt moved hearing about this dream and the little bird and the wish for flight, but wanting to go back to the safety of the cage, but needing someone to comfort her. I asked how the dream made her feel? Sad, scared? Happy? Rania said, "happy, the bird let me stroke her." I said the bird had wanted her to stroke her whilst she was both in and out of the cage. How did she feel in the cage? Rania shrugged, "ok, safe, but if she got out to fly, she might fly too far and get lost." I asked about her bad dreams? Rania said, "I was on my own, my parents weren't there, I had to do everything by myself, I had to make my dinner, I had to cross the road by myself, go to school by myself, family not there." I asked how that made her feel? She said in a quiet voice, "really horrible and scared."

Her dreams show that although Rania had a wish for independence, that she understood that growing up required comfort and safety from her family. Her worry about her parents not being there may be related to both the normal fears of increasing separation when growing up, but also, this may have increased due to their experiences of having to flee their home and leave their extended family behind. The assessment and data analysis suggest that despite their experiences, Rania felt she had had some very good care and had internalised this:

Session 3: Rania then made a girl out of plasticine.. ..then she made her a dress out of two pieces, I was struck how attentive and thoughtful she was to the girl and what she needed. It made me think about her own experiences with her parents. Rania then made a pillow and very big warm blanket for the girl.

As I described previously, at the beginning of the assessment, Rania often felt that her parents were not able to stop her brother Ibrahim from taking her things and her mother felt a more absent and lost figure. However, the data analysis showed that by end of assessment, she felt that her mother was more active and

so she felt more protected, not only from her ‘naughty’ brother, but also from her own internal fears:

> *Session 4: Rania said, “I was cross this morning because Ibrahim went outside to see if his plant had grown strawberries and it hadn’t, it was still green, so he had watered it, then he watered my plant! But my plant didn’t need water and I told him to stop and he didn’t! So I told my mum!” I asked if this had been a fight and she shook her head. I said she and her brother really wanted to look after their plants and she nodded. Rania said, “my mum knows how much water my plant needs and she told Ibrahim to stop!” There seemed to be a sense of Rania feeling contained. I said I also remembered that she had had bad dreams. Rania said, “they have stopped now, I have a little book next to my bed, with [home country language] and my mum helps me read it and the book stopped all the bad dreams.” I said her mother was helping her with many things and she nodded.*

At the time, I had also wondered if she was letting me know that her mother was the person who could help her, and whether this was also a reaction to the end of the assessment and saying goodbye to me. I was aware that I felt sad to say goodbye to her. When I met her parents for the review appointment, they were clearly able to think about Rania’s emotional needs and requested help for themselves as parents to be able to help her even further.

Sub theme - Housing and school

For Rania, the sub theme of ‘housing and school’ manifested as denial of any concerns. Rania was initially keen to tell me about her school and the good experiences she had there. The data analysis did not reveal that she had any significant worries in school about her ability to make friends or learn. She also seemed to be able to relate to the teachers as people who were there to help her and keep her safe, as her parents did:

Session 1: Rania said would need to be really careful cutting it out, as her dad told her to be careful using scissors because they can slip and go in your eye. She asked, "would your eye bleed and you would have to go to hospital for this?" I said I didn't know if your eye would bleed but yes, she would have to go to hospital. I asked had that ever happened? She shook her head, and said, "my teacher tells me to be careful too." Rania showed me how to hold the scissors so they don't slip. Rania suddenly asked, "do you know which school I go to? I said that I was sorry, but I didn't know. She said, "I can show you." She got up and unzipped her coat and came closer to me to show me her uniform. I asked if she liked school? She nodded and said, "I have lots of friends."

Rania often mentioned having friends at school, and this seemed important for her. She described many friends who also had come from other countries and the data analysis revealed how the normal latency aged school experiences played out with these friends:

Session 3: Rania said her friend Zarah had left, "she went back to her own country." I asked how she felt about that? Rania said, "sad but I have another friend now and she is my favourite." Rania then said she would do something for her new friend Ana. As she started drawing, she said, "at Christmas, other children went back to their own country or the seaside." She seemed sad. I commented on this and said it was sad. I asked did she want to go back to [home country] or somewhere on holiday? She nodded but then said in a very ordinary way, "holidays are so boring, staying at home all day!"

The assessment did not reveal any significant issues relating to the family's housing situation (as if often the case with families who are refugees). Rania often spoke of missing home, and this will be described in the next sub theme, but in relation to the accommodation the family lived in, she seemed to feel safe with her brothers:

Session 3: Rania said, "I sleep with my brothers, we all share a room, back home mum and dad said I could have my own room." I asked about their house in [home country]. Rania said, "it was much bigger." When I asked if she would like her own bedroom, she said something about being scared to sleep on her own.

I was aware that Rania's parents had been allocated their accommodation relatively quickly when their son was born, due to his physical disabilities. Therefore, Rania had not experienced living in many different places or being in unsuitable accommodation, which is often the experiences for many families who are refugees. For Rania the most significant issue for her relating to housing was the loss of her home when she had to leave her country. This loss and other losses will now be described in the final sub theme.

Sub theme - Refugee issues

For Rania, the sub theme of 'refugee issues' manifested as a profound sense of loss and homesickness. As I have already described, Rania seemed to have internalised a sense that her parents and adults could help her. Therefore, she felt able to speak to her parents and me about her losses and wanting to go home:

Session 2: Rania nodded, and shivered and said, "my dad told me that my [pet] turtles couldn't come here because they would die, their skin would get all brown and dry and they needed to stay at home." I said she was thinking of home and what she had had to leave behind, her turtles? She missed them and she wondered what could live here? She didn't answer and I thought perhaps that was a bit complicated for her.

Despite Rania feeling comfortable to speak to her parents, the data analysis showed that her homesickness still felt very painful for her, even after being in the UK for 3 years:

Session 4: Rania said, "I miss my country, I heard my dad talking to [she paused, trying to remember who it was, for a few moments, really trying to remember], I can't remember who he talked to but they said that that the war was getting better, so…" She looked at me, "maybe we can go home soon." There was a real sense of longing and missing home and I felt very sad, thinking that it was very unlikely that they would be returning home soon. I was thinking about how much medical attention her brother needed and her parents reason for fleeing. I was left with a huge sense of unresolved loss. I asked if her parents know how much she misses her country and home? Rania nodded and said, "I ask them every day, when can we go home and they say when the war finishes." I thought that this must also be hard for her parents and I asked her if she thought that her parents wanted to go home and she nodded.

When I met with her parents for the review appointment, I let them know that one of the main findings from the assessment was Rania's sense of loss and how homesick she still felt. It felt very painful to discuss this and her mother immediately started crying herself when I spoke about it. We thought about how homesick they both felt and their acute worry about their family who were still in the country, who they missed terribly. Their extended family were in places of relative safety in terms of the war, but they were very scared that this may change.

Discussion of findings for Rania

From analysing the data from Rania's assessment, it is clear that the impact of her loss of home, loss of her mother's attention and Rania's rivalry with her brothers were major sub themes in the assessment, and contributed to a number of other sub themes identified. I think that for Rania, the loss of home also signified a loss of the mother she had when she was very young. At the beginning of the assessment, she was still missing her 'Rainbow Bear' [idealised mother-infant relationship] but by the end of the assessment, she had recovered a sense of being able to make use of the support her mother offered her. However, her

loss of home, still felt very painful at the end of the assessment. It could be that her profound homesickness was due to this combination of loss; her 'idealised' mother and her home, which combined, and focussed her grief on her lost 'motherland.' I also believe that her ongoing homesickness could also be linked to her parents' losses, and that she was also identifying with and carrying this. Perhaps she was also reminded of this loss at the end of our assessment, and maybe some of her sadness related to this. In the final session, I was aware of feeling sad at saying goodbye to her.

When I met with her parents, they were thoughtful about Rania's needs and were aware of some of their own needs. They were keen for support for themselves, as well as Rania. This corresponded to my findings of the assessment and data analysis; that she was a child who had had some very good care giving experiences and she felt safe within her family. The assessment demonstrated that she could make good use of an adult mind and thinking. The child psychotherapy assessment contributed to further assessment by the psychiatrist, who concluded that Rania did not meet criteria for PTSD and supported the recommendations I made.

The clinical recommendations from this assessment were:

1) Further parent work and/or individual work to help Rania's parents speak about their own worries and losses in relation to their experiences as refugees, but also their experiences as parents with a child with profound disabilities.

2) Consideration for further family work with Rania, her parents and her siblings, to think about how they support each other as a family and understand their experiences.

However, after analysing the clinical material, I am also more aware now of the sub theme of denial. The assessment and data analysis demonstrate that at the time of assessment, Rania was a child who defended herself against her anxiety about her negative feelings towards her youngest brother Hassan, by splitting her

own feelings and projecting them into her brother Ibrahim. Rania's identity of being a good girl, who needed protecting from all the children who she expected to take things from her, was strong in her mind. When I met with her parents, they were already aware that this was not quite as straightforward as Rania believed and they had a good sense of her also having feelings of wanting to take things and wanting more from them.

However, what the child psychotherapy assessment and data analysis also showed, is that Rania was a child who had experienced losses, both in her external world, but also her internal world. This may have led her to have greater levels of anxiety or fears of further losses, which resulted in fights with her brother Ibrahim and anxiety about whether she can have similar feelings towards her brother Hassan.

On reflection now, I wonder if I overestimated the parents' capacity to be able to tolerate and understand Rania's emotional needs. My sense is that they were parents who had already provided Rania with very good care giving and support, but perhaps because of this feeling, I then underestimated the stress that they were under themselves, which may then have affected their capacity to provide this for Rania. I wonder now, if Rania may also have benefitted from some individual child psychotherapy as a space to express and explore her fears and intense feelings of rivalry and loss.

Overall discussion

The data analysis of the child psychotherapy assessments have revealed some very interesting findings, which I have described individually for each child. I will now compare the assessments, and discuss the main commonalities and differences between the findings and how this could help inform a better understanding of each child.

Theme 1) How the child and family relate to the structure of the assessment

Sub theme ‘Beginnings’

For all the children, the beginning of each of the 4 sessions meant a separation from their parent. Typically, at this age, children in the UK, have experience of being apart from parents for positive reasons, such as school and seeing friends. Even still, they will be drawing upon their internal resources and previous experiences to help with these moments of separation, especially when meeting someone new (Bowlby, 1969). The findings of this research demonstrated that all of the children and families responded differently to this, due to their own internal resources and external experiences.

The beginning for Ebi was marked by lateness, and so each session began with a loss of time, frustration (on my part) and confusion about whether the loss was related to his father’s state of mind or something that Ebi was also active in. In my experience, lateness can be relatively common for families who are refugees. It is often understood as a difference in culture and expectations or an indication that families are under strain. However, what I observed to be different for Ebi, was the frustration and anger that I experienced in my countertransference, which was not as common in my previous work with refugee families. I wonder if for Ebi’s family, the lateness also related to anger about having to conform to someone else’s time and rules, as described in the paper by Sinason (2002). This may have been a significant factor, in addition to any anxiety about being apart, and what this may have reminded them about their previous experiences of torture. When Ebi did say goodbye to his father at the beginning of the session, there were times he seemed to hold himself together by staring at objects in the waiting room, the bookcase, the fish tank, perhaps in a second skin defence (Bick, 1968), which suggests the separation from his father and beginning with me was something that caused him anxiety.

For Samer and Rania, the beginning of the sessions seemed more related to how they and their parents could manage the separation. Samer seemed to need me and himself, to believe that he was not anxious about this and he could manage being apart from his mother. In the first session, this way of coping led to a sudden intrusion of anxiety and danger that everything could collapse at any

minute. For Rania, she also did not appear outwardly anxious, though her father was active in helping her with this. Both Rania and Samer seemed to initially expect me to be a benign, 'teacher' figure, perhaps as a way of managing any anxiety they felt about meeting me.

Sub theme 'Endings'

The data analysis demonstrated that all of the children reacted to the end of the session by avoiding saying goodbye to me and they had to rely on their parent to help facilitate a goodbye. All of the parents were able to do this and help their child to acknowledge a transition from something finishing, to something else beginning again. Both Ebi and Rania seemed to use objects in the waiting room to help with their anxiety, for example, staring at the bookcase, perhaps as a 'second skin defence' (Bick, 1968), whilst Samer sought contact from his mother.

These findings indicate that children who are refugees may be more sensitive to the end of something, especially if this involves a separation with a person. Perhaps due to their previous experiences of loss, leaving their homes and countries and the subsequent separations from family, friends, and their community. The impact of this may be underestimated in children who arrived at a young age, or with their family, when compared to the losses and separations experienced by unaccompanied children. It may be something that parents or other adults who work with the child are also not as attuned to. They may think that the child is being rude or difficult or that the person or experience was not important for the child. I know that in my clinical work with refugees up to now, I was less aware of this with accompanied children, and this is something that I shall keep firmly in mind as a result of this research.

Theme 2) How the child relates to me and the institution

Sub-theme 'Transference and re-enactment'

The findings of this research indicate that for all of the children, my countertransference was crucial in being able to observe and understand how the children related to and experienced me and the institution and issues of re-enactment. These were often experiences that the children could not verbalise or communicate about directly with me because they were unconscious experiences, for example, Ebi and, his parents' experiences of torture, or because the children themselves did not fully understand their meaning or impact. This supports the findings of previous work, that trauma and loss is often felt in the emotional experience with the child, rather than what is verbally reported (Hindle, 2007). It also supports previous work that found that parental trauma can continue to impact on the child and parents in an unconscious state (Grünbaum, 1997, Youell, 2002).

Observation and reflection of the clinician's own emotional responses and close observation of the child's emotional state of mind and communication, is a key and unique aspect of a child psychotherapy assessment (Heimann, 1950, Hopkins, 1986). The data analysis shows that this was a very important tool in helping me to understand each child and their individual responses during the assessment.

Sub theme 'Behaviour'

The data analysis showed that all of the children related to me as being on their 'best behaviour'. They were all outwardly compliant, polite, if anxious. This was in direct contrast to how their parents described their behaviour at home. With me and in the clinic, their behaviour seemed similar to how they were reported to be at school. I understood this to be an indication that they were all children who could control themselves, their impulses and they had been able to pick up the social rules of the clinic. This is in contrast to other children who I have worked previously with, who displayed much higher levels of distress and disturbance during the assessment. I think that for Ebi, Samer and Rania, this indicated that they probably had 'good enough' early experiences and so could contain themselves for short periods with me, an unfamiliar adult. I also think that they

were all keen for me to see them as ‘good’ children, perhaps anxious about how I may respond or what I may tell their parents.

It is interesting therefore, to think about their behaviour at home and perhaps the differences between the children. I think for Ebi, his distress, anger and physical complaints of pain related more to the high levels of anger, distress, and depression of his parents, as well as his own feelings of loss and anger, as demonstrated in previous work (Judd, 2001, Martin, 2012). I do not think that this was a conscious process from his parents; they clearly loved him dearly and wanted the best for him. For Samer, his behaviour at home seemed to relate more to competition with his siblings, and his need for attention from his mother, and lack of clear expectations and boundaries, perhaps due to her own experiences of trauma and loss (Youell, 2002, Mooney, 2016). Rania was also a child who struggled with her feelings of rivalry with her siblings, as well as her feelings of loss. I imagine for all the children, they also felt ‘safer’ to display their difficulties at home, and that even if this caused them some anxiety, I observed that all of the children related to their family as safe adults, who cared about them and looked after them.

Theme 3) How the child relates to their own self

Sub theme ‘Identity’

The data analysis revealed that the children all understood themselves and their identities differently. As I have described, the common feature they shared was denial, but how this manifested in their identities was different. Ebi seemed a shy child, who understood himself to be independent and self-sufficient and denied that he needed or wanted any help from adults or that he felt frustrated when they could not help him. Samer was clear that his identity was someone who could do anything, he was good at everything and he was the same as an adult and his older siblings. For Rania, she seemed more identified with being a good and grown up girl, whose only problem was her ‘naughty’ brother. Though she was

painfully in touch with the loss of her home and country, she seemed able to identify with the other children in her school who were in a similar situation.

Sub theme 'Denial'

The data analysis revealed that all of the children used denial to protect themselves from different anxieties. For Ebi, the denial that he had any needs, or needed anything from adults, seemed to protect him from the disappointment and frustration of not having these needs met. For Samer, the denial that he was different to adults and his denial of any anxiety, seemed to protect him from feelings of being small, vulnerable, confused and scared. For Rania, her denial of her feelings towards her youngest brother, helped protect her from her anxiety of what damage her anger, envy and rivalry could do to her family relationships and so protect her from further losses.

This supports previous work that suggests denial is a very common way for refugee children and adults to protect themselves from feelings and states of minds that could disturb them or the people around them (Almqvist and Broberg, 1997, Jarkman Bjorn et al, 2011). My concern is that for Ebi, Samer and Rania, their denial of their own needs and feelings may be stronger, due to their anxieties about the impact on their parents (Ajdukovic and Ajdukovic, 1998). This denial may then lead to them not being able to recognise their own needs and ask for help and support. This could then lead to further deprivation, which was another commonality between the assessments.

Sub theme 'Deprivation and loss'

The sub theme of deprivation and loss emerged for all three of the children. The sense of loss was profound with Rania, who seemed most affected by the loss of her home and country, and loss of aspects of her early maternal relationship. However, Rania was also the child who was most in touch and able to verbalise and communicate these feelings to me. The data analysis showed that for Ebi

and Samer, their losses and corresponding deprivation, were also very powerful but they were communicated through their behaviour and unconscious processes.

I think it is important to understand why for all three assessments; I did not recommend individual child psychotherapy as a first point of treatment. On further reflection now with the data analysis and discussion, I wonder if for all three children, their deprivation, loss and denial of anxieties, were underestimated by me. Did this lead to further deprivation by not being offered ongoing child psychotherapy? Or, was it correct to recommend further parent and family work in the first instance, with the aim of creating stronger and more stable relationships at home before beginning individual work? I imagine that all of the children may benefit from individual work at a later stage as they grow up and reach different developmental stages. In my experience, adolescence can be a particularly difficult time for children from refugee families. The increasing independence and expectations of adolescent life in the UK can be a challenging time for both the young person and parents. For Ebi, Samer and Rania, I would hope by the time they reach adolescence, the work with their families and parents, will have created a more secure base for later individual work to be supported, if it is needed.

Theme 4) How the child relates to their external experiences

Sub theme 'Parents and family'

When I first completed all the assessments, I was expecting that parental capacity and mental health would be a common feature for all of the children. I was aware that all of the parents were under significant strain and anxiety. They were all struggling with their own losses, experiences, coping with life in the UK and trying to do the best for their children, who for all of them, they loved dearly. Parental mental health has been shown to have an impact on children and the parents' ability to recognise, respond and contain to their children's emotional states and needs (Murray and Cooper, 1999, Field, 2002, Emanuel, 2008).

However, the data analysis revealed that the parents revealed differences in their capacity to support the assessments and their own well-being. Ebi's father was the parent who I was most concerned about at the time. The family were still waiting for a decision about their asylum application one year after the child psychotherapy assessment, though he did eventually request adult mental health support in his own right. Samer's mother was able to fully support the assessment and continued with parent and family sessions, which have been reported to have made significant improvements for the family and Samer's behaviour at home. Rania's parents both sought and received their own individual support, as well as family sessions.

Sub theme 'Housing and school'

The data analysis showed that all three of the children seemed to have good experiences in school and that school was an important part of their lives (Fox, 1995, Blackwell and Melzak, 2000). They did not express any worries about school in words, but neither did it come up significantly in their behaviour or unconscious communication. This finding is supported by their parents, who did not report serious concerns about their children in school. All of the children's parents reported that the children behaved better in school than at home. However, I did wonder if Ebi and Samer were at risk of not being able to make full use of the teachers as adults to learn from and support them. Both boys seemed to deny they had their own needs and at times did not actively seek, or could make use of my mind to help them.

All of the children attended primary schools where there were many children from different communities and countries. I strongly believe that this was a protective factor for all three of the children. Children who are refugees, and in a minority, can be exposed to issues such as bullying, if they are the only ones who are from different cultures and communities.

Sub theme 'Refugee issues'

The data analysis also showed that the children all had different ways of understanding and relating to their own experiences as refugees. Ebi was trying to cope with his current life in the UK and seemed to have little understanding of why his family had had to leave their home country. Samer was a child who wanted to understand wider world events and why people and countries did what they did. Rania was still waiting to go home and recover her and her parents' profound sense of loss.

It seems significant that none of the parents or children spoke about their experiences on the journey to the UK. I wonder if this is due to their journeys being felt to have been relatively safe, or the opposite, that their journeys included traumatic experiences that they did not want to think or talk about.

Overall outcome of findings

The research findings demonstrate that child psychotherapy assessments have been able to reveal some of the individual differences and commonalities between children who are refugees. These findings are perhaps suggestive that the children's experiences as refugees interact, affect and are affected by, their previous and ongoing care giving relationships and the children's internal and external experiences. These findings will now be discussed further in the final chapter; the conclusion. In the conclusion, I will discuss these findings in relation to the research question, previous research, limitations of the study and overall implications of this work, including recommendations for clinical practice, policy and guidelines and further research.

Chapter 5) Conclusion

In this final chapter I will summarise the findings of the thesis, in relation to the research question and the aims of the study. I will describe how the findings relate to previous research and clinical work as outlined in the literature review. The limitations of the research will be then be examined. Following this, I will describe the implications of the findings and make recommendations for further research. I will conclude with my own reflections on the research.

The research question

This research developed through my clinical work as a Child Psychotherapist, during my clinical training, and once qualified, as a member of a Refugee Service within CAMHS. As I outlined in the introduction, my clinical work led me to a question about whether a typical way of assessing the internal worlds of children, a child psychotherapy assessment, could be a helpful and relevant assessment method for children who are refugees and living with their parent(s). In this thesis, I explored how this type of assessment could contribute to the understanding of children's individual internal states and the impact that their external experiences had on them. I aimed to answer the central research question which was:

How can a child psychoanalytic psychotherapy assessment contribute to the understanding of the individual experiences of children who are refugees?

I hoped that by answering this question, this research would be able to demonstrate in a small way, how a child psychotherapy assessment could be helpful (therefore, verification of clinical practice in this field) but also, if there were differences and/or commonalities to specifically working with refugee latency aged accompanied children (discovery of new ideas and/or validation of previous work). I will now summarise the outcome of the findings and discuss how they relate to previous work.

Summary of research findings

As I discussed in depth in the previous chapter, the findings suggest that a child psychotherapy assessment can illustrate how each participant had their own internal worlds as evidenced by their individual ways of understanding themselves, and relating to their present and past experiences. The findings also showed that there were areas of commonality, as well as difference between the children. It also highlighted many important aspects of the assessment process; for example, work with parents, impact of loss, defences used and sources of support for the children. I will now describe these findings in more detail in relation to the main areas identified in the literature review.

Overview of child psychotherapy research

The overview of child psychotherapy research revealed that further research was needed to identify the different groups of patients for whom child psychotherapy could help, as well as the methods of assessment used (Fonagy, 2003 and Fonagy et al, 2015). Further research on assessment was also recommended by Kennedy (2004), who emphasised the value of identifying a standardised assessment method for child psychotherapy which could be used as a research tool. In relation to these recommendations, this thesis has in a small way contributed to these areas and it has showed that some accompanied refugee children are able to make use of a child psychotherapy assessment.

Child psychotherapy assessment

The findings have also contributed further to previous research regarding child psychotherapy assessment. Previous work suggested that child psychotherapy assessments are able to assess a wide range of important aspects for children, including, the child's understanding of themselves, the child's way of relating, their behaviour, their development and identify defences they use when anxious (Walker, 2009, Green, 2009). I believe that the child psychotherapy assessments

in this research have been able to contribute in a significant way to the understanding of each participant in these areas.

A unique aspect of a child psychotherapy assessment is the use of the clinician's observation of their countertransference and the use of this to help inform their understanding of the child's internal world and ways of relating to others and themselves. The findings of this research indicate that observation of the countertransference as a way of understanding the unconscious communication and transference, is a crucial aspect of gaining further insight into the child's needs and difficulties. This supports previous work by Dyke (1985) and Mees (2016) who reported that child psychotherapy assessments can capture the unconscious communication of the child. The findings also highlight the importance of being open and attending to all aspects of the countertransference, no matter how uncomfortable it is for the clinician (Horne, 2009, Woods, 2010, Allan, 2016).

This outcome of the research also supports previous work by Hindle (2007) who suggested that observation of the countertransference and close observation of the child was able to capture the emotional experience of the child, that the child could not put into words, and was at risk of being missed by the network. Refugee children who are with their parents and family are often assumed by the network to have less needs when compared to unaccompanied children. However, this research has shown that these children do have their own needs, and that some parents also have significant needs which can continue to affect their children.

In terms of the practical issues of relating to assessment (i.e. number of sessions, toys, length between sessions), previous research suggested that although there was not a standardised method, there did seem to be a shared understanding (Petit and Midgley, 2008). The method used for this research was adapted from previous work (Bradley, 2013) who used a 4 session model of assessment for children in the care system, and whose work was very sensitive to the needs of children who had suffered multiple traumas and losses. The findings support this research, which emphasised the importance of an additional clinician being involved with the child and family, alongside and following, the child

psychotherapy assessment. I strongly believe that for the children and parents involved in this research, the ongoing contact with another clinician who supported the family and held the case throughout the assessment was crucial as it provided the opportunity for continuity in their care during and after the research.

Child psychotherapy work: trauma and loss

The findings of this research are also relevant to previous child psychotherapy work on trauma and loss. The children who participated in this research all showed individual differences in the ways that they related to themselves and their experiences (Boston, 1967) and presented with both conscious and unconscious memories of this (Hopkins, 1986). The differences between the children can be understood in a number of ways and this suggests that there are multiple influences on internal resources and resilience, including the child's own predisposition and early experiences (Mendelsohn, 1997).

The findings are also in line with previous work that has suggested that trauma and loss can have a profound effect on some parents and their relationship with their children (Judd, 2001, Youell, 2001, Jackson, 2004, Mooney, 2016). For all 3 of the children, I recommended parent work and/or individual work for the parents, in order to provide support and containment for the parents and the family. Previous work described how trauma and loss can be experienced as overwhelming and intrusive and the importance of the clinician being able to withstand and contain these states, which are often unconscious. This suggests that work within a psychoanalytic framework may be essential for recognising and containing trauma in some parents who are highly distressed.

Much of the previous child psychotherapy work on trauma and loss described long-term or intensive work (Emanuel 1996, Judd, 2001, Youell, 2001, Ehensaft, 2008, Keenan, A., 2014, Mooney, 2016). These papers describe the importance of the clinician being emotionally available and responsive, and the child needing time to work through their experiences within the structure of the therapy. The

findings of this thesis also indicate the importance of being emotionally available and responsive. It has shown that short-term assessment can indicate if further work is needed, but of course, it cannot replace long-term and intensive work as a treatment for severe trauma and loss. However, for some families and clinical presentations, short-term work can be a meaningful therapeutic intervention in its own right (Miller, 1992, Emanuel, 2006, Wittenberg, 2008). This research suggests this may need further consideration when working with refugees.

Child psychotherapy work with refugee children

Child psychotherapy work and research with refugees is a relatively small but important field. Melzak, who has written widely about her work, emphasises the importance of recognising the external as well as the internal world, when working with refugee children and families (Melzak, 1992, 1995, 2009). She recommends that clinicians need to attend to the child's experiences in both the past and present, and consider the different types of losses and trauma they have experienced and are experiencing, in the context of living in a different culture and community. The findings of this thesis strongly support this. I believe that the different assessments demonstrated how for accompanied children, their external lives, their school, their friends, world events, housing, their parents' health, all had a very significant meaning and had an impact on them. The differences in both their internal worlds and their external experiences were partly evidenced in the diverse clinical content of the assessments and their ways of relating to me.

The issue of length of assessment may need further work. In line with previous assessment work with vulnerable children (Bradley, 2013), I used a 4 session assessment method. I think for Samer and Rania, this was appropriate and helpful for them. I think for them, an extended assessment, may have been confusing and led to greater disappointment when it ended. For Ebi, I do think he may have benefitted from an extended assessment, due to the nature of his difficulties. However, I would also be concerned that without robust parent work,

an extended assessment may have also prolonged the sense of deprivation if the lateness could not be fully understood and addressed.

In thinking about the lateness to sessions, the findings of this research are in line with Sinason's work on the meaning and impact of time boundaries (Sinason, 2002). As I have described, I think the time boundary for Ebi's father was felt to be something that I was imposing on him, when he felt so much of his life was out of his control. Again, the research shows the importance of recognising and understanding the individual differences amongst refugee families. Sometimes, there can be an assumption that some refugee families are late for appointments due to different cultural expectations. Whilst this may be true for some families, I think the response to time boundaries, needs to be carefully and sensitively understood and responded to individually for each family, depending on their circumstances. In this research, I was aware of how strong the pull was within me to extend Ebi's session. I was aware I was tempted to allow the session to run over, to give him more time and aware of how mean and withholding I was left to feel at times when I did not do this. However, if I had not adhered to the time boundary, I would not have felt this and so may have missed this chance to understand the communication from both Ebi and his father, but also, it then would then have taken time away from my next patient, and so passed on the sense of deprivation.

Additional parent or family work may have been able to address the issues relating to the time boundary, but this research has also demonstrated that for some families, issues of denial and silence are present which will impact on the work (Melzak, 2009). Ebi's parents were only able to speak about their own experiences of torture and imprisonment much later, after the assessment, and many months into their parent sessions, when they felt able to. Therefore, this way of protecting themselves and family members, needs to be acknowledged but respected in clinical work. I think there may be a temptation to encourage parents to speak about their experiences before they are able or ready to do so, and that this could actually affect the child more, by causing the parents more distress. It may be that for some parents, they may never feel able to speak about their own traumatic experiences, particularly if their experiences are

something that has left them feeling profoundly ashamed, guilty and/or angry about, for example, rape, or violence they chose or had to commit themselves, or were forced to witness. It is these types of traumatic experiences, ones that individuals may never feel able to speak about, that are at risk of being passed on through intergenerational trauma, which can have a profound effect on children and families (Fraiberg et al, 1975). In addition, some adult refugees themselves may also be carrying their own family's previous intergenerational trauma (Sangalang and Vang, 2017).

The findings also support previous work that highlighted how the unconscious nature of trauma in refugee families can sometimes be expressed through the body in somatic issues (Martin, 2012). This is something that is certainly common in my clinical experience and it needs to be understood both as a possible unconscious symptom of distress, but also that real, physical symptoms need to be attended to by a medical professional. For Ebi, his headaches and stomachaches needed medical attention to ensure physical causes were ruled out, but also to help him and his family feel that his pain was being attended to. But alongside this, it would be crucial for him and his family to get further mental health support to help understand and relieve the unconscious, somatic aspect of his pain.

Other work with refugees from other modalities

The findings of this research are relevant to previous research from work with refugees by other modalities, for example, emergency or crisis refugee workers, psychologists and psychiatrists. Many authors recommended that further research was needed to identify the broader, individual needs of refugee children, in the context of both their past and present experiences (Jones, 2008, Goldin et al, 2008, Montgomery, 2008, Hebrebrand et al, 2016). Current methods for assessing children tend to rely on parent or teacher reports, using both semi-structured questionnaires and/or clinical interviews.

However, these methods may be limited as they rely on parents and teachers being able to recognise the distress. Some children may hide their distress from parents to protect them, as well as some parents may be less likely to be able to recognise their child's needs due to their own distress. In addition, these measures rely on verbal reports, rather than observation or direct contact with the child. Gadeberg and Norredan (2016) argued that urgent research was needed to identify assessment methods that could identify individual needs for children, including methods that included non-verbal techniques such as observation of play, drawings. I believe that this research has demonstrated that a child psychotherapy assessment can be an effective method of assessment for identifying the needs of some younger refugee children, one that does not rely on parent report or verbal capacity of the children.

This research has also contributed to work that has emphasised the importance of an initial generic assessment (Elliot, 2007, Montgomery, 2011), work with the family (Fox, 2002), and being aware that attending clinic appointments may remind parents of previous trauma and interrogations (Enholt and Yule, 2006, De Haene et al, 2013). I have already discussed in length the issues relating to parent distress and its impact on children but I also want to highlight the role of siblings. For Samer and Rania, their siblings seemed to be both a source of intense rivalry, but also I think support and company (Hindle, 2007, Rustin, M.E., 2007).

The findings have also demonstrated how important school is for refugee children as somewhere consistent, supportive and able to provide containment (Fox, 1995, Blackwell and Melzak, 2002). As described previously, all 3 children in this research attended primary schools where there were high numbers of children from many different cultures and countries, including other refugees. I think that this served as a protective factor for the children. Certainly for other children that I have worked with previously, school has been much more challenging due to bullying, isolation and/or having to change schools frequently. All of the parents in this research were very supportive of their children's education and school, which is in line with other research which reported that

school can be a very important link in engaging families who may not attend clinic based work (O'Shea et al, 2000, Durà-Vilà et al, 2012, Hughes, 2014).

One of the other main areas of previous work, which this thesis could contribute to is the area of resilience. Previous work has linked resilience to maternal well-being (Miller, 1996), parental well-being (Ajdukovic and Ajdukovic, 1998), which seems relevant for Ebi and Samer. Other protective factors include high parental support, family cohesion, positive school experiences and friends (Fazel et al, 2012) which especially links with the findings for Rania. Resilience will be under more strain if the child has had several changes of residence, parental exposure to violence, single parent families, parental mental health issues (Fazel, et al, 2012), which seems significant for the findings of the assessments with Samer and Ebi. Of course, it is important to recognise, that even with these different and significant factors, this research has in a small way also shown that each child will have a different experience due to the interaction between their and their parents' own internal worlds and resources.

In summary, to answer the research question, this thesis has been able to show that for the 3 children who participated in this project, a child psychotherapy assessment was able to capture some of the ways they understood themselves, protected themselves from anxiety, and related to their past and present experiences. Overall, this outcome shows that the children are all individuals, with different internal worlds and so with different resources and needs. At the time of the assessment they all lived within families with who loved and cared for them, but who as individuals and as a family, were trying to adjust to life in the UK, whilst living far away from home and their extended family.

However, these findings need to be understood and applied with care, as there are of course, limitations to this study. I shall describe these now.

Limitations of the study

The results of this research need to be treated cautiously for a number of reasons. Firstly, there were only 3 children involved and so it is a small study. The participants were all the same age and came from the same geographic region (though three very different countries). Therefore, it is not clear if these results are generalisable to children of different ages, or from different countries and cultures. In addition, all of the participants had been living in the UK for 2 to 3 years, and had travelled and were living with their parent(s), who were from professional families with some of their own resources. The children were relatively settled in school and could speak English. Apart from one child (Rania) the children were not reported to have witnessed any violence in their home country and they had not had any family members or friends killed, therefore the trauma and loss they suffered may not be representative of other accompanied children's experiences (though of course, I am aware that this is what their parents reported, but there may have been other traumas or losses that the children did not tell their parents in order to protect them, or that there were also experiences that their parents did not want to talk about).

The research could also be limited because only one method of child psychotherapy assessment was investigated. This study used a method and structure that is commonly used within NHS CAMHS, and so it needs to be acknowledged that other types of services may use a different methodology when working with refugee children and families. This will be discussed in more detail later in a critical evaluation of the assessment method.

Another limitation of the research is that the findings were drawn from purely observational and subjective data, which only I collected. I did speak to parents and teachers, but it may have been helpful to use similar methods to analyse this data and/or compare it with quantitative measures to add breadth to the data. I am also aware that the thematic analysis may be limited due to my own inexperience in using this method.

Even though there are a number of factors that may have limited the generalisability and validity of this research, I do believe that the findings may still

be useful to think about and have implications for working with children and families who are refugees. I shall discuss some of these now.

Implications

Use of child psychotherapy assessments with refugee children

The findings suggest that for some accompanied children, a short-term child psychotherapy assessment could be a helpful way of identifying children's individual resources, areas of need and their own understanding of themselves, which can help inform treatment decisions.

However, each child would need to be considered carefully before beginning an assessment. It would be important that any short-term assessment work is part of a wider assessment, and for a separate clinician to hold the case and see the parents during the assessment and for follow-up work with the family if needed.

A short-term assessment may also not be indicated for children who are known to have suffered extreme trauma and/or loss. For these children, they may benefit from an extended assessment with a clinician who ideally, would be able to continue work once the assessment is completed.

Observation and reflection of the clinician's emotional response

The research demonstrated how valuable the methods used in child psychotherapy (close observation of, and reflection on, my own emotional experiences) were to understand the unconscious and non-verbal communication of the child and family. The feelings that I often noticed in myself during the assessment sessions were anxiety, feelings of helplessness, sadness, frustration, that I had nothing to offer to help, wanting to look after and provide many things, and responding to this by wanting to do more and more, or to being

propelled into action in the face of such loss, or wanting the children and families to respond to me in a very positive way. I have already discussed the implications of these feelings for the boundaries of time in the session, but it could also be helpful to think about this in terms of the breaks in the work, due to holidays, and how this impacts on both the family and clinician.

In other areas of work, I have experienced similar feelings, but in this research, I was struck by how strong my feeling was of 'wanting to do more, give more, help more.' I do wonder if this relates to my own feelings of empathy and sympathy towards refugees, as well, as perhaps to some of the children and families own sense of deprivation, loss and helplessness. It may be that this is something that needs further thought, to understand how these feelings could risk perpetuating the sense of helplessness and dependence in refugee families.

Transference to the clinician and the institution

The assessments in this research were all undertaken in the clinic, which does look like an 'official' building or institution. I think the research shows that for some families, this may remind them of previous traumatic experiences in institutions. I think the meaning and impact of this needs to be carefully thought about for each family, rather than necessarily changing the location of the appointment (though some families may need this). I think even if the building does not disturb the child or family, there may still be an expectation and transference to the clinician and institution.

In this research, I think the families related to me as someone who may be able to help their child, but I think there were other expectations or hopes. Following appropriate requests, I wrote supporting letters for Ebi's family to both the housing association and the Home Office. I explained to his father that my letters may help, but that I did not have any authority to make decisions in these institutions, which I believe on some level must have been his hope. This links to my previous clinical work, that as well as an expectation of being helpful, sometimes there can

also be frustration and anger from families that as clinicians, we cannot fix everything, no matter how much we want to help or try.

Another finding in relation to the transference to the clinician was informed by my awareness of feeling very maternal to Rania and Ebi and very paternal to Samer. I understood this to be an indication of perhaps an absence or loss that they felt, and were looking for in me, perhaps a hope that I could in a very small way, contribute to lost objects and figures. I think this is something that also needs careful observation and thought when working with refugees. The hope that a clinician can provide something that may have been lost can feel comforting and very important for the child but if this cannot be understood and thought about, then I think there is a risk that any loss is then amplified at the end of treatment.

Working with interpreters

The issue of the transference to the clinic and clinician is also relevant to work with interpreters. The findings in this research showed how for one interpreter, working with Samer and his mother provoked a response in her (though benign). The impact of the work on the interpreter needs to be recognised, especially if they are translating very distressing material or finding themselves having a strong emotional response to the work. In this research, the interpreter had worked with Samer's family in previous appointments, which can be helpful for continuity, but it can also have other meanings for the child and parents. Again, I think this needs to be acknowledged and thought about to understand the meaning and significance of the interpreter for the family. The parents of the other children in this research, were insistent that they did not want an interpreter present, perhaps because their English was sufficient for them, but perhaps also due to worries about confidentiality, especially if they are from the same country and community.

Anger

A finding of this research which I think has been helpful for me to understand has been the issue of anger. I have described the frustration and anger of Ebi's parents and within my countertransference. I think that this is a feeling that is not commonly spoken about when working with refugee families. Anger as a response to loss and trauma is a very normal reaction but I think it can be difficult if this is not acknowledged, thought about, understood and contained. In the assessment with Ebi, I was aware that I wanted his father to experience me as being a helpful, supportive, nice, and sympathetic person but I do not know if I then missed the opportunity to address and contain his frustration and anger. I had the opportunity to speak with my colleague about this and we thought together about how it could be understood and contained.

Work with parents

As I have already described, the findings of this thesis have indicated that parent work can be essential when working with refugee children, and that this may be needed before further individual work can begin. I think this research has also shown in part, that sometimes a psychoanalytic framework can be very helpful when working with parents and families in which there has been trauma and/or loss that cannot initially be thought or spoken about consciously. Work with parents is an important part of child psychotherapy work, as the clinician can observe, attend and think about both the conscious and unconscious communication between the child and parents, and between the parents and the clinician. This can help support and contain the parents' states of mind, which enables them to create a space in which to think about and understand the child (Miller, 1992, Rustin, M.E., 1998, Emanuel, 2006, Wittenberg, 2008).

School and the network around the child

This research also has implications for the network around the child and family. The findings support previous work that have described the importance and

function of school for refugee children and that their day to day experiences in school often have a very significant impact on the children. I also think that school is an important part of the network. It is helpful if the network includes a number of adults who are responsible in different roles for the child and family, rather than just one professional working with the family on their own.

Developmental issues

The assessments in this research have shown that refugee children continue to have the same developmental tasks to work through as other children, which however, can be complicated further due their and their parents' experiences. Though this may seem an obvious point, I am aware that it may be difficult to keep in mind when working and looking after children who are refugees. In the assessment with Rania, on a number of occasions my anxiety about her experiences (and perhaps her own unconscious memories) intruded on the session and my understanding of the material. Whilst she was showing me her rivalry and anxiety about other children, I was thinking about refugee issues. We were able to speak later about her rivalry with her brothers, but it made me aware that there may have been other areas that I missed. Also, how for Rania, the difficulties she had trying to navigate through ordinary childhood experiences, in the context of her and her parents' losses. I think this may also be relevant for other children and it would be important for families and professionals to be aware of. As the children continue to grow and develop, there will naturally be additional demands on the child and family, for example, increasing independence, separation from their parents and the increasing importance of peers in adolescence etc. Therefore, some accompanied children may face further challenges later in their development, and may benefit from child psychotherapy and/or family work at this time.

Supervision and reflection

The final area that I think this research has highlighted is the importance of personal reflection and supervision. The assessments in this research have demonstrated that working with children and families who are refugees can be complex and difficult work. Certainly, I am more aware from this research of an anxiety that I may have underestimated the level of need for some of the children, perhaps as a result of their own denial of their needs, but perhaps also due to my own knowledge that there were other children who were waiting to be seen at the same time, who were presenting with much higher levels of distress and trauma. Further supervision and case discussion with the multi-disciplinary team, may have helped with this. As a team we would meet regularly to think about the impact of the work on ourselves, but naturally we would speak about the most painful and distressing work and less so about the confusing or less concerning work.

A critical account of the methodology and structure of the child psychotherapy assessments used in the research.

As previously described, this research used a method of child psychotherapy assessment as commonly used in clinical practice within the structure of a specialised NHS CAMHS (see page 22 for a full description). The service accepted referrals from parents and professionals who were concerned about the emotional state and behaviour of the children. The aim of the assessments in this research was to identify initial needs of the children and their families and make recommendations for further support and treatment if needed, whilst taking into account the less conscious meaning of the children's behaviour.

One of the outcomes of this research is a question about whether short-term assessment is appropriate and helpful when assessing and working with children in both a NHS CAMHS setting and other types of services. It is important to consider if these assessments should be adapted depending on the type and nature of each referral and the type of service provided. I will now summarise and critically evaluate the main methodological issues.

i) Length of assessments

Even though the research showed that there seemed to be a shared understanding about the number of sessions usually offered in a child psychotherapy assessment (3 to 6 sessions), it is worth considering if for some children and families, an extended assessment (more than 4 sessions) would be beneficial. One of the questions about short-term assessment is whether it can fully identify if the child/and or family needs long-term work. This was discussed in the literature review in relation to long-term psychotherapy work with children who have suffered from significant trauma and loss (Mooney, 2016, Youell, 2001, Judd, 2001 and Keenan, A. 2014). I think it would be important that if an extended assessment was offered, then ideally, it should be with a clinician who could continue to work with the child if longer term treatment was needed. This would hopefully allow the child to begin to develop a trusting therapeutic relationship with the clinician and prevent further loss for the child.

ii) Parent work

As previously described, an important finding from the research has been the importance of parent work alongside the child psychotherapy assessment. Within this, an area of parent work that may need further consideration and research is whether more individual sessions with parents before a child psychotherapy assessment commences would be beneficial. In this research, and in my normal clinical practice, the parents were seen by a colleague for parent work before the child psychotherapy assessment.

However, the modality and length of this work varied, as well as whether the clinician asked specifically about their past experiences of violence and trauma. Parental exposure to violence is one of a number of risk factors identified for mental health issues in children who are refugees (Fazel et al, 2012). Therefore, an important question arising from this research is how can short-term assessment assess this and other risk factors best? Can past violence and trauma be explored sensitively in short-term work without re-traumatising the parents or can this only be addressed with longer-term, extended assessments

with parents before commencing any direct work with the child? Additional sessions with parents may also result in them feeling more supported themselves, which perhaps could reduce the difficulties some parents have in attending consistently and punctually.

The results of this research have shown that parents and children are all individuals, with different internal resources, internal and external experiences, and relate to the therapist and assessment process differently. Therefore, I do not believe that there can be a single approach to assessing risk factors or addressing all the factors that impact on attendance and engagement. For some parents, being asked directly in a short-term assessment about their experiences of violence and trauma may be relieving, for others, there may be a risk of re-traumatising them.

This aspect of assessment and parent work may also depend on the type and structure of the service the family are being seen within. For example, in some services, the parents are the referred patient in the first instance, either by self-referral or by professionals. Therefore, the parent may be seeking help for themselves and be more aware of the impact of their own experiences on them and their children. I imagine that in these circumstances, it might be appropriate and parents may feel more comfortable to explore their own experiences first. In the service that this research was undertaken, the child was the identified patient and parents were extremely worried about their child/children. It was only through longer-term work could the parents begin to think about their own experience and think about how their child/children could be affected by this.

iii) Location

Another finding from the research was the transference to the institution and the clinic building. An important question is whether the families who took part in this research would have felt less anxious and more comfortable if they had been seen in a school or other community setting. As discussed in the literature review, therapeutic work with refugees in the community has been reported to improve engagement (O'Shea et al, 2000, Hughes, 2014).

However, in my clinical experience, some parents have reported that they prefer to be seen somewhere separate as they are worried about confidentiality in school and community settings. Again, this emphasises how the individual needs of parents and children are different. I would therefore suggest that it would be important to ask the parents what they would prefer, but still keep in mind that there will be transference to the clinician and the setting, wherever the family is seen. There are also practical issues to consider in terms of the therapeutic room available and if it can offer a consistent, private space in which the clinician can still attend to detailed observation of their countertransference and the transference relationship.

Summary of critical evaluation

The method of child psychotherapy assessment for children who are refugees may need further consideration and adaption depending on a number of factors, as discussed above. However, what this research has shown is how crucial parent work alongside the assessment is. Ideally this should be consistent, regular and with a clinician who could continue if longer-term work is needed. Each clinician should discuss carefully with the clinical team they work in, to decide how best to approach assessment and issues of the parent's own trauma and experiences of violence, as well as identifying the everyday difficulties and if needed make referrals for longer term work if they are unable to provide it themselves.

Recommendations for future research

From the outcome of this thesis I recommend the following:

Further research on child psychotherapy assessments and treatment of working with refugee children, and children who have experienced trauma and loss.

Further research in working with refugees and the type of family and parent work that can be helpful.

Further research on the impact of the work on clinicians and defences employed in this and how clinicians and teams can address this.

Autobiographical reflection

I would like to conclude with some of my own reflections on the research process and the project itself. I started this research 5 years ago and it has been a challenge to fit it in to my clinical work and everyday life. I often felt disconnected from it, or slightly persecuted by it, feeling that I was not able to give it more time and attention. I often felt as if I was a preoccupied and busy mother, and felt guilty for not being able to give it 'more and more'. When I was able to give it time, at times it felt overwhelming and intrusive. Reflecting on this now, it is very interesting to see how the states of mind that I experienced at different times, have also mirrored some of the feelings I experienced in the assessments, and perhaps mirrored how many of the parents may also have felt at times. The families who participated in the research all cared deeply about their children and clearly wanted the best for them, but they were also under stress and preoccupied at times, with their own experiences of adjusting to life in the UK and the losses that they had experienced.

Of course this may say more about my own internal states, but I think it does also make me think about the reach and depth of unconscious communication from the children and families we work with. It again highlights the importance of supervision and the containment provided through this. I was extremely fortunate to have supervisors who were consistently able to offer me kind and generous support, but with firm encouragement and determination to keep going and complete the work.

This containment enabled me to complete this research. In doing so I have been able to reconnect with the pleasure of working with the children, and so, with the interest and value of this work. This research has helped me enormously as a

clinician, from starting whilst still training, to now, 4 years later and still feeling as if there is so much to learn and develop. I hope that this research can also be of some help to other clinicians, and that the generosity of the families involved in this research, can also perhaps help other families.

Chapter 6) Bibliography and references

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Chapter 7) Appendices

Contents:

NHS
Health Research Authority
NRES Committee London - Westminster
Level 3, Block B,
Whitefriars
Lewins Mead
Bristol
BS1 2NT

Telephone: 0117 342 1381

23 June 2014

Ms Lynne Taylor
[redacted]

Dear Ms Taylor

Study title:	**Understanding the state of mind of children who are refugees; can a short term child psychotherapy assessment identify the different ways they understand their experiences and relate to therapeutic support?**
REC reference:	**14/LO/0701**
IRAS project ID:	**110715**

Thank you for your letter of 10 June 2014, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair together with Dr Muzaka.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager, Mrs Vicky Canfield-Duthie, nrescommittee.london-westminster@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the

study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Covering letter on headed paper		08 April 2014
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)		
Other [Letter to GP]	1.0	16 March 2014
Other [CV of supervisor Barbara Harrison]		
Other [Letter from funder]		04 November 2014
Other [Invitation letter to participant]	1.0	16 March 2014
Other [Report from supervisor]		24 February 2014
Participant consent form [Assent form for children]	1.0	16 March 2014
Participant consent form [Parents / Caregiver with parental responsibility]	2.0	10 June 2014
Participant information sheet (PIS)	2.0	10 June 2014
Participant information sheet (PIS) [for children aged 6 to 11 years]	1.0	16 March 2014
REC Application Form	110715/5919 13/1/230	07 April 2014
Research protocol or project proposal		16 March 2014
Response to Request for Further Information		10 June 2014
Summary CV for Chief Investigator (CI)		
Validated questionnaire [(currently used in clinic as standard measures]	validated	

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

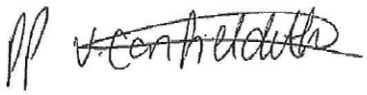
You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

14/LO/0701	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely



Dr Alan Ruben
Chair

Email:nrescommittee.london-westminster@nhs.net

Enclosures: "After ethical review – guidance for researchers" *[SL-AR2]*

Copy to: *Prof Neville Punchard*
Ms Angela Williams, Head of Research & Development, Central and North West London NHS Foundation Trust/Noclor

noclor NHS
Research Support Service

Bedford House, 3rd Floor
125-133 Camden High Street
London, NW1 7JR

Tel: 020 3317 3045
Fax: 020 7685 5830/5788
www.noclor.nhs.uk

25 June 2014

Ms. Lynne Taylor
Child and Family Department
[redacted]

Dear Ms. Taylor,

I am pleased to confirm that the following study has now received R&D approval, and you may now start your research in **the Trust identified below**:

Study Title: Understanding the state of mind of children who are refugees; can a short term child psychotherapy assessment identify the different ways they understand their experiences and relate to therapeutic support?

R&D reference: 110715
REC reference: 14/LO/0701

This NHS Permission is based on the REC favourable opinion given on **23 June 2014** and the most recent request for further information submitted to REC on 10 June 2014

Name of the trust	Name of current PI/LC	Date of permission issue(d)
[redacted] NHS [redacted] Trust	Ms. Lynne Taylor	**25 June 2014**

If any information on this document is altered after the date of issue, this document will be deemed INVALID

Specific Conditions of Permission (if applicable)

If any information on this document is altered after the date of issue, this document will be deemed INVALID

Yours sincerely,

Pushpsen Joshi

Research Operations Manager

Cc: Professor Barbara Harrison, Professor Neville Punchard

noclor NHS
Research Support Service

Bedford House, 3rd Floor
125-133 Camden High Street
London, NW1 7JR

Tel: 020 3317 3045
Fax: 020 7685 5830/5788
www.noclor.nhs.uk

May I take this opportunity to remind you that during the course of your research you will be expected to ensure the following:

- **Patient contact:** only trained or supervised researchers who hold the appropriate Trust/NHS contract (honorary or full) with each Trust are allowed contact with that Trust's patients. If any researcher on the study does not hold a contract please contact the R&D office as soon as possible.
- **Informed consent:** original signed consent forms must be kept on file. A copy of the consent form must also be placed in the patient's notes. Research projects are subject to random audit by a member of the R&D office who will ask to see all original signed consent forms.
- **Data protection**: measures must be taken to ensure that patient data is kept confidential in accordance with the Data Protection Act 1998
- **Health & safety:** all local health & safety regulations where the research is being conducted must be adhered to.
- **Serious Adverse events:** adverse events or suspected misconduct should be reported to the R&D office and the Research Ethics Committee.
- **Project update:** you will be sent a project update form at regular intervals. Please complete the form and return it to the R&D office.
- **Publications:** it is essential that you inform the R&D office about any publications which result from your research.
- **Ethics:** R&D approval is based on the conditions set out in the favourable opinion letter from the Research Ethics Committee. If during the lifetime of your research project, you wish to make a revision or amendment to your original submission, please contact both the Research Ethics Committee and R&D Office as soon as possible.
- **Monthly / Annually Progress report:** you are required to provide us and the Research Ethics Committee with a progress report and end of project report as part of the research governance guidance.
- **Recruitment data:** if your study is a portfolio study, you are required to upload the recruitment data on a monthly basis in the website: http://www.crncc.nihr.ac.uk/about_us/processes/portfolio/p_recruitment/
- **Amendments:** if your study requires an amendment, you will need to contact the Research Ethics Committee. Once they have responded, and confirmed what kind of amendment it will be defined as, please contact the R&D office and we will arrange R&D approval for the amendment.
- **Audits:** each year, noclor select 10% of the studies from each service we have approved to be audited. You will be contacted by the R&D office if your study is selected for audit. A member of the governance team will request you complete an audit monitoring form before arranging a meeting to discuss your study.

[redacted] NHS
Child and Family Department
[redacted]

Centre Number:

Study Number: 110715

Name of child:

Patient Identification Number:

INFORMATION SHEET FOR PARENTS/CAREGIVERS WITH PARENTAL RESPONSIBILITY

Title of Project: *Understanding the state of mind of children who are refugees; can a short term child psychotherapy assessment identify the different ways they understand their experiences and relate to therapeutic support?*

Name of Researcher: Lynne Taylor

I am a Child Psychotherapist who works with children and families. I am working on a project which is a student research project for a professional doctorate in Child Psychoanalytic Psychotherapy. I would like to invite you and your child to take part in my research study.

Before you decide I would like you to understand why the research is being done and what it would involve for you and your child. **Myself and an interpreter will go through this information sheet with you and answer any questions you have.** I'd suggest that this should take about 20 minutes.

(Section A tells you the purpose of the study and what will happen to you and your child if you take part. Section B gives you more detailed information about the conduct of the study). Please ask me if there is anything that is not clear.

Section A)

1) What is the purpose of this study?

As children and families, who are living in London, as Refugees, I understand that you have all had different experiences in your home country and living here in the UK. I also understand that every person, adult and child, are unique and different and are affected by experiences in different ways.

However, often in my experience professionals who work with children and families who are refugees, tend to focus on any traumatic experiences you and your child may have experienced in your home country and the associated stress of living as a refugee in the UK (legal status, language, housing etc). Professionals can assume that all of these experiences affect children and adults in the same way.

Therefore, I think that it is important to do some research work to understand more about how each child is unique and an individual, and so understand more about how each child may or may not, be affected in many different ways by their experiences in their home country and here in the UK.

In the UK, child psychotherapy assessments are already used in clinics and schools to assess these individual emotional and educational needs of many different children. These assessments are thought to show how each child is different and how each child understands themselves and their expectations of adults, and how they are affected by each child's experiences.

There has been research to show that child psychotherapy assessments can do this and can be helpful for many children. However, there has not been any research to specifically see if these assessments are helpful for children who are refugees, many of which can have complex needs regarding their experiences of living in their home country and the ongoing

issues of living in the UK, for example, school, housing, legal status, separations from family and friends.

2) Why have you been invited?

I am talking to you about this project because your child has been referred for a child psychotherapy assessment. Your [GP, school, member of team etc] has met with you and [child's name] because you/they are worried about [child's name]. [Name of referrer] thought that a child psychotherapy assessment would help your child as it will help your child, you, the professionals understand [name of child]'s worries and what help is best for them to help them at home and school.

3) What will happen to me and my child if we take part?

I am not asking you or your child to do anything different to what would happen during a normal child psychotherapy assessment. I am asking if you would allow us to use the information from the assessment to be studied to see if child psychotherapy assessments are able to identify the individual emotional needs of children who are refugees.

The standard procedure for short-term child psychotherapy assessments will be followed which is as follows:

It will start with an initial meeting with you and your child before the assessment (50 minutes). I will talk with you about the assessment and answer any questions you may have about it. We will also think together about why your child has been referred for a child psychotherapy assessment and I will ask you to complete some routine questionnaires. An interpreter will be available to join us if you would like.

We will then plan the assessment appointments. The assessment comprises of 4 meetings, which last for 50 minutes, usually once a week in the clinic, during which I will meet your child on their own (if you and the child are comfortable and agree to this). In these meetings, I will provide toys and drawing materials for your child, and I will carefully observe your child's behaviour and play, in order to understand more about your child. After each meeting, I will write detailed observation notes about your child's behaviour and play.

After the 4 individual sessions, I will meet with you again to talk about the outcome of the assessment and recommendations for treatment and support for your child. I will also ask

you to complete some routine questionnaires. This meeting will be for 50 minutes. An interpreter will be available if you would like. You will be able to ask me any questions or anything you would like to have further information about, or any concerns you have about the assessment.

I will then write a report and you will be given a copy (translated if necessary). With your permission, this report will then be shared with your child's GP and any other professionals as appropriate, so that they have a better understanding of your child's emotional and educational needs.

You and your child will be seen at the [redacted] Travel expenses to the clinic are available through the NHS if you and your family are entitled to them.

There are other types of assessment available to your child if you do not want your child to receive a child psychotherapy assessment. You can discuss this with another clinician in the team or myself and this will not affect the standard of care you and your child receive.

If you or your child are being seen for any other treatment or are on any medication, please let me know. You and your child should continue to take any medication and receive any other treatment as normal throughout the research process. Please let me know and also ask your GP if you have any questions about this.

4) Participation

Participating in this study is entirely voluntary. It is up to you if you would like you and your child to join the study and go through this information sheet. If you agree to take part, I will ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This will not affect the standard of care you receive or the treatment your child receives. Your child will still be offered a child psychotherapy assessment as described above.

If you think it is appropriate, I will also ask your child if they agree to taking part in the research. I will give them the child's version of the information sheet and consent form and they will be able to ask me any questions that they may have. If your child does not want to take part in the research project, then they do not have to and this will override your consent. This will not affect the assessment or care that they receive.

If at any time, something arises which would affect the research [conflict of interest], your child will be withdrawn from the study. In both of these situations, your child will still be seen for an assessment and it will not affect their treatment in any way.

Children will also be excluded from the research, if at any time there are concerns about your child's safety. If such concerns arise, this will be discussed with you and child protection procedures will be followed in line with standard clinical practice.

5) What are the possible disadvantages and risks of taking part?

I will do my best to offer appointments at a convenient time for you and your child, but sometimes this isn't always possible.

6) Possible benefits of taking part

I hope that a child psychotherapy assessment will be helpful for your child and that it will help identify their emotional and educational needs. However, I cannot promise that the study will help your child but the information I get from this study will help improve the assessment and treatment of children who are refugees.

7) What happens when the research study stops?

Once the assessment is completed, and I have met with you and written the report, the outcome will help plan the treatment and support that could help your child. Treatment and support will be recommended from the appropriate services.

8) What if there is a problem?

Any complaint about the way you or your child have been dealt with during the study or any possible harm will be addressed. The detailed information on this is given in Section B.

9) Will taking part in the study be kept confidential?

Yes. I will follow ethical and legal practice and all information about you and your child will be handled in confidence. The details are included in Section B.

If the information in Section B has interested you and you are considering participation, please read the additional information in Section B before making any decision.

Section B

1) What happens if I and/or my child don't want to continue with the research study?

You and your child can withdraw from the study at any time without giving a reason. This will not affect the standard of care that you receive or the treatment your child receives. I will not use any of the information that relates to you and your child in the study. Information relating to the assessment and treatment recommendations will be kept in your child's individual patient file in the clinic.

2) What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to answer your questions (Ms Lynne Taylor, tel: [redacted]. If you remain unhappy and wish to complain formally, you can do this (Patient Advice and Liaison Service, [redacted]

3) Harm

In the very unlikely event that something does go wrong and you or your child are harmed during this research and this is due to someone's negligence then you have grounds for a legal action for compensation against the [redacted] Trust, but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you (if appropriate).

4) Will my taking part in this study be kept confidential?

Detailed notes from each session with your child will be written up by myself. These notes will be placed in the individual clinical file of your child. Only members of the clinical team will have access to these notes.

A copy will be made of the session notes, in which all the personal and identifiable information will be removed or changed. These anonymous notes will then be used in the

research study and saved on encrypted memory stick and computer file. Only myself will have access to these notes. The session notes will be analysed to identify if there are themes in the way your child behaves, thinks and relates in the assessment process. This will help us determine if a child psychotherapy assessment is helpful in being able to identify why child behave, think and relate in different ways. These notes will be kept for the duration of the research study (4 years).

5) Contacting your child's GP.

If you would like to participate in the research study I will ask you if I can write and tell your GP. This is standard practice for research in the NHS. I will also write to them with the outcome of the child psychotherapy assessment and our recommendations for treatment.

6) What will happen to the results of the research study?

I will write up the research as a professional doctorate in Child Psychoanalytic Psychotherapy. The results be potentially published and made available to a wide range of professions, community groups and Commissioners if relevant.

7) Who is organizing and funding this research study?

[redacted]

8) Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research ethics Committee, to protect your interests. This study has been reviewed and given a favourable opinion by Westminster Research Ethics Committee.

9) Further information.

i) General information about research in the NHS - http://www.nihr.ac.uk
ii) General information about child psychotherapy research - www.childpsychotherapy.org.uk
iii) Advice about participation – a member of the clinical team, Biddy Youell, Consultant Child Psychotherapist could discuss it with you

iv) Who to approach if you are unhappy with the study – Patient Advice and Liaison Service, [redacted]

Please ask me if you have any questions.

[redacted] NHS

Child and Family Department

[redacted]

Centre Number:

Study Number: 110715

Name of child:

Patient Identification Number:

CONSENT FORM FOR PARENTS AND CAREGIVERS WITH PARENTAL RESPONSIBILTY

Title of Project: **Understanding the state of mind of children who are refugees. Can a short-term child psychotherapy assessment identify the different ways they understand their experiences and relate to therapeutic support?**

Name of Researcher: **Lynne Taylor**

Please initial all boxes

1. I confirm that I have read and understand the information sheet dated **10.6.14** (version number 2.0) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my and my child's participation is voluntary and that we are free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐

3. I understand that relevant sections of my child's medical notes and data collected during the study, may be looked at by individuals from [redacted] from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐

Consent form date of issue: [10.6.14]
Consent form version number: [Version 2.0]

iv)

4. I agree to my child's GP being informed of our participation in the study. ☐

5. I agree for me and my child to take part in the above study. ☐

Name of Participant	Date	Signature

Relationship to child: _____

Name of interpreter (if used)	Date	Signature

Name of Person taking consent.	Date	Signature

Consent form date of issue: [10.6.14]
Consent form version number: [Version 2.0]

Centre Number:

Study Number: 110715

Name of child:

Patient Number:

POSSIBLE ASSENT FORM FOR CHILDREN

(to be completed by the child and their parent/caregiver with parental responsibility)

Project title: Understanding the state of mind of children who are refugees. Can a short-term child psychotherapy assessment identify the different ways they understand their experiences and relate to therapeutic support?

Child (or if unable, parent on their behalf) /young person to circle all they agree with:

Has somebody else explained this project to you?	Yes/No
Do you understand what this project is about?	Yes/No
Have you asked all the questions you want?	Yes/No
Have you had your questions answered in a way you understand?	Yes/No
Do you understand it's OK to stop taking part at any time?	Yes/No
Are you happy to take part?	Yes/No

If any answers are „no" or you don't want to take part, don't sign your name!

If you do want to take part, you can write your name below

Your name _____

Date _____

Your parent or caregiver also needs to sign too:

Print Name _____

Consent form date of issue: [10.6.14]
Consent form version number: [Version 2.0]

v)

Relationship to child _____

Sign _____

Date _____

The interpreter who translated this project to you needs to sign too (if used):

Print Name _____

Sign _____

Date _____

The clinician who explained this project to you needs to sign too:

Print Name _____

Sign _____

Date _____

Thank you for your help.

Consent form date of issue: [10.6.14]
Consent form version number: [Version 2.0]

[redacted] NHS
NHS Foundation Trust
Child and Family Department
[redacted]

Centre Number:

Study Number: 110715

Patient Identification Number for this trial:

INFORMATION SHEET FOR CHILDREN (aged 6 to 11 years)

Title of Project: **Understanding the state of mind of children who are refugees. Can a short-term child psychotherapy assessment identify the different ways they understand their experiences and relate to therapeutic support?**

Name of Researcher: Lynne Taylor

1) What is research?

Research is a way we try to find out the answers to questions. We want to see if a Child Psychotherapy Assessment helps children who are living in London because they can't live in their home country.

2) Why are we asking you if you want to take part in this research?

We are inviting you to take part because your family/caregivers and school/GP think that a child psychotherapy assessment will help them understand how you are feeling and what you may be worried about.

3) Did anyone else check the study is ok to do?

Before any research is allowed to happen, it has to be checked by a group of people called a Research Ethics Committee. They make sure that the research is fair. Your project has been checked by the --- Research Ethics Committee.

4) Do I have to take part?

No, it is entirely your choice if you want to take part or not.

5) What will happen to me if I take part in the research?

You will come here to this clinic 5 times, over a few months.

The first time will be with your mum and dad [change as appropriate].

You will meet a child therapist called Lynne Taylor, who is a woman who works with children and families. She will introduce herself to you and talk to you and your mum/dad and give them some questionnaires to fill out.

She will ask your mum/dad to make 4 appointments for you to come to the clinic to see her. She will see you on your own for 50 minutes. She will bring toys and paper, pens and will try to understand what things make you happy or unhappy. If during the appointment you want to see your mum/dad or go to the toilet etc, you can ask Lynne and she will take you to the waiting room where your mum/dad will wait for you..

After the final appointment with you, she will think very carefully about you and how to help. She will then let your mum/dad/school etc know how they can help you.

You may have to miss some school to come to the clinic. You can ask your mum/dad and the researcher now about this and we will do our best to make sure that you don't have to miss your favourite lessons in school. We will tell your school so that they know you will have to miss some lessons.

6) Will it upset me?

Sometimes children can become upset if they remember things that make them sad or frightened. You can tell Lynne about it and she will try to understand and think about what will help. She can take you to your mum and dad if you want her to.

7) Will joining in help me?

We cannot promise the study will help you but the information we get might help treat other children who are living in London because they can't live in their home country at the moment.

8) What if something goes wrong?

If anything goes wrong or there is something you don't like, you can talk to Lynne, and your mum and dad and someone else who isn't part of the study can also talk to you.

9) Will my details be kept private? Will anyone else know I'm doing this?

Yes, your details will be private. We will talk to your parents and GP/school.. about what we think may help you at home and school. Only these people will know that you and your family are coming to the clinic.

10) What if I don't want to do the research anymore?

If at any time you don't want to do the research anymore, just tell your parents/caregivers. Doctor or therapist (Lynne). They will not be cross with you. Your doctor will help you decide how best to help you afterwards.

[redacted]

Lynne Taylor

By email

22 May 2017

Dear Lynne,

I am pleased to inform you that your change of title was considered by the Trust-School Research Degrees Subcommittee and approved on the 20 March 2017.

Your new registered title: *How can a child psychoanalytic psychotherapy assessment contribute to the understanding of the individual experiences of children who are refugees*

Please contact us at academicquality@[redacted] if you have any queries regarding this confirmation email.

Please keep this confirmation email for your records.

Best regards,

[redacted]
Secretary to the Trust Research Degrees Subcommittee
[redacted]

cc. Barbara Harrison, DoS
[redacted]

vii)

Materials

Contents of clinical room:

Clear plastic box.
Doll's house (plastic) and box of furniture
Blanket and pillow on chair
Box of tissues

Contents of box:

Paper – purple, pink, yellow and white A4 paper.
A3 lined paper notebook.
Sellotape, 30cm ruler, colour pens, colour pencils, lead pencil, scissors (metal and plastic – in error), elastic bands, paper clips, glue, biro and plasticine (neon block – pink, yellow, orange, green and purple).
Mobile phone
2 cars, 1 rescue motorbike, 1 fighter plane
Ball
Soft teddy bear
6 plastic fences and animals – pig family (2 adults, 2 babies), horse family (2 adults and 1 baby), donkey, wild animals – bear, 2 rhinos, 2 gorillas, elephant, crocodile.
Wooden dolls: Asian family (1 adult woman, 1 adult man, 1 child boy, 1 child girl), Indian family (1 adult woman, 1 adult man, 1 child girl).

Example of coded session

Rania (session 1)

Transcript	Detailed coding	Description	Analysis	Main theme	Sub theme	Manifestation
Session attended as planned	Action	Boundary	Parents able and supportive of assessment	Parents appear supportive of assessment - keen for help	Beginnings	Facilitated by father
Attended on time,	Observation	Boundary	Parents able and supportive of assessment		Beginnings	Facilitated by father
brought by her father and younger brother also attended.	Observation	Family	Brought by father, who takes them to school and back - mother looking after youngest son. I wondered how it would feel for brother to come and not be seen?	Mother does not attend		Facilitated by father
R was sat opposite her dad	Observation	Relating to parent	Close to her dad, can see him but not set right next to him.	Relationship and attachment to parent	Beginnings	
as I went into the waiting room, said hello	Speech by me	Relating by me	Waiting for me in waiting room			
and she smiled shyly at me.	Observation	Relating to me	Feels shy to see me again and aware first session on her own and I wondered what she made of this.	Response to me	Beginnings	

viiii)

Table of themes:

		Ebi	Samer	Rania
Themes	Sub themes	Manifests as	Manifests as	Manifests as
How does child and family relate to structure of assessment?	Beginnings	Late	Separation from mother	Facilitated by father
	Endings	Avoidance of goodbye	Avoidance of goodbye	Avoidance of goodbye
How does the child relates to me?	Transference Re-enactment	Torture and interrogation	Confusion of place	Intrusion of refugee experiences
	Behaviour	Best behaviour	Best behaviour	Best behaviour
How does child relate to own self?	Identity	Alien	Omnipotence and competition	Good, grown up girl
	Denial	Denial of need and self sufficiency	Denial of own anxiety	Denial of strength of own negative feelings
	Deprivation and loss	Projection of deprivation and loss	Feeling deprived and insatiable	Loss of maternal figure
How does child relate to their external experiences	Parents and family	Parental mental health	Infantile response to mother	Safe and supported by her family
	School and housing	Denial and avoidance	Denial of any issues	Denial of any issues
	Refugee issues	Loss of home	Wanting to understand world events	Loss and homesickness

X