Between a Rock and a Hard Place
An insight into the Psychological Therapist's experience of having Safeguarding Concerns for their Clients' Children

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Abstract

This study explores the therapists' experience when managing safeguarding concerns about their clients' children, with the aim of raising awareness and bringing the child into the therapists' mind. A review of the literature indicated that this is an undeveloped area, with existing research lacking attention to the impact of the therapeutic relationship on this ethical dilemma.

IPA (interpretative phenomenological analysis) was used to analyse the findings from six semi-structured interviews with a mix of psychological therapists who had experienced concerns for their clients' children while working in non-NHS settings. This approach allows for an in-depth exploration into the subjective experience of the participant, while also recognising the reflective role of the researcher.

The findings indicate that therapists are struggling with a lack of confidence and experience in managing their child protection concerns, with an indication of a training need. This lack of confidence, combined with a range of complex emotions evoked in such work, increased the participants' need for support and supervision. Participants felt the need to alter their therapeutic practice and become more directive in order to ascertain clearer details about their concerns.

The findings have implications for the training and continued professional development requirements for psychological therapists. There is an indication for training focused on managing concerns in the context of the therapeutic relationship, more training around assessing the level of risk and the development of a prompt sheet with reflective questions to aid therapists in their thinking.

An identified limitation of this study is the range of participants in terms of gender and ethnicity; further research could explore more thoroughly whether these factors influence how concerns are managed. There is also scope to explore more specifically the impact of the therapeutic placement, to identify whether those working within large organisations, such as the NHS, feel more supported and contained in this type of work than those working more independently.

To my supervisors and tutors, who didn't give up on me.
To my family, for their patience and support
To all therapists struggling with these issues

Abstract

Acknowledgements

1 Introduction and Literature Review: Contextualising My Research

"We've got to work to save our children and do it with full respect for the fact that if we do not, no one else is going to do it"
Dorothy Height

1.1 Introduction

The aim of this research is to explore the complexity of handling child protection concerns that arise through psychotherapy with adult clients in the context of non-NHS settings. It is an exploration into the in-depth, phenomenological experience of the therapist, when faced with challenging ethical dilemmas, where the safety and welfare of a child, is potentially at risk.

Within Chapter 1, I shall begin by locating myself in relation to the subject matter, both personally and professionally; providing the reader with an understanding of how I was drawn to this area.

I will move on to a review of the literature, firstly reflecting on the multiple research questions that were considered and then thinking about what the concept of child abuse means, before shifting into an exploration of the research area. I shall demonstrate the lack of existing research on the topic and progress into a discussion on factors such as legal and ethic issues, counter-transference and risk assessments, before concluding with my chosen research question.

Chapter 2 will provide a more in-depth discussion on the methodological aspect of the research; reflecting on the choice of a qualitative methodology and then more specifically on the decision to use Interpretative Phenomenological Analysis. I will then move on to explain the research design, including the sampling, recruitment, interviewing processes, ethical considerations and validity measures. This will be followed by a step-by-step description of the actual data analysis, explaining how the final superordinate themes were established.

Chapter 3 presents a story of the findings; outlining the superordinate and subordinate themes identified as key to this research, supported by verbatim quotes from the interviews. These are discussed in greater detail along with a reflection on the implications for psychological therapy, in Chapter 4.

1.2 My personal and professional relationship to this area

My interest was drawn to this research area following my experience of working with parents, as part of an outreach service for young people and their families who were at risk of family

breakdown. These parents were struggling in their relationships with their children and often there were issues of neglect and emotional abuse.

I recall the challenge of balancing the therapeutic relationship with the parent, while holding the welfare of the child in mind. As my clinical training progressed, I noticed the limited attention given to managing child protection concerns; while I appreciate the numerous ethical dilemmas that need attention, I experienced a sense of dissatisfaction with how the issues were covered. Working for the local government meant I received in-depth child protection training, however this lacked coverage from a therapeutic perspective.

In my naivety, I assumed that it was the law for all practitioners to report child protection concerns and was surprised to realise that this wasn't the case. I developed a curiosity about whether the training needs of counselling psychologists around child protection were being met. Given my training was in working with adults, my interest lay in how to respond to concerns that arise out of working with an adult, rather than with the child. Imagine a therapist working privately with a depressed mother, who reports spending most of her day in bed; how much does the therapist explore how her children are being looked after? As I explored the literature, it became clear that there is little information on this area; reinforcing my decision to use this as a research topic. My interest was also fuelled by the discovery of movements within the BPS around child protection, requiring a basic level of qualification for all psychologists around issues of child welfare (BPS, 2007). This solidified my sense that this is a subject matter of extreme relevance and importance to the field of psychology and psychotherapy.

1.3 Literature Review

The main focus of the research was therefore identified as looking at the position of safeguarding children in the field of psychotherapy with adult clients. However this area had many potential strands, as multiple potential research questions came to light, for example:

- Are our reactions influenced by the type of abuse? Would we be more likely to act if we thought the child is at risk of sexual abuse than emotional, for example?
- Is our client the perpetrator, or is the child at risk from someone else in the household, as in the instance of domestic violence? And how does this influence our actions?
- What are our counter-transference reactions to our clients when we hold these concerns? Are we able to hold onto our empathic, unconditional stance, or are we consumed with negative emotional reactions to their behaviour?
- How does our personal experience influence our response? Are we influenced by

our own past trauma or experience of being a parent?

- What is the personal and emotional impact of working with such a case?
- What do we do with our concerns? Do we discuss them with the client? Do we act on them and make a report to Social Services? How do we make this decision?
- What happens to the therapeutic alliance with the client? Are we able to work with the concerns and use them to inform the therapy and help the client make positive change?
- How do we use professional support and training to inform our practice?
- Does theoretical orientation affect how we address these issues?

Given the enormity of the topic, a thorough literature review was conducted in order to establish what has already been explored within this field and where further research is warranted. Consideration was given to those areas most relevant to dealing with safeguarding concerns in the context of adult psychotherapy and what may impact the therapists' experience of having these concerns. The literature review consists of a range of both primary and secondary sources, combining both academic research and writings by government agencies, such as the Department of Health, newspaper articles and other published works.

In order to set the context and a sound theoretical base to the research, the most appropriate place to start is in reflecting on why child abuse is an important issue to be addressed and what the concept actually means.

1.3.1. Child Abuse As A Growing Concern

Child abuse is a sad reality in today's society. The real incidence of child abuse remains unknown, as many cases will remain unreported or unproven; however the statistics that are available, reveal some of the horrors. Statistics from the Department of Education, indicate that at the end of March 2015, there were over 49,000 children in England with a child protection plan (DfE, 2015). The NSPCC also estimates that for every child that is subject to a child protection plan, there are another eight that are suffering unreported abuse (NSPCC, 2013). In the same report it is highlighted that 1 in 5 children will have experienced some form of serious abuse at some point in their life.

Given these disturbing statistics, it is likely that therapists are going to encounter child abuse or at least have concerns about potential abuse, at some point in their career. However, the reporting of abuse is a delicate area, and while the research associated with this is limited in the UK, studies from around the world illustrate that abuse is being widely under-reported. Lagerberg (2001) conducted a survey of child health nurses in Sweden, to explore how nurses identified abuse and

made the decision about how to act on their concerns. Of the three thousand surveys that they sent out, only fifty-five percent responded. The results from those who did participate, indicated that only three out of ten participants decided to report their concerns to authorities. The low response rate in studies exploring experiences around child protection is a common thread throughout this literature review; this poses the question whether this is because professionals are being naïve and unaware of situations that they may be facing, or whether they are scared or embarrassed to participate in research discussing their actions or knowledge about it.

A report by the Children's Commissioner (2015) found that only 1 in 8 victims of sexual abuse came to the attention of the authorities; many victims didn't come forward until they were older. This is concerning as it means that many cases of abuse are going undetected. Children are often fearful about reporting what is happening to them and feel unable to speak out voluntarily; a degree of responsibility therefore lies with the adults around the child, to notice signs that something is wrong, to ask the questions and enable the child to feel safe enough to disclose.

Out of the many ethical dilemmas faced by therapists, issues concerning the welfare or safety of a child are some of the most serious. It could be argued, that regardless of our profession, if someone has knowledge that a child is at risk, it is a basic human responsibility to take action to ensure that the child is protected.

In work with adult clients, it is unlikely to be a regular occurrence, perhaps presenting more with certain client groups or in particular clinical situations; however, it is still a realistic possibility that the concerns may arise. For example, working with a woman who describes domestic violence from her partner; or someone who's depressed and struggling to meet their own basic needs, let alone those of a child. It may not be the client, who is being abusive, but they may know of someone else who is, or is witness to their partner being abusive for example. Should concerns arise, the question is how confident do therapists feel in managing them? Existing research available has tended to focus on dealing with disclosures of abuse/concerns arising from therapy directly with the child (Yarrow and Churchill, 2009); yet the guidance for working with the adult, is sparse.

One of the key factors here, is peoples' understanding of what constitutes abuse, as it is a complex definition which is heavily influenced by subjectivity.

1.3.2. What is meant by child abuse?

Child abuse is a serious allegation to make against someone, so being clear about what constitutes abusive behaviour is crucial. However, in an area where clarity is craved, there is a lot of subjectivity and vagueness, influenced by factors such as culture, gender, ethnicity and age. Each situation is unique and impacted by a multitude of factors such as the severity and frequency

of the abuse, the level of intent and premeditation and the relationship to the perpetrator (Working Together, 2010:36). Children may not be the direct victim of abusive behaviours, such as with domestic violence, however they will still be suffering the emotional consequences.

Child maltreatment can broadly be defined as "*all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power*" (Butchart et al, 2006:9). The Working Together to Safeguard Children document (2010) recognises that "*abuse and neglect are forms of maltreatment of a child*" but also that "*failing to act to prevent harm*" is in itself, a form of abuse.
The language used to talk about child abuse has shifted over the years and may vary from country to country and even from one profession to another; terms such as "child maltreatment", "child protection", "safeguarding" and "non-accidental injury" all refer to effectively the same idea (Waterhouse and McGhee, 2015). There currently seems to be some preference for the idea of "safeguarding", with concerns that the words "abuse" infer an accusation.
In order to provide some degree of clarity, governing bodies have broken down the construct of child abuse into different categories, providing in-depth explanations to aid professionals in their assessment of potentially abusive situations. The following definitions are found in the Government document, Working Together To Safeguard Children (2015).

- Emotional abuse can be defined as *"The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone"* (Working Together, 2015:92). Beckett (2003:75) describes emotional abuse as being about

both the verbal and non-verbal messages given to children and stresses that "*words can do as much harm as sticks and stones*"; the damage emotional abuse causes is often underestimated and more attention is often paid to physical and sexual abuse because it is easier to prove.

- Physical abuse is perhaps considered more clear cut; defined as "*a form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of or deliberately induces, illness in a child*" (Working Together, 2015:92).
- Sexual abuse is also more clearly defined: "*Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet)*" (Working Together, 2015:93). It is also stressed that sexual abuse can be committed by men, women and other children – challenging the assumption that it is predominantly a male offence, which could lead to dangerous oversights.
- Neglect, like emotional abuse, is possibly more complicated, as it can be hard to prove. Neglect can be defined as "*the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to: provide adequate food, clothing and shelter (including exclusion from home or abandonment); protect a child from physical and emotional harm or danger; ensure adequate supervision (including the use of inadequate care-givers); or ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs*" (Working Together, 2015:93)

While these definitions give good guidance, individuals may still vary on what they perceive as what constitutes a "*developmentally inappropriate*" expectation for a child, as in emotional abuse;

or as in the case of neglect, what "*adequate supervision*" means. This is where other factors need to be taken into consideration.

1.3.3. Abuse as a Subjective Concept

As can be seen above, the definitions given are relevant to the UK and arguably other modern Western countries; however, in other parts of the world, behaviour that would be undoubtedly abusive in the Western context is considered completely normal and acceptable. Anthropologists study other cultures and have researched how children are raised and disciplined in other countries across the world. Some of their customs may be shocking and disgusting to the Western society, but the role of the anthropologist is to withhold judgement; they argue that behaviours need to be understood in their own terms (Lorenz, 2015). As Beckett (2003:16) points out, "*every culture has its own system of values and meanings*", meaning that what is considered abusive in one culture, may be deemed totally acceptable in another.

Korbin (2005) also supports this argument, recognising that definitions of abuse vary depending on the cultural setting. Look at the example of co-sleeping, in Western culture it is often considered inappropriate for parents to sleep with their children beyond a certain age; however, in other parts of the world, it is considered cruel to leave children alone in a dark room at night (Shanalingigwa, 2009). Beckett (2003) uses the example of overt strictness on education that is found in some cultures; in Western culture, we may perceive this as abusive, yet in the cultural context it can be understood as families ensuring their child escapes poverty by achieving a good education.

In a country as diverse as the UK, there needs to be respect and acknowledgement that cultural differences may occur; however, it is also important to acknowledge that some activities acceptable in other cultures are actually deemed illegal in the UK – female genital mutilation being a prime example. Female circumcision is practiced in over twenty countries across the world including parts of Africa, Latin America and Asia. However, since 1985 this practice has been outlawed in the UK (BSCB leaflet). In these cultures, justification is made on the grounds of social acceptance, cleanliness and custom, however in the UK, there is such a strong disagreement with this practice that in 2003 the Female Genital Mutilation Act was introduced, prohibiting not only the actual act taking place in this country but also against any UK citizen being taken abroad to have the procedure performed.

Cultural differences become particularly important when thinking about neglect; Beckett (2003) uses the example of risk taking behaviour, arguing that there is a continuum along which children are allowed to develop their freedom. For example, at what age should children be allowed to play outside on their own? Or be able to walk to school alone? Allowing a toddler to do so would clearly be neglectful, however what about an eight year old or a ten year old? How do people

decide what age it becomes ok? It is likely that these decisions are influenced by other factors, such as the personality of the child and the safety of the neighbourhood in which they live for instance. However, this illustrates how hard it is to easily define neglectful behaviour and therefore prosecute care-givers appropriately. Beckett (2003) advises that we consider the context and explore the norms of the given community, but that we also need to look at the general behaviour of the caregiver to see whether they are neglectful in other ways – in other words, we need to look at the wider picture of what is happening in a child's life, rather than looking at one incident in isolation. Often people are quick to make judgements of others, without necessarily taking the time to understand the meaning certain behaviours may have to them.

Religious views can also play a role in how people perceive abusive behaviour: Bennett (2011) looks at the relationship between law and religious practice in America and explores how some practices, which elsewhere would be considered child abuse, are deemed acceptable due to religious reasoning. Take the example of a sick child, religious parents could legally deny medical treatment in the place of spiritual treatment alone; yet non-religious parents would be considered neglectful if they refused medical treatment for their child. Interestingly in the UK, parents are not allowed to refuse medical treatment which are in their child's best interests; so while an adult Johovah's Witness can refuse a blood transfusion for themselves, they are not allowed to do so for their child (Finn & Savulescu, 2011).

Attention also needs to be paid to social class and the assumption that is often made about child abuse not happening in upper class families. In an on-line article in Community Care, Nicolas (2015), who is a social worker, speaks candidly about a number of serious incident reviews which have been influenced by the parents' social class. Within his article, Nicolas refers to the serious case review published by Kingston LSCB by Carmi and Walker-Hall (2015); within this document, the role of the parents' class and cultural background was highlighted as a significant factor in how professionals managed the abuse allegations and dealt with the family. Nicholas also refers to the serious case review by Brabbs (2011) in which the parents were charged with eighty-eight counts of child cruelty which took place over ten years. The investigation highlighted one of the key factors that influenced the handling of the case was that "*many professionals struggled to maintain a child focus when faced with M and F's aggressive behaviour and their "disguised compliance", and that their approach was affected by perceptions and assumptions made regarding the parents' social class, professional status, and high academic qualifications, and the attitude of M and F towards them" (Brabbs, 2011).* Nicolas (2015) acknowledges that the child can often become invisible in child protection conferences when the parents are upper class and have lawyers present. Therapists may be inclined to think that their clients couldn't possibly be abusing their

children because they are professionals or well-educated; but this simply isn't the case. When addressing a concern for a middle class family, Nicolas (2015) advises that we should strip away all other factors and ask *"Would I be responding in this way if the child lived in social housing, in an area of extreme deprivation, with a single mother with five children by five different partners?".*

Similar assumptions may also be made based on gender; some people readily admit that when they think of child abuse, they automatically think of the father, rather than the mother, particularly in the case of sexual abuse (Kierski, 2002). However, in a NSPCC publication, Radford et al (2011) stress that while some types of abuse may be "*relatively rare*", we must not become "*complacent about children's safety*".

This also filters down to an individual level, with each individual having a different combination of factors and experiences, including culture and religion, that will influence their own personal experience of what child abuse means and how much value they place upon it. With so many complex factors at play, it remains that the circumstances surrounding each individual case maybe so entangled, that it is almost impossible to give concrete, black and white rulings for every situation.

1.3.4. Existing Relevant Literature

Existing research within the forensic field offers some insight into the therapists' experience of working with child sex offenders; Brampton (2010) interviewed Prison Service staff working with sex offenders on the Sex Offender Treatment Programme (SOTP); she provides an insight into the impact of this work on the worker, in terms of stress, burnout and vicarious traumatisation. Brampton raises an interesting dilemma about whether those who have been sexually abused in their past, should be allowed to participate in the programme; this is a controversial suggestion and could be considered discriminatory. It is also a recommendation that would be hard to transfer to psychotherapy as it is impossible to predict when or if a client might disclose abusive behaviour. It is recognised that some therapists have experienced their own trauma or abuse; Jung (1951) spoke about the concept of the wounded healer, in which people are drawn to therapy as a result of their own wounds. Personal therapy is a requirement for trainee psychotherapists as a means of helping them to address such issues; it would be unrealistic and discriminatory to ban victims of abuse from becoming therapists, in case they might encounter an abuser. What needs further consideration is how these professionals can be supported to manage the emotions and responses that might arise should they be faced with such issues, through supervision for example.

A later study by Mulligan (2013) used IPA to explore the impact of working with sex offenders on the personal life of the therapist. A limitation of Mulligan's study is that he had a professional relationship with the participants, as they were all colleagues from within the prison in which he

worked; this may have affected the findings as the participants may have felt uncomfortable disclosing certain elements of their experience to someone they know and work with; especially if there could be complex countertransference from their own past.

Hill (1995) reflects on the concept of dual counter-transference in forensic settings, in which therapists need to be aware of their feelings towards their patients in terms of them being "*both an offender who has violated a societal law and as a client who needs help*".

These studies give an indication of some of the complexities faced by working with offenders; what needs to be held in mind is that they have focused on the experience of people who have chosen to work in the forensic field; the focal point of this research is on the experience of those who would not have anticipated working with offenders.

There is also a wealth of research exploring what it is like to work with the victims of abuse, both with children and adult survivors (Shevade et al, 2011; Toombes, 2009). While this research is helpful as it provides a good illustration of the impact of working with such issues; what appears to be missing is a focus on working with *parents* who are the abuser (or as the one failing to protect). Some of the cases may incorporate parent sex offenders, but this isn't the angle of the research. There also seems to be a gap around how to handle *suspicions* of abuse and the delicate dilemma of balanced the needs of the client and the child.

One of the most relevant studies was that of Maddocks' et al (2010), who undertook an interesting phenomenological study with mental health nurses whose patients were also parents. The study recognised the conflict of interests faced by the nurses, who are challenged with actually meeting their patients' children and explored the difficulties the nurses experienced in remaining impartial. Some differing views emerged in the discussion around the level of the nurses involvement with the children; one participant acknowledged their child protection responsibilities and agreed that they need to place the child's needs above the needs of their patient; another participant used the boundaries of their role to remain impartial and with reference to her patient's behaviour towards their children, stated "*that's not my job to know about*" (Maddocks et al, 2010:678). This raises an important question: how do therapists perceive their responsibility towards their clients' children? Is it their job to know about abuse? Therapists working with adults will understandably have a relationship with their client and feel responsible to maintain their trust and prioritise their needs. However, how does this fit with their legal and ethical responsibilities in respect of child protection? Perhaps a key difference for psychological therapists to the nurses in Maddocks' study, is that they often don't have contact with their clients' children; while an important focus for both nurses and therapists is being able to develop a trusting relationship with patients, it is worth considering whether having direct contact with the child influences the practitioners' ability to distance

themselves from the child and prioritise the patient.

A similar phenomenological study by Carter (2010) looked at the experience of Phunket nurses in New Zealand, in deciding whether to report child protection concerns. Amongst her findings, Carter (2010) acknowledges that one of the challenges faced by the nurses was maintaining a balance between developing a trusting relationship with hard to engage families versus their legal responsibilities to protect the child. This is a valid concern which may be influenced by the strength of the relationship at the point when anxieties arise. As with other phenomenological studies, a limitation of both Maddocks' and Carter's (2010) studies are the small sample size and lack of generalisability, meaning that it cannot be assumed that these findings apply to the wider population of nurses, but are the detailed experience of a few. However, the similarity of findings between the two studies does indicate something warranting further attention.

The recommendations from Maddocks' (2010) research, was an integrated model of care, in which patients have two allocated nurses, one to provide a person-centred approach and the other to focus on the family. This is a dynamic idea and has massive implications for resources; however, it also appears too simplistic; it could be a challenge to keep individual roles so separate. In terms of applying this to the field of psychotherapy, it could be likened to the systemic practices seen within child and adolescent mental health services, in which the child would receive individual therapy and the family may receive systemic psychotherapy; however, this is not a model of care found in adult mental health services.

What can be taken from these studies is that working with parents with mental health issues is challenging and can create split loyalties.

1.3.5. The Role of Parental Mental Health

It appears that there is also a lack of research on what it is like to work with parents who abuse their children or are failing to protect them from harm. However, it is inevitable that a large proportion of adults who enter psychological therapy, will be parents or step parents; thus bringing children into the therapist's field of vision. Some therapists may argue that their client is their priority and may question their responsibility towards the child; yet the BPS (2014:2) has clearly stated that:

> *"it is the responsibility of all adults to work to prevent abuse and neglect, to protect children from harm, and to identify and report concerns about child abuse"*

This raises the conflict of interest faced by therapists working with adults; balancing the needs of their client and those of the child is a very complex professional dilemma (Weir, 1999). So therapists cannot escape the fact that it is their responsibility to be mindful that their clients may be parents and that their clients' behaviours could be negatively impacting their children. There is also a positive opportunity here, not only are therapists able to monitor the needs of the child from a once-removed distance, they are also in a position to enable the parent to reflect on their behaviour and to make positive changes in their relationships with their children.

Howe (2010) has written extensively about the role that mentalisation plays in therapy with parents. Mentalisation is "*the capacity to understand how one's own and other people's mental states affect behaviour"* (Howe, 2010:335). It also means being able to recognise the impact our behaviour has on the thoughts and feelings of others and vice versa. This is an important process as it is linked to the development of secure attachments, emotional regulation and a coherent sense of self (Howe, 2010). It is thought that for many parents who abuse their children, they find it hard to enter into their children's worlds; leaving them feeling confused and frustrated as they lack understanding of their children's behaviour, thus responding in abusive ways. It has been suggested that often these parents have their own traumatic histories of abuse and neglect, which impact their ability to mentalise (Howe, 2010). The therapist's role in working with parents, can therefore, focus on holding both the parent and the child in mind, and enabling the parent to gain awareness of their child's mental state and how this links to their child's behaviour (Howe, 2010).

Slade (2008:220) describes his work with parents,

> *"when I work with a parent, I am trying to create a context in which he or she can slowly shift from a physical to a reflective or mentalizing stance. That is, I hold the child in mind for the parent as a mentalizing being, as a person whose feelings and behaviours are inextricably intertwined with theirs as a parent. Most important, I see the child's behaviour as meaningful. Hopefully the parent will come to internalize this view of the child, which will in turn allow them to hold this in mind for the child".*

Attention needs to be paid here to the focus and purpose of the therapy with the parent; do they have a different agenda and is the therapist influencing the path of therapy by having their own agenda of being watchful of the child? This might sit differently depending on the theoretical stance of the therapist.

One of the biggest challenges around working with parents where child protection concerns are in the picture is making that decision about involving external agencies. One of the biggest dangers of reporting to Social Care is that the client will disengage from therapy, resulting in greater risk to the child, as the parent is no longer receiving psychological help. However, by not reporting,

therapists could potentially be further risking the child's safety and be preventing positive intervention from social services.

For parents who are in therapy, whether this be as a direct result of their struggles as a parent, or for separate issues around their own mental health, keeping them engaged in therapy is crucial so that the child can be helped indirectly. As Howe (2010:332) beautifully summarises, the *"more recognised, acknowledged and contained the parent feels, the more the worker can help the parent keep the child in mind and the more the worker can keep the child in sight"*.
It therefore feels, that consideration needs to be given to how therapists can feel confident in managing their concerns in a careful and considered way, to ensure the therapeutic alliance is not jeopardised.

Mental health is also a factor here; whilst not everyone coming to therapy will have a psychiatric illness, a large proportion will have some degree of mental health problem. Statistics by the Royal College of Psychiatrists (2012) indicate that "*68% of women and 57% of men with a mental illness are parents*". While parental mental illness has been proven to have adverse effects for the child (Berg-Nielsen *et al*, 2002), in another report it is stressed that parental mental illness does not necessarily result in child abuse (Royal College of Psychiatrists, 2011). It is acknowledged that *some* parents with mental disorders are unable to meet all the needs of their children, thus placing these children at a greater risk (RCP, 2011). Some mental health conditions pose a greater risk than others; for example, substance misuse, personality disorders and maternal depression (DoH, 2010). Mental health is therefore, a factor that needs to be considered when assessing the risk of child abuse.

There is also the theory of intergenerational transmission of abuse which suggests that children who experience maltreatment will become abusers themselves in adulthood (Cohen, 2006). While this claim is not unfounded, there is also recent research that is challenging the theory and suggesting that "*individuals with histories of childhood abuse and neglect have higher rates of being reported to CPS for child maltreatment but do not self-report more physical and sexual abuse than matched comparisons" (*Widom et al, 2015:1480). There is an indication that the sources of data used to determine transmission of abuse influence the findings and a detection bias may be occurring. Some parents who have histories of abuse will go to great lengths to ensure their child has a different experience to them and they become more protective, something which fits with the researchers' experience. It is important to be mindful therefore, that although our clients may have experienced abuse or have mental health difficulties, they are not necessarily abusive to their children; but perhaps these factors bring the possibility more into the reality. The Royal College of Psychiatrists (2004:8) make a valid statement, "*unless this possibility of such*

harm is borne in mind, it is unlikely to be recognised".

Another strand to consider is the impact of parental learning disability and the role this plays in relation to child abuse. Horwath (2010:341) states that "*parental learning disability in itself, should not be equated with wilful neglect and abusive parenting*"; however, she recognises that other factors in combination with the disability can affect parental capacity, for example, domestic violence, substance abuse and physical disability. An Australian study had similar findings and argued that *"Intellectual disability can contribute to parents experiencing other problems and stressors, which are associated with an increased risk of child abuse and neglect, such as social isolation, parental stress, past histories of abuse and neglect, poverty, and physical and mental health problems"* (Lamont & Bromfield, 2010:16). The study concluded that intellectual disability alone is not a risk factor for child abuse and neglect but recommended that it needs to considered as part of a full risk assessment if there are concerns about parenting capacity. It needs to be held in mind that this study was a review of pre-existing literature and this carries with it the methodological limitations of each of the research studies evaluated, such as different definitions and interpretations of parenting capacity and intellectual disability.

What is almost inevitable is that professionals working with adult learning disabilities are likely to encounter child protection concerns at some point in their career. It is also important to reflect on the role of adult autism and the potential implications for child protection; however, this raises complex issues that are beyond the realm of this research; therefore therapists working with adult learning disabilities and autism have purposively been excluded from this study.

While having a mental illness or a learning disability do not necessarily predict child abuse, they are factors that could increase the risk, amongst other factors such as substance abuse and socio-economic status. Such factors need to be considered when making a risk assessment.

1.3.6. Fact or Fear? Assessment of Risk

Therapists may become concerned about the safety of a child on the basis of a variety of factors, such as their client's behaviour or descriptions of their home life. One of the first issues is whether they are concerned that potential abuse has already happened or whether they are concerned it might happen. Why is this an important distinction to make? If they believe that abuse is or has taken place already, this is serious as it means that a child has actually suffered harm and this is something that needs addressing.

If they have a fear that abuse *might* happen, this needs to be assessed in a different way as it is about the risk posed to that child, rather than actual harm that has taken place. This doesn't make it any less serious and is equally important, as prevention of harm is also a priority.

The term "*risk*" implies danger, harm or damage is going to happen; Munro (2008) highlights how using the term "*risk*", shifts the focus from the here and now, into the future – thinking about what *might* happen. For example, a therapist is concerned that a child is being emotionally abused and is worried that the child *might* experience mental health difficulties when they are older. The child may not be displaying symptoms at the current time, but if the situation continues, the risk of mental health difficulties increases.

The level of risk also depends on the context and nature of the concern; a parent may have decided to allow their seven-year old to play alone outside, which could be considered neglectful; however if they are also leaving the child alone at night while they go out drinking, the level of risk is dramatically increased.

There are also some long standing assumptions that certain types of abuse should be taken more seriously, with physical and sexual abuse often being people's primary concern. While the risks associated with these types of abuse can be incredibly serious, sometimes resulting in death; we also shouldn't underestimate the damage caused by emotional abuse and neglect. Gerhardt (2005) explains, it can be harder for adults to understand the serious impact of being told you are "*useless*" or being left to fend for yourself at a young age; the word "*abuse*" often conjures images of violent, malicious behaviour, rather than the subtle but still damaging verbal put-downs. However, research is starting to indicate that psychological abuse alone can result in changes in the brain structure and be associated with mental illness (Teicher, 2000). A study by Chaney et al (2014:50) supports this and indicates that "*early child maltreatment is associated with brain structural changes*". Further research by Vachon et al (2015) has directly challenged these assumptions; they studied over two thousand children to explore the impact of different forms of child maltreatment on psychiatric and behavioural disturbances. Their findings suggested that all forms of child abuse can lead to *"equivalent, broad and universal effects"* and therefore all would benefit from treatment. One criticism of this study is that they only studied the children of low income families; this encourages the stereotypical assumption that child abuse doesn't happen in upper class families.

Assessing risk of child abuse is one of the roles of social care and the importance of a thorough social care assessment is crucial in determining outcomes for children. Unfortunately a good assessment doesn't guarantee a good outcome for the child (Turney et al, 2011); however, the consequences of a poor assessment can be devastating and have found to be connected to severe cases of child death (Rose and Barnes, 2008).

In order to help identify the level of risk, risk assessment tools have been developed to aid

professionals to look at the interplay of a variety of factors, such as family history, mental health, socio-economic status, amongst others. However, one of the big difficulties with assessing risk is that it bases decision-making on probability and the likelihood of something happening, rather than actual fact. Of course, we don't want to wait for the fact because that would mean a child has actually experienced harm, but Munro (2008) points out that humans can not always accurately make decisions based on probability.

Controversially there is a movement in some countries, such as New Zealand and America called "*predictive analytics*", which can be defined as "*the practice of extracting information from data sets to determine patterns and predict outcomes and trends*" (Packard, 2016). A more specific form of this known as "*predictive risk modelling*" is being used to focus on risk factors of child abuse, whereby children are given a score calculated on how many risk factors they have; the aim is to be able to target services to those identified at risk. This approach has been heavily criticised particularly on ethical grounds for invading the individual's right to privacy as the government would need certain information about the family to base the assessment on (Keddell, 2014). There are also concerns that it is drawing attention away from the promotion of general well-being, instead focusing resources on a small proportion of problematic families (Keddell, 2014).

There is limited evidence on the effectiveness of risk assessment tools in general and some would argue against the attempts to predict risky situations; claiming that we are becoming a risk society and that the preoccupation with assessing risk is in reality about people trying to protect themselves from litigation (Dean, 2016). Munro (2007) explains how risk assessments can result in dangerous predictions, with innocent families being wrongly accused and abusive families deemed as safe. It is a disconcerting prospect that child abuse cannot always be accurately predicted and prevented, yet it feels understandable that society would want to try and understand and control such distressing experiences from happening.

Traditional *"risk assessment"* within psychological therapy tends to have a different focus, looking more at the client's risk taking behaviour in terms of self-harm, suicide or violence and offending. Therapists may however, be conscious of other risks, such as the risk of clients' disengaging from therapy. When therapists confront their clients with their concerns and discuss breaking confidentiality and involving other services, there is always a fear that the client will feel betrayed and will withdraw from therapy. This has potentially devastating consequences for the child as it means the parent will no longer be receiving the therapeutic help that may help them ultimately change their behaviour. There is also no guarantee that social care will take action, so therapy could be jeopardised for no reason.

If a therapist has concerns that a child might be being abused, it is *not* their role to establish

whether this is true; they have an ethical duty to report the concerns to Social Care, who are *specially trained to assess the risk to the child*. Although therapists may not therefore, be required to complete a risk assessment for our clients behaviour, they will still hold the question – how to decide if the concerns warrant further investigation? This feels an appropriate moment to reflect on exactly what is required by psychological therapists.

1.3.7. Legal and Ethical Considerations

There may be an assumption that therapists are legally bound to report their concerns, however surprising in the UK, this is not currently the case. The current British law gives mixed messages about how to respond to child protection concerns; a therapist who did not disclose concerns on the grounds of maintaining client's confidentiality would be supported by common law. However, if a therapist did decide to report their concerns, their decision could be understood as being in the public interest (Jenkins, 2007). This contradiction leaves therapists in a difficult position and demonstrates how law and counselling are incompatible; Jenkins (2007) describes how the objective, societal-based approach of the law doesn't sit well with the more subjective, artistic and individual-based philosophy of counselling. As Grayson (2017) points out, there is a misconception that therapists have a legal duty to report child abuse; while therapists may be "*bound by their contract of employment*" and may face consequences such as disciplinary action, they cannot currently be legally prosecuted.

However, child protection is increasingly becoming the focus of attention, following numerous serious incidents and revelations about historical child abuse by public figures, such as Jimmy Saville (HM Government, 2016). The UK government have recently released a consultation document exploring the idea of reforming the legal requirements around reporting child protection concerns; the two options being considered are the mandatory reporting of concerns or the duty to act on concerns (HM Government, 2016). This would bring UK law in line with other countries such as Australia and the USA.

Should this change in the law take place, it will have significant implications, not only for children and families but also for professionals, including psychological therapists. The hope for mandatory reporting is that it would increase awareness about the importance of reporting, it would allow for earlier interventions and identification of abuse and would ensure that social workers (those best trained for assessing abuse) are doing the risk assessments, rather than the untrained.

Even so, there are also some concerns; the increased demand on social care by an increase in referrals means that focus may be taken away from supporting actual cases of abuse and instead be deferred onto more assessment and investigation. Other concerns centre on the potential

reluctance by individuals to make disclosures due to increased fear about the consequences of doing so; also a worry that professionals will become distracted about the need to report rather than thinking about how to intervene (HM Government, 2016). There would also be professional implications in terms of sanctions for those who fail to report concerns, which may increase levels of anxiety amongst professionals.
Obviously, this will be a huge change and will take time to implement; the UKCP are involved in the process and have asked members to offer their views on how this would impact their practice.

Focusing back on the current situation, with the lack of legal regulation, therapists are therefore guided by the ethical guidelines of their regulating bodies e.g. UKCP, BPS, BACP. There is no doubt that although there isn't a legal requirement to report, there is a strong moral and ethical duty.
Ethics can be defined as "*a generic term for various ways of understanding and examining the moral life*" (Beauchamp & Childress, 2001:1). Therapists are faced with an array of ethical dilemmas; dual relationships, colleagues' conduct, competence and confidentiality are just a few discussed by Clarkson and Lindsay (1999). Their study looked at the experiences of UKCP registered psychotherapists who had recent experience of an ethical dilemma; they compared their results to similar studies completed with members of the BPS and APA (American Psychological Association). Interestingly out of a sample of 1000 psychotherapists targeted for the research, only twenty-one percent responded; within their article, Clarkson and Lindsay (1999) give limited reflection on why the response rate was so low. The question they posed was "Describe in a few words, or more detail, an incident that you or a colleague have faced in the past year or two that was ethically troubling you". One important reflection from this project has been on the wording of the research question in the process of recruitment; I wonder whether the use of the word "incident" limited the responses as it primed respondents to think of specific incidents rather than an accumulation of concerns or instincts that raised concern.

The results from Clarkson and Lindsay's study showed that in all three studies, the most prevalent ethical concerns were about confidentiality, and within this, concerns about child abuse and risk to others. People's main concerns centred around risking the therapeutic relationship to fulfil child protection requirements when there is lack of evidence; participants spoke of the difficulty in balancing the needs of the child and their clients' need for help. A common theme emerging in research studies around this area is the emphasis that mental health professionals place on respecting confidentiality (Bunting, 2010; Clarkson & Lindsay, 1999). Decisions around these issues will be influenced by therapists' personal moral values surrounding confidentiality, trust and societal obligation; however, they can also seek guidance from their accrediting body's Code of

Ethics.

In recent years there has been a move towards ethical decision making within psychology, with codes of ethics outlining ethical values and principles, rather than specific rules about how to respond to ethical dilemmas (Strawbridge, 2003). This is made explicit in the British Psychological Society's (BPS) Code of Ethics (2006), which outlines four ethical principles on which it is based, namely respect, competence, responsibility and integrity. The Code states that "*each Ethical Principle is described in a Statement of Values, reflecting the fundamental beliefs that guide ethical reasoning, decision making, and* behaviour" (BPS, 2006:9). However, this is still vague and is open to interpretation.

Under the principle of respect, the statement of values outlines the importance of value being given to the dignity and worth of all people and stresses the need to give regard to an individual's right for privacy. It is here that issues of confidentiality are addressed, and it is within this context that responsibilities in terms of child protection are briefly touched upon.

The Code clearly states that breaches of confidentiality should only be made under exceptional circumstances, with the "*health, welfare or safety of children*" (BPS, 2006:11) being one of these. There is a positive move towards recognising the individual complexities in ethical decision-making; however, it is not clear how practically helpful it is to psychologists' facing these ethical dilemmas.

The British Psychological Society has been making child protection issues an important focus of their thinking in recent years; in 2007 they released a child protection portfolio to clarify psychologists' responsibilities around child protection. This has been updated more recently in 2014, with a position paper on Safeguarding and Promoting the Welfare of Children. This paper is to be updated with a full review in May 2019, illustrating the Society's commitment to ensuring they are responding from the most current and relevant position. Within the position paper, there are clear statements about psychologist's responsibilities in respect of child protection:

> *"it applies equally to those who work with individual adult clients, seen, for instance, in clinics, hospitals and prisons, who may make historical disclosures of abuse or raise concerns about child protection within their families or communities"*

This stresses that even for those working with adults, their responsibilities towards the child remain crucial.

The UKCP (2009) makes a concrete statement about the expectations of therapists in relation to

child protection issues; under the subsection of general ethical principles of their code of ethics, they state, *"The psychotherapist undertakes to know and understand their legal responsibilities concerning the rights of children and vulnerable adults and to take appropriate action should the psychotherapist consider a child or vulnerable adult is at risk of harm."* While this clearly acknowledges an expectation for the therapist to take "*appropriate action*", it remains vague as to what this means; it also places a significant responsibility on the therapist's judgement about the level of risk.

What appears unwritten and therefore perhaps unclear to therapists who have not encountered these situations, is the role of professional indemnity insurance when thinking about how to manage these decisions. Experience of colleagues seems to imply that the insurance company have a vital role in whether or not therapists should report their concerns, with therapists potentially leaving themselves vulnerable and uncovered if they do not follow the company's advice.

The guidance is therefore undefined; while training is available to help therapists understand the definitions of abuse and the reporting thresholds, this is not mandatory in all settings and still does not address the complexities of managing issues such as the therapeutic alliance and confidentiality. Bunting et al (2010) particularly place an emphasis on a need for more specific training, aimed at addressing these issues, which will be explored in further detail later.

Another factor to consider is that therapists working in private practice arguably have more freedom about how to manage their concerns than those working within organisations (Brown, 2006). The majority of organisations will have policies and procedures around child protection and what to do with concerns; perhaps more obviously those that have actual involvement with children, such as schools or NHS services. Private practitioners are arguably more vulnerable when it comes to handling these concerns and could find the "freedom" more of a burden. Private settings are not only vulnerable due to the lack of access to training and policy guidance, there is also potentially less support. In a recent blog, Kirkbride (2016) reflects on the loneliness of working privately as a psychotherapist; while this is the opinion of one individual, it raises the question of how these feelings may be shared by others in similar situations. For those working independently, there is a greater risk of isolation unless the therapist ensures they have a supportive professional network. The potential change in the law could place a challenging strain on those working in the private arena.

1.3.8. Factors Affecting Reporting

In many countries there are mandatory reporting laws (USA, Australia, some European countries), although this is not currently the case within the UK; there have been numerous studies looking at

the under-reporting of child abuse and it seems that despite the mandatory laws, it is still a subjective decision-making process.

In 2004, Lazenbatt and colleagues conducted a survey of medical practitioners across Northern Ireland to explore their perception and ability to recognise child physical abuse in their practice. Their results were concerning; of the sixty percent of respondents who had experienced concerns, only forty-seven percent of them had made a report, with thirteen percent of respondents taking no action. Similarly, Talsma (2015) looked at Swedish GP's reporting rates and discovered that despite mandatory reporting laws, twenty percent of participants had suspected but not reported child abuse. It needs to be acknowledged that in many of these studies, the response rates are low and this limits the reliability of the data.

There has also been research exploring the factors that influence people's decision about whether to report their concerns, trying to understand the reasoning for this problem of under-reporting; this research covers a range of professionals, including medical doctors, teachers, dentists as well as psychological therapists.

Crenshaw et al (1995) found that willingness to report was influenced by the reporters view on the importance of solid evidence, identifying that "*non-reporters are unwilling to make reports without greater evidence*" (Bunting et al, 2010). This connects to the idea of certainty and wanting to be confident before making any accusations; sometimes however, evidence is hard to accumulate and suspicions are based on instincts and a sense of unease.

In later research, Lazenbatt and Freeman (2006) consider the fears and anxieties connected with making a misdiagnosis of abuse, which undoubtedly influence people's decision to report. They identified fears of being wrong, damaging the relationship with the family and of facing legal or disciplinary action as a result of reporting concerns. A lack of certainty around guidelines and protocols was also recognised as an important factor.

As discussed earlier, the legal and ethical framework around reporting child protection can be confusing and result in professionals facing a real dilemma about their duty of care versus their patient's needs and wishes. Bunting et al (2010) use the example of a paediatrician who was called in front of the General Medical Council because he decided his duty of care was to the child and acted accordingly; while he was found "*not guilty of professional misconduct*", the fact that it was investigated sends a challenging message to others. Bunting et al continue to report how a survey undertaken by the Royal College of Paediatrics and Child Health indicated that fourteen percent of paediatricians had received official complaints after making child protection reports. This has serious implications for professionals' reputations and respectability.

Not only is there fear about the professional implications of involving social care in terms of complaints, unfortunately, social care has not always been portrayed positively, which doesn't encourage professionals to want to involve them. Facing emotionally demanding situations, with a lack of support and overwhelming caseloads, there is no wonder that the profession is struggling. The media hasn't aided the profession; in her blog, Pemberton (2013) talks about the "c*ynical propaganda against social workers"* reported mainly in the Daily Mail following a ruling by Lord Justice Munby. The newspaper was accused of focusing on the distressing act of a child being removed by an emergency care order, without covering the real facts of the case. Social workers have been accused of being "*child snatchers*", reportedly ripping children from their parents with no due cause; although these claims have been thrown out by a Ministry of Justice study (Samuel, 2008), it has undoubtedly damaged the reputation of the professional group.

There is some indication that the thresholds for accessing child protection services is increasing and consequently reporting cases doesn't necessarily mean it will be accepted and deemed as worthy of intervention. In Steinberg et al's (1997) study it was recognised that mandated reports were often being dismissed by social care, leaving reporters feeling that "*nothing good happened*" as a result. In fact, it was noted that some therapists were left feeling quite the opposite, that reporting did more harm than good (Steinberg et al, 1997). In Talsma's (2015) study, they found that only thirty percent of respondents had trust in how child protective services (CPS) would investigate and respond to their concerns; there was limited exploration into why their confidence in CPS was so poor and there is scope for further research here.

With such a negative image and professionals having little faith in the social care system, it is no wonder that families are often worried about what involving social care might entail, with the assumption often made that removing the child is the only role of a social worker. The positive support that social care can implement often gets overlooked. In his online article, Novell (2013) has tried to fight against this negative image, suggesting that social workers use social media to portray a more realistic picture of their role to the public. However, until this perception has been challenged involving social care may remain a scary outcome for some families and professionals.

Within the research, there is also a focus on recommendations for ways to overcome these barriers, with particular attention being paid to training needs. It is suggested that training could focus on reporting methods and encouraging professionals to develop positive relationships with the child protective services (Alvarez et al, 2004).

In their 2010 study, Bunting et al explore the multiple *"professional barriers"* to reporting child maltreatment and recommend the importance of training on both the recognition of abuse and the reporting processes. However, the title of the paper is not entirely accurate; while the focus is on

the "*professional*" barriers, Bunting also acknowledges that there are personal factors, such as gender and personal attitudes, that impact on reporting behaviours. Their recommendations are positive, concluding that "*future training must go beyond restating the obvious to emphasising some of the salient issues raised in the literature that have shown to impact on reporting tendency*". They are highlighting the importance that training needs to extend beyond identifying signs of abuse and pay closer attention to the concerns and barriers faced by different professional groups, such as the impact of breaking confidentiality and the effect on the therapeutic relationship. Something Bunting et al (2010) have failed to address within their recommendations, is the need for training to help individuals consider the role of cultural differences and to reflect on their own personal biases in evaluating the need to report concerns.

Steinberg et al (1997) preceded these recommendations and had already identified that training needs to help therapists learn how to be clear about their reporting responsibilities and also consider how to handle the therapeutic relationship once a report has been made.

Given there are so many recommendations focused on training needs, some research has started to look at the usefulness of training on child protection; In 2004, Alvarez et al, looked at the range of existing research looking at training programmes on child protection, they found little empirical evidence to support the effectiveness of these trainings. Kenny (2007) conducted a study on the usefulness of a web-based training for undergraduate and graduate students on the signs of child abuse; his post-training findings concluded that there was an improvement in participants' knowledge of abuse. A criticism of this study however, is that it doesn't evidence whether the information is retained on a longer-term basis, it simply proves that after an hours' training session, people's knowledge increases.

Research by Hawkins and McCallum (2001) showed that in cases where there was solid evidence of abuse, participants' experience of training made no impact on their likelihood to report; this suggests that there is a correlation between certainty and confidence in reporting.

There is an assumption that current training on child protection is inadequate, given numerous research studies that indicate more training is needed; however, it is also evident that there is limited research exploring the effectiveness and quality of existing training and what is needed to improve it.

Another way in which therapists can explore their concerns and seek guidance on these difficult issues is within clinical supervision.

1.3.9. Importance of Supervision

Throughout the literature, there are references to the role of clinical supervision as an important place for therapists to explore their feelings and receive support. However there is a lack of clarity about the definition and role of clinical supervision, with different models emphasising different elements as important (Waskett, 2009; Padesky, 1996; Stoltenberg and Delworth, 1998). One influential model is that of Proctor (2001) who describes three functions of supervision: formative (focusing on skills development and learning), restorative (emotional support to supervisee) and normative (ensuring safe practice). These are all valid functions, particularly when thinking about how safeguarding concerns can be supported; having the normative function enables more senior and experienced practitioners to ensure safeguarding is handled in an ethical and legal way. The formative function allows therapists to be guided in how to develop their skills in approaching these issues and the restorative role of supervision provides the emotional support required for such delicate and emotive topics.

Interestingly, the evidence to prove the effectiveness of clinical supervision is limited. Milne (2007) provides a comprehensive overview of existing research on clinical supervision and expresses his concerns over the apparent lack of outcome evidence, given how much emphasis is placed on its importance. There is the idea that despite supervision being highly valued, it is poorly understood (Milne, 2007: 5). There have been some studies that show clinical supervision has been proven to reduce levels of stress and burnout amongst supervisees (Edwards et al, 2006; Brunero & Stein-Parbury, 2008); which support the belief that it is an important source of support. What is clear in the message from professional bodies is that there is no one particular way to do clinical supervision, but it is important to do it.

When managing ethical dilemmas in therapy, there are inevitably going to be a range of complex counter-transference reactions, questions and uncertainties faced by therapists. The restorative function of supervision may be key in helping therapists to explore these in a safe, containing environment.

1.3.10. Intuition and Counter-transference

Often, people may have a sense of unease, a bad feeling or instinct that something isn't right; this can be referred to as intuition. These intangible feelings are perhaps some of the most powerful indicators that something is wrong, yet they are also potentially the most unreliable. One of the simplest definitions of intuition is that it is "*knowing something but being unable to explain it at the*

moment" (Jeffrey, 2008:2). Often therapists might experience an emotional reaction to something, have a sense that something is not right, that a client is not telling them the whole story; they might not have any physical evidence to support their suspicions, so how much attention do they pay to these feelings?

Munro (2011) speaks at length about the role of intuition and emotional responses in several of her publications. She explains how neurobiological research has challenged the perception that our logical thinking capacity is superior to the role of intuition. Intuition is something that is out of our control, an unconscious, automatic process that interferes with our ability to be solely logical creatures. As with many things, the key is finding a balance between our logical and emotional brains.

Some people may dismiss the importance of intuition; seeing it as unreliable. However, Munro (2011) argues that these gut instincts are far from stupid, but they actually allow people to take fast action, which is often accurate, although admittedly not perfect. It is therefore important to think through these feelings, as one of the risks identified here is that people rely too strongly on their instincts and lose sight of any reason or factual evidence. For example, Munro (2011) reflects on how some parents have raised feelings that their social workers had made up their minds about them and been unwilling to hear other explanations for certain situations. So while it is important not to completely dismiss instincts about what might be happening, it also needs to be balanced with looking from a logical, more factual perspective – this is where supervision plays a vital role in enabling practitioners to make sense of their feelings and to challenge them (Munro, 2011).

In the field of psychotherapy, attention is also paid to the feelings experienced by the therapist in response to their client; counter-transference can be defined as "*all the therapist's feelings and attitudes toward the client*" (Kahn, 2001:129). This can further be broken down into reactive counter-transference (Clarkson, 2006), which means the feelings that are directly connected to the client's presentation; or proactive counter-transference, which are feelings related to the therapist's own personal experience (Clarkson, 2006). Being able to differentiate these feelings and recognise the role of our own past traumas is very important and one of the key reasons therapists undergo personal therapy and regular clinical supervision.

Linked into this is the idea of therapists' personal boundaries, values and prejudices, as to how they respond to certain information will undoubtedly be influenced by the views and opinions they hold. Psychotherapy training will address these issues, encouraging trainees to reflect on the types of clients they may find it hard to work with, either due to their past personal experiences or simply their views on certain behaviours or characteristics that might affect the therapeutic alliance. These discussions may explore whether trainees could work with paedophiles, murderers,

offenders, or simply someone of a different race or religion. It is important to be aware of your limitations as a therapist and how certain issues might bring up your own feelings, which could then impact the therapy; this can be seen as part of our ethical responsibility (Pope and Vasquez, 2016).

One of these personal bias is the therapists' own experience of being a parent and if/how this affects how they respond to child welfare concerns. Does being a parent impact the way the therapist feels towards offenders, either increasing their anger or alternatively, their empathy? This is an area which has very little research, the key study found exploring this was by George (2010) who completed an interesting study looking at the experiences of trainee psychologists who hold a dual parent role while working within CAMHS. One of the main themes emerging was the inability and lack of desire, for participants to separate their role as a parent from their role as a trainee; George (2010:94) entitles one of her themes as "*seeing an all too familiar face in the therapy room*", which inevitably explores the counter-transference reactions experienced when working with child protection issues and being a parent. Fascinatingly she not only uncovers the anticipated response that parents find child abuse work very emotive and painful, due to identifications with their own child; but also, that by holding a parental role, it enabled participants to hold empathy and understanding for how difficult it is to be a parent (George, 2010). One of her participants' states, "*Your patience with other parents is much greater…your care with other parents is much greater, you really understand that it"s hard being a parent".* Again, this highlights the complexity of our human responses; how we can be faced with holding a whole range of emotions and be challenged with targeting our reactions appropriately.

The outcome of George's (2010) research, highlights the need for trainees in the position of becoming a parent while working in CAMHS, to have sufficient support when managing delicate clinical material and she has also indicated implications in relation to training and supervision. It feels a relevant acknowledgement that for anyone who is new to parenthood and involved in child protection work, that particular attention needs to be given to supporting the worker. George's research is limited; there was a mix in the status of participants' relationships; for example, there was one single participant, while the others were in relationships. George (2010) doesn't really address this variable and how important it may be in the experience of the participant; does being a single parent change the level of responsibility they hold and affect their experience of working in CAMHS? Interestingly, George fails to identify this as an avenue for further exploration, which poses the question as to whether this was due to a lack of evidence that there is more to explore or whether it has been overseen.

People could ask why counter-transference is so important? Why do therapists need to pay

attention to these feelings and opinions? Often these responses are very powerful, and they can be influential in how therapists react and respond to their clients. Friedrich and Leiper (2006) studied the counter-transference responses of therapists working with incestuous sexual abusers; they discovered that therapists had very negative feelings including the sense of being controlled and deceived, which subsequently influenced their ability to maintain the therapeutic relationship.

The therapeutic relationship provides an environment that facilitates positive change; Carl Rogers (1995) made an invaluable contribution to the field of psychotherapy in his work on the core conditions that he feels are necessary and sufficient for change to take place. He argues that if warmth, empathy and genuineness are present in a therapeutic relationship, regardless of the type of therapy, change will take place. However, as Friedrich and Leiper (2006) have illustrated, it can be incredibly hard for therapists to hold on to these conditions when they are faced with an abusive parent.

Carter (2010) describes the counter-transference responses of the nurses in dealing with child protection concerns, discussing a range of emotions from anger to worry, and the immense impact the work has on their emotional well-being. One participant quoted, "*I actually feel real sick in the stomach. I find it hard to get it out of my mind. It troubles me a lot, I take it home. I can't turn it off*" (Carter, 2010:72). With such strong responses, it is inevitable that this will affect the nurses' engagement with the patient and influence how they cope with the emotional demands of the job. This has implications in terms of the level of support and supervision that may be needed.

Another important finding from Carter's study links back to the idea of intuition, with a common emergent theme entitled "*gut feelings*". Participants repeatedly reported feelings of concern, that they just could not explain; one nurse described her gut feeling as "*a feeling of something that isn't right"* (Carter, 2010:84). This links back to the earlier discussion on how sometimes therapists have suspicions that they find hard to put words to. Given the vagueness of these feelings, they can be difficult to record in clinical documentation and even harder to justify taking action on. It is considered inadvisable for practitioners to base clinical decisions on intuition alone, especially when the consequences could be potentiality damaging to a child (Welsh & Lyons, 2001); yet, sometimes there isn't anything more than these feelings and therapists are left holding uncomfortable feelings that they can't act upon. Ling and Luker (2000) suggest that health visitors can use these feelings and intuition productively, as a "*silent alarm*", which prompts them to look at things more closely and to pay more attention to potential evidence to support their suspicions. It seems they are suggesting that rather than acting on these feelings alone, to use them as indications that certain behaviours or dynamics need to be explored in greater detail.

It needs to be noted that these studies are based on professionals such as nurses and health visitors, who often go into the patients' homes and potentially even see the children;

psychotherapists get a different perspective, only seeing and hearing about what the client allows them to. Whether this impacts the role that intuition and instinct play in their concerns may be hard to decipher.

1.4 Research Question and Aims

Throughout the course of this research, the main research question has evolved and altered in response to both changes in thinking but also reactions from others; in the methodology chapter, more attention is given to how the wording played particular importance in recruitment.

The main aim for the research was identified as being able to get an understanding of the therapist's *experience* when they are in the difficult situation of having child protection concerns – how does the situation *impact* on them? The term "*experience*" is used broadly, wanting to encompass not only the emotional experience but also the other aspects of experience as explored within the literature, such as their experience of support/supervision, their experience of working with these ethical dilemmas from a professional stance and the complexities of experience in terms of personal bias.

The following research question was therefore proposed:

"What was your experience of working with a client where you had concerns for their child's welfare?"

Through the course of this study, the hope is that the findings will provide useful reading for therapists who find themselves facing such dilemmas. It will demonstrate that therapists are not alone in their struggles and potentially offer guidance on how to manage situations, highlighting areas of support that others have found useful.

1.5 The value of this research to the practice of psychological therapy

My anticipation for this research is that it will provide an answer to some of the questions I have just raised. By exploring the in-depth experience of the therapist who has worked with child protection concerns, I hope the research will provide insight and learning to practitioners who are being faced with these dilemmas. I also hope the research will be of interest to supervisors, who may not face the situation directly, but be involved in guiding and supporting those who are. I shall look at the guidance already in place in codes of ethics and the law, and hold in mind that through

the process of this research; more information to clarify the ethical decision-making process for child protection, may come to light.

One of my main goals from this research however, is to raise awareness and conversation about the issue of child protection in work with adult clients; to encourage practitioners to be holding the child in mind and to be mindful of their responsibilities towards both their client and the child.

In terms of distribution, I shall be looking to publish articles in several publications, such as the British Psychological Society's *Counselling Psychology Review*, the *Psychologist* magazine and the UKCP *Psychotherapist* magazine. I will also explore publication in more specific journals such as *Child Abuse and Neglect* or *Child Abuse Review*.

I hope that it will be enlightening and I hold an awareness that information about necessary skills and effective models of working with child protection, may emerge. This could hold implications for training; my initial interest was in addressing the training needs of psychologists in relation to child protection, the following chapter will illustrate how the research has developed away from this as the primary motivation.

1.6 Closing remarks

This chapter has provided an introduction to the research matter; illustrating the lack of existing research on working with abusive parents. It has tackled some of the complexity in defining and identifying abusive behaviours and considered the legal and ethical dilemmas faced by therapists.

It has led into a discussion of the research question being addressed and how this has been adapted to manage the delicacy of the topic. The following chapter addresses the theoretical underpinnings of the chosen methodology and moves on to explore the procedural aspects of the research.

2 Methodology

2.1 Overview

The initial focus of this chapter will explain my justification for choosing a qualitative methodology, more specifically interpretative phenomenological analysis. (IPA) I shall explore how the theoretical roots of IPA provide the perfect methodology to analysis my research question. Details of the research design including the interview procedure, validity and ethical considerations shall be discussed; followed by a step-by-step description of the analytical process. Finally, I shall think about the role of reflexivity, exploring what I bring personally to the research and reflect upon the various aspects of the research process and the challenges I have faced.

2.2 The Rationale for Qualitative Research

Epistemology is focused on trying to understand "*how and what can we know*?" (Willig, 2010:2). This is relevant to research as we need to adopt a position about what we believe we can know in order to decide what to research; our epistemological position will influence our choice of a research question and also our methodology.

One of the main reasons I decided to become a psychologist was a fascination with human behaviour and desire to understand what motivates people; it makes sense for my research to follow in this line, to have an opportunity to take one specific part of the human experience and to try and understand it on a deeper level. It was inevitable therefore that I would need to use a qualitative methodology. I also recognise that my clinical skills are one of my strengths and that a qualitative methodology would allow me to utilise these.

So once I had identified that I needed to use a qualitative methodology, the task became choosing which approach to use. My original intention was to develop a theory about the factors that affect the therapeutic relationship when child protection concerns are raised in therapy, using grounded theory.

However, after taking some time away from the research to have my first son, when I returned, I struggled to re-connect, feeling like the project was missing something. I realised that my research question was too cognitive and that I was struggling with the epistemology of grounded theory. I was confused by the divide within the field, between those holding a more positivist stance and the social constructivist movement of Charmaz (2008). This prompted me to give more consideration to my epistemological position and to explore other methodologies and re-evaluate my research question.

Laying claim to my own epistemological position feels daunting, with so many complex

terminologies such as naïve realist or radical relativist (Willig, 2010). As I have explored this however, certain issues struck me as important. I think my resistance to purer phenomenological approaches was a result of my natural inclination to interpretation. I feel that part of me would be dissatisfied by establishing a description of a phenomenon without trying to make some sense of it. I also feel it is important to reflect on how I make sense of what my clients bring, is undoubtedly influenced by my own experiences, assumptions and beliefs. Connected to this, I recognise that there are multiple views of the world and that each individual perspective is valid (Baker et al, 2005), one of the factors influencing my decision to study integrative psychotherapy.

I realised that I wanted to hold on to the subject matter of interest, but bring it to life by focusing in on the *experience*; I wanted to know what it is like to have concerns about a client's children, what is the impact of managing such complex issues? To try to understand the clinical, ethical, personal and conceptual issues that can arise from such complex work. This approach feels richer in potential and I concluded that I needed to adapt my research question accordingly. This shift onto the *subjective experience* required a phenomenological methodology.
After exploring the different phenomenological methodologies I felt that interpretative phenomenological analysis was the most fitting.

2.3 Rationale for IPA

Interpretative Phenomenological Analysis (IPA) is a fairly recent methodology, created in the mid-nineties by Jonathan Smith; developed originally in relation to health, it has quickly become popular among social scientists. It is a qualitative methodology that focuses on how the individual makes sense of their personal significant experiences, making it perfect for my subject matter.
However, IPA is more than a research method; it is not just a simple recipe about how to undertake research; it is a *methodology*, with roots firmly grounded in philosophy and theory (Smith, 2004).
Part of IPA is it's idiographic nature – by this, I mean the focus on understanding the particular experience of particular people (Smith et al, 2010). While many therapists are likely to be faced with child protection concerns at some point in their career, it is unlikely to be a regular occurrence; the diverse nature of concerns and the multiple variables at play, meaning that no two cases will be the same. Consequently, IPA does not aim to make generalisable theories but instead focuses on gathering a small number of participants' whose experience can be analysed to an in-depth level. However, it does not mean that once each case has been considered individually, that similarities and more general claims cannot be made (Smith et al, 2010). As in the case of this research, the focus is looking at the therapists' experience, making the findings more pertinent for other therapists; it is unlikely that people working from other professions, would be knowledgeable about

certain aspects of the therapeutic alliance, for example.
Willig (2010) speaks about how IPA adapts a relativist ontology, it "*questions the out-there-ness of the world and it emphasises the diversity of interpretations that can be applied to it*" (Willig, 2010:13). Again, this recognition of the individuality of experience is crucial to this research; the issues raised for therapists in managing child protection concerns will be different to those raised for other professionals, due to the complexities of the therapeutic relationship. How each individual therapist responds will be different, dependent on their own experiences, both personally and professionally. Attention needs to be paid to these differences, but also to recognise the similarities; IPA allows for this level of analysis.

Taking this small number of participants, IPA engages a phenomenological approach to understand the subject matter from the individual's point of view; phenomenology can be defined as "*a philosophical approach to the study of experience*" (Smith et al, 2010:11). The aim of this research is to get into the shoes of the psychological therapist working with child protection concerns, to see the situation from their perspective.
IPA incorporates the theories of key authors on phenomenology, particularly Husserl and Heidegger. Husserl proposed the concept of bracketing, arguing that the researcher's fore conceptions need to be bracketed and they need "*to go back to the things themselves*" (Husserl, 2001) in order to analyse the data freely (Smith et al, 2010). This resonates with my approach to therapy; phenomenology undoubtedly informs my integrative model of psychotherapy, as I aim to get into my clients' shoes and to understand the world from their perspective; while at the same time, holding a position of curiosity. However, I also recognise that to completely bracket my own beliefs and experiences is unrealistic and unachievable. I was therefore relieved to discover that IPA moves beyond this to consider Heidegger's perspective that we can never truly make reductions, as our own perspectives will always influence how we see things; interpretation was inevitable. Heidegger drew upon the concept of hermeneutics to the phenomenological idea. Hermeneutics, the study of interpretation, already existed, originally focusing on understanding biblical texts; however Heidegger, along with other theorists, such as Schleiermacher and Gadamer, successfully integrated phenomenology and hermeneutics. A quote from Smith et al (2010:37) beautifully summarises the importance of both phenomenology and hermeneutics: "*without the phenomenology there would be nothing to interpret; without the hermeneutics, the phenomenon would not be seen*". This immediately connected with me; I find it impossible to explore a phenomenon without giving it some meaning, so the idea of understanding different levels of interpretation, seemed crucial. As Heidegger points out, sometimes we are not aware of our fore-conceptions until something has already happened, meaning we need to be constantly re-

evaluating our assumptions throughout the process. So while IPA recognises the value of bracketing our preconceptions, it also accepts that this is only partially possible; therefore bracketing is considered a more cyclical process.

Within IPA, the double hermeneutic is relevant, as "*the participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world*" (Smith and Osborn, 2008: 53). The researcher is shifting between positions of empathy (trying to see something from the participants' point of view) and suspicion (exploring and being inquisitive over what the participant says).

As Willig (2010) also highlights, IPA holds onto the importance of social interaction, appreciating that our interpretations are not "*free-floating*" but are grounded in experiences with others. This is also important to reflect upon, as how my participants' experience managing their concerns is likely to be influenced by their past experiences both professionally and personally; how I understand them talking about their experiences is also going to be affected by my experiences of working with children and of being a parent.

Consequently, reflexivity is an important part of IPA research as it facilitates the relationship between phenomenology and hermeneutics. Reflexivity involves the researcher holding an awareness of what fore-conceptions they bring to the research process, making it a reflective experience. There is a cyclical process as the researcher reflects on their own preconceptions, accepting Heidegger's assertion that interpretation is inevitable; the researcher then aims to bracket these preconceptions while they engage in the interviewing process, revisiting them in a new light as part of the analysis, (Smith, 2010). There is an acceptance that how the data is interpreted will be influenced by the personal experience of the researcher (Smith and Osborn, 2003). Later I will explore my own reflective process throughout the research, to illustrate this.

I will now shift my attention to detail the actual design of the research, explaining the actual processes that took place.

2.4 Research Design

This research is a qualitative study, consisting of six semi-structured interviews that have been analysed using IPA methodology. The methodological approach, interpretative phenomenological analysis, requires a focused research question, as the aim is to get an in-depth insight into a specific issue, rather than to establish a broad, generalisable theory.

2.5 Procedures

2.5.1 Sampling and Recruitment

IPA requires purposive sampling (Barker et al, 2002) which targets participants who will be relevant

to the research question. Consequently, in order to achieve a homogenous sample, certain inclusion/exclusion criteria were needed to guide the selection of participants. Inclusion criteria included the following:

- The therapist must be a Chartered Counselling Psychologist or UKCP accredited psychotherapist; or a trainee on an accredited course.
- Have had concerns for the welfare of one of their adult client's children.
- Have been working privately or for a voluntary organisation.

Exclusion criteria covered the following:

- Cases in which the adult patients have learning disabilities or drug and alcohol addictions.
- Therapists who work within the NHS.

In order to recruit participants, various methods were utilised including the use of social media (Facebook and LinkedIn), email, UKCP and BPS websites and word of mouth.
Due to difficulties in recruitment, I needed to loosen my inclusion criteria; initially, I aimed the research only at integrative practitioners but opened this up to include practitioners from any theoretical orientation.

2.5.2 Participants

The table below illustrates the key demographic information about the participants involved; it also correlates with the pseudonyms used in the findings. As can clearly be seen, it was difficult to get a gender balance amongst the participants, with only one male participant volunteering. An important factor to pay attention to is that all participants were White British, therefore limiting the reflection on cultural factors. It should also be noticed that there are two counselling psychologists, with the majority of participants being UKCP registered psychotherapists. I wonder if this could be a reflection of more psychotherapists working in private practice than psychologists. All the participants were working in non-NHS settings, such as voluntary organisations or private practice. It is also important to note that all the participants are parents; it is therefore not possible to evaluate whether this factor may affect participants' experiences.

Participant	**Gender**	**Qualification**	**Professional Registration**	**Pseudonym**
1	Female	Counselling Psychologist	BPS	Sarah

2	Female	Psychotherapist	UKCP	Lynn
3	Female	Psychotherapist	UKCP	Kate
4	Male	Psychotherapist	UKCP	Simon
5	Female	Counselling Psychologist	BPS	Vicki
6	Female	Psychotherapist	UKCP	Sue

2.5.3 Interview Procedure/Data Collection

The method for collecting data was the use of a semi-structured interview; this has several advantages over a structured interview, as it allows the researcher to follow the important strands that arise and to follow a more natural conversation, rather than following a rigid interview schedule (Smith et al, 2010). This enabled me to utilise my skills as a clinician to engage participants.

Prior to the interview process, an interview schedule was developed to act as a guide to the main themes that needed to be addressed within the interview; the semi-structured approach meant that the schedule was used flexibly, acting largely as a prompt. An example of the interview schedule can be seen in Appendix 1. Open-ended questions were chosen to invite the participants' views and elicit as much detail as possible. The interviews lasted around an hour to an hour and a half.

A pilot interview was conducted and the results have been included in the study as participant 1; following this interview, some minor alterations to the interview schedule were made.

2.5.4 Ethical Considerations

Ethics approval was obtained from the Metanoia Institute in order to complete this research (Appendix 1).

Several ethical issues presented themselves at the onset of this research; child protection is an emotive subject and it was possible that some participants may have found it difficult. There was an awareness that the interview could provoke feelings of guilt or regret, as participants were asked to reflect on their past decision-making processes.

Various strategies were implemented, to ensure participants felt as comfortable and safe as possible within the interview process. A clear information sheet (Appendix 3) outlining the purpose of the research, demands on the participant and confidentiality was given prior to the interview; alongside this, participants were also asked to sign an informed consent form (Barker et al, 2005), which can be found in Appendix 4. Participants were given the right to withdraw from the research at any time.

In order to protect participants identity, pseudonyms have been used throughout the analysis and discussion; interviews were transcribed by myself, avoiding the need for others to hear the dictation. Recordings were destroyed once they had been transcribed and transcripts and recordings were stored on a password protected memory stick, kept in locked storage.

Holding in mind the delicate subject matter, the interview schedule was designed carefully, with questions framed in a non-judgemental and inquisitive manner. The first part of the interview focused on developing an alliance with the participant, so they would feel more comfortable to be as open and honest as possible as the interview progressed. More sensitive questions about their personal process were left for later in the interview. A robust support plan was also formulated, should any concerns have arisen, ensuring participants took any clinical issues of concern to their clinical supervisors and agreed to assist them in finding support if more personal issues arose.

2.5.5 Validity

Validity is a tenuous matter in qualitative studies; when investigating human experience, things are not as clear-cut as right and wrong. The tools used to assess the validity and reliability of quantitative studies, cannot be applied to qualitative studies; yet it is still crucial to ensure these matters are addressed.

Smith et al (2010) discuss this comprehensively in their text on completing IPA research, outlining Yardley's (2000) four principles on assessing validity; it is from them that guidance is taken.

- Sensitivity to context – the use of purposive sampling demonstrates the importance of using participants who are specifically relevant to the research question. Throughout the written study, excerpts from the interviews have been included to ensure participants' voices are being heard.
- Commitment and rigour – I utilised my clinical skills throughout the interview process to engage the participant in a respectful and non-judgemental way. Skills of reflection were used to ensure participants were heard and understood as accurately as possible, paying close attention to detail. I transcribed the interviews personally, ensuring that I had listened to the data numerous times so was familiar with it. Throughout the transcription process, strict verbatim was used to attend to all aspects of the interview content, including hesitations and pauses. The use of external supervision with both the research supervisor and with colleagues has also ensured objective opinions on the method of data collection and the conclusions drawn.
- Transparency and coherence – to ensure coherence, careful consideration has been

given to ensure this research has been produced in a clear logical manner; being attentive to the order in which the document flows. Numerous drafts were proof-read by the research supervisor and colleagues before final submission. An independent audit trail can be seen in the appendix, which provides raw data detailing the process, from consent forms, interview schedules, transcripts and analytical process; this demonstrates transparency.

- Impact and importance – the hope is that this study will prove useful and interesting to all practising therapists, in providing an insight into the complexities of working with such an emotive topic. Once completed, the results will be shared in relevant journals, to encourage and promote discussion around the topic.

In order to address the issue of reliability and validity, a colleague experienced in IPA analysis was asked to code sections from different interviews, so a comparison could be made with the researcher's coding. In appendix 5, the researcher has demonstrated this process, showing the same section, coded by both parties, with the codes shown in italics.
Within the findings chapter, verbatim quotes are used throughout to ensure closeness to data and that the findings are grounded in examples and evidenced (Barker et al, 2005).

2.6 Data Analysis

Smith (2010:80) recognises that while there is "*no right or wrong way*" to undertake IPA analysis, he has helpfully provided some detailed guidance around the steps for analysis, although recognises that individual researchers may approach these in different ways. I used his steps to guide me through the process and appreciated the flexibility and accessibility of this method. I also appreciated the freedom allowed by this method; as Smith (2003: 67) states "*This is close to being a free textual analysis. There are no rules about what is commented upon*". This allows the researcher to concentrate on the most relevant parts of the transcript, recognising that some sections will be richer in data than others.

2.6.1 Transcribing

In IPA, all interviews are completed and transcribed before the process of analysis is begun; this ensures that the researcher is not influenced by apparent emerging themes during the interview process.
I decided to transcribe my own interviews; I found this helped me become really familiar with the interviews. It is important to be mindful that the process of transcription is translating the oral word

into a written form, which in itself is an interpretative process (Kvale & Brinkmann, 2009).

While I initially transcribed my interviews into a "word" document, I later discovered that the use of a spreadsheet programme provided a much easier way to manage the data. I subsequently used the spreadsheet programme, using a new row each time someone different spoke. During the transcription process, I underlined significant words or quotes that stood out, doing what Layder (1998) describes as "*pre-coding*".

2.6.2 Step 1: Reading and Re-Reading

Before beginning the coding of the interviews, the first step involved the reading and re-reading of each transcript, at least twice; this enabled me to become even more familiar with the text and to pay attention to all aspects of the interview, including the non-verbal details such as laughter and pauses.

2.6.3 Step 2: Initial Noting

Within the spreadsheet, I used the first column to the right of the transcript to record the "descriptive themes"; this was the initial notes, which focused on either linguistic-al features such as repetitions, tone, metaphor use; or more conceptual comments, looked at the transcript from a more interpretative level.

2.6.4 Step 3: Developing Emergent Themes

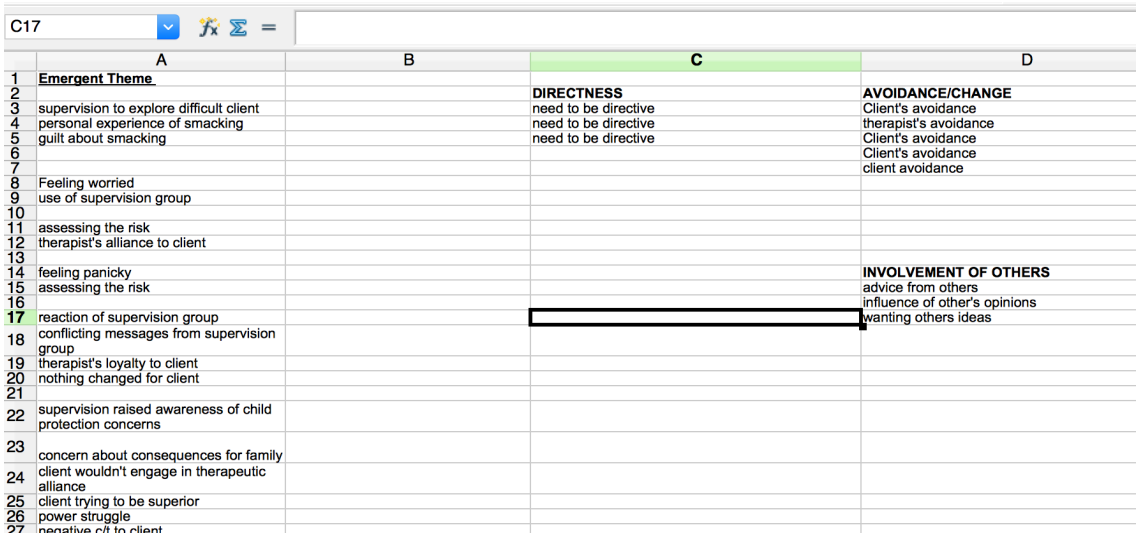
The emergent themes were shown in the next column; these are more concise and technical phrases, still staying close to the original text. The aim was to summarise the essence of a piece of transcript in such a way that it was still grounded within the transcript but was also on a higher conceptual level. An example of this can be seen in the table below.

Yes, there's no point. I mean, the children, i think they're about 7 and 10. So, they're not tiny children, but obviously they've been in a different environment. I mean, the conclusion i was coming to... because, at this point, rather than being person-centred, i'm thinking, "god, i've got to go in there and i've got to have this agenda. I've got to see if these children are in danger," and that was really quite hard really because instead of just going with what he wanted to talk about...	therapist felt need to have an agenda	need to be directive
You felt you had to an agenda and...?		

2.6.5 Step 4: Searching for Connections across Emergent Themes

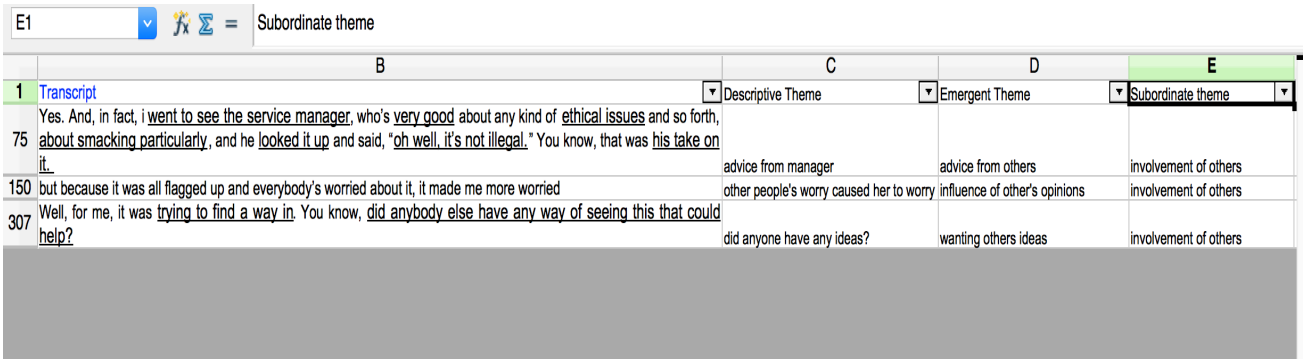
To develop the subordinate level of themes, I moved the list of emergent themes into another spreadsheet, so I could move them about into groups according to what seemed connected. Smith et al (2010) use a helpful metaphor of a magnet, drawing themes together into clusters. The screenshot below illustrates a stage of this process, with the emergent themes listed to one side and them gradually being moved across into groups according to relevance. At this point, there

was also some culling of themes as there were so many emergent themes for each interview and many were not relevant. I then decided an appropriate "title" for each group, for example, "directness" or "avoidance/change" which became the subordinate theme.



	A	B	C	D
1	**Emergent Theme**			
2			**DIRECTNESS**	**AVOIDANCE/CHANGE**
3	supervision to explore difficult client		need to be directive	Client's avoidance
4	personal experience of smacking		need to be directive	therapist's avoidance
5	guilt about smacking		need to be directive	Client's avoidance
6				Client's avoidance
7				client avoidance
8	Feeling worried			
9	use of supervision group			
10				
11	assessing the risk			
12	therapist's alliance to client			
13				
14	feeling panicky			**INVOLVEMENT OF OTHERS**
15	assessing the risk			advice from others
16				influence of other's opinions
17	reaction of supervision group			wanting others ideas
18	conflicting messages from supervision group			
19	therapist's loyalty to client			
20	nothing changed for client			
21				
22	supervision raised awareness of child protection concerns			
23	concern about consequences for family			
24	client wouldn't engage in therapeutic alliance			
25	client trying to be superior			
26	power struggle			
27	negative c/t to client			

I then returned to the original spreadsheet and added another column for the subordinate theme, coordinating the subordinate themes to the relevant emergent themes in the transcript – the use of filters aided this process. The screenshot below illustrates how the filters could be used to pull out the relevant quotes connected to a particular theme.



E1 = Subordinate theme

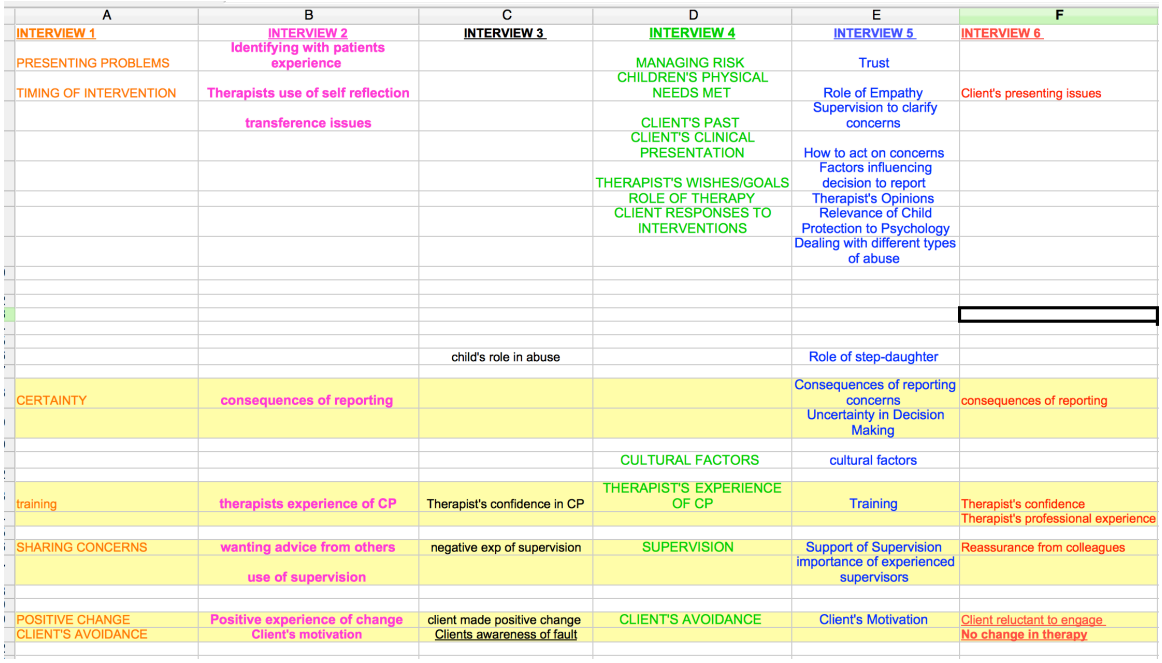
	B	C	D	E
1	Transcript	Descriptive Theme	Emergent Theme	Subordinate theme
75	Yes. And, in fact, i went to see the service manager, who's very good about any kind of ethical issues and so forth, about smacking particularly, and he looked it up and said, "oh well, it's not illegal." You know, that was his take on it.	advice from manager	advice from others	involvement of others
150	but because it was all flagged up and everybody's worried about it, it made me more worried	other people's worry caused her to worry	influence of other's opinions	involvement of others
307	Well, for me, it was trying to find a way in. You know, did anybody else have any way of seeing this that could help?	did anyone have any ideas?	wanting others ideas	involvement of others

2.6.6 Step 5: Moving to the Next Case

Once an interview had been coded to the subordinate theme level, I took a short break before moving on to coding the next interview. The same process was repeated for each of the six interviews.

2.6.7 *Step 6: Looking for Patterns Across Cases*

Once all interviews had been coded to this level, it was time to start collating the themes from across all six interviews. This process had several steps, the first of which was to create another spreadsheet, in which I listed all the subordinate themes for each interview. I then repeated the clustering process as in the previous step, bringing all the associated subordinate themes together.



A	B	C	D	E	F
INTERVIEW 1	INTERVIEW 2	INTERVIEW 3	INTERVIEW 4	INTERVIEW 5	INTERVIEW 6
PRESENTING PROBLEMS	Identifying with patients experience		MANAGING RISK	Trust	
TIMING OF INTERVENTION	Therapists use of self reflection		CHILDREN'S PHYSICAL NEEDS MET	Role of Empathy	Client's presenting issues
	transference issues		CLIENT'S PAST	Supervision to clarify concerns	
			CLIENT'S CLINICAL PRESENTATION	How to act on concerns	
				Factors influencing decision to report	
			THERAPIST'S WISHES/GOALS	Therapist's Opinions	
			ROLE OF THERAPY	Relevance of Child Protection to Psychology	
			CLIENT RESPONSES TO INTERVENTIONS	Dealing with different types of abuse	
		child's role in abuse		Role of step-daughter	
CERTAINTY	consequences of reporting			Consequences of reporting concerns	consequences of reporting
				Uncertainty in Decision Making	
			CULTURAL FACTORS	cultural factors	
training	therapists experience of CP	Therapist's confidence in CP	THERAPIST'S EXPERIENCE OF CP	Training	Therapist's confidence
					Therapist's professional experience
SHARING CONCERNS	wanting advice from others	negative exp of supervision	SUPERVISION	Support of Supervision	Reassurance from colleagues
	use of supervision			importance of experienced supervisors	
POSITIVE CHANGE	Positive experience of change	client made positive change	CLIENT'S AVOIDANCE	Client's Motivation	Client reluctant to engage
CLIENT'S AVOIDANCE	Client's motivation	Clients awareness of fault			No change in therapy

One of the challenges was when a subordinate theme could fall into different clusters; at times, a theme was held in two places until it became clearer as the analysis progressed, which cluster was most appropriate.

This created around twelve clusters of subordinate themes; at this point, I moved onto paper, as it felt easier to have physical pieces of paper to move around and so that a greater volume of data could be seen at the same time. The filters on the spreadsheet enabled me to easily pull out the quotes relevant to each subordinate theme, which I then printed and cut into individual pieces. I gathered all the quotes relevant to each cluster and checked closely that the theme was connected to what was actually being said. I gave each cluster a title, which was ultimately the final subordinate theme title.

The next stage was to cluster the subordinate themes to identify the superordinate themes – the main overarching themes, which ideally want to consist of no more than three or four subordinate themes. Again, there was overlap, and much time and thought were spent reflecting on which

subordinate themes were connected most appropriately. For example, the subordinate theme entitled “consequences” could have been clustered into the superordinate theme “not being alone” with the argument that people didn't want to be alone because of the possible consequences to their actions. However, after further reflection, the theme was renamed “fear” (of consequences) and was linked in with the other emotional responses.

After much deliberation, three superordinate themes were identified, each consisting of three subordinate themes; however, to reach this conclusion, several themes had to be dis-guarded.

I have created a table which can be seen in Appendix 6; this shows each of the identified superordinate and subordinate themes and in which interviews they are portrayed; this shows how equally themes are represented across the interviews.

2.7 Personal and Procedural Reflexivity

As already mentioned, reflexivity is an important aspect of IPA and I value how important it is for me to be aware of how I am personally approaching this research. As a clinician, I acknowledge the co-created relationship with my clients and use Casement's (1985) concept of the internal supervisor to help me critically reflect on this. I extended this idea to research, recognising that as a researcher, my own position and views have impacted how I approached the research. I agreed with the belief that reflexivity

> “*facilitates a critical attitude towards locating the impact of the researcher context and subjectivity on project design, data collection, data analysis and presentation of findings*” (Finlay & Gough, 2003; p.22)

I recognise that I am primarily a practitioner and that my passion and experience lie within my clinical practice; however, I hoped to bring this research alive by using my skills in reflexivity and in engaging and empathising with clients, to explore this delicate subject matter.

In order to ensure a reflective stance throughout the research, I initially composed a research journal, in which I would write my thoughts and experiences. However, when I reached the analysis phase, I found that these reflections were noted more on pieces of paper, scattered amongst diagrams of clustering and lists of themes. This is perhaps representative of the creative, dynamic process which needed to extend beyond the boundaries of an A4 sheet of lined paper.

2.7.1 Personal

On a personal note, this research has been part of my life for the past seven years; moving in and out of the spotlight as life has thrown me various challenges. During the course of this research

process, I have become a mother to two young boys, dealt with some challenging health difficulties and renovated a home. These are important factors to acknowledge, partly because they are valid reasons why the research has spanned such a long time frame, but also because they have influenced the direction in which the research has gone. After having my first son, I made the decision to change my methodology and re-write my research question in order to revitalise what felt like a dry concept; I feel this was heavily influenced by my increased emotional state following the birth of my son. I see this as a positive shift as it enabled me to focus the research on to the actual experience of my participants; it also challenged me to work out of my comfort zone and to step away from cognitive processes and pay more attention to emotional experience.
I also noticed that hearing about stories of child abuse has become more emotionally disturbing since having my own children, particularly when it concerns children of a similar age. Within my workplace, I utilise supervision and the support of my team in deciding whether to become involved with such cases, reflecting carefully on whether my feelings can be bracketed or will influence my work. I have become more curious about how my colleagues are influenced by their parenthood and whether it affects their decision-making around child protection issues.

I feel that it is also important to reflect on how my own professional experience in working with children and families has influenced my perspective on these issues. Working within a child and adolescent mental health service has shaped my views on the role of social services and the challenges faced by both families and professionals in dealing with child protection concerns. Some of my experiences echo those of the participants, in terms of having negative dealings with social care and facing the frustrations of a limited and under-resourced system. I can empathise with clients who fear that social care involvement will make things worse and I can appreciate the complexity of the emotional reactions described by the participants as I can identify with their experience. I am also mindful that my experiences in this field may provide me with a different insight that for those who have not worked with children and families; meaning they may consider child protection concerns in a different way. I have been mindful of keeping my own opinions in check, to try and avoid judgement of my colleagues (participants) management of their concerns and to ensure that my reflections on the findings of the research, stay close to what the participants said, rather than using it as a platform to express my own views.

2.7.2 Procedural

I'd like to start by reflecting on one of the most important procedural issues I faced from the start of the research process – the wording of the research question and its role in the recruitment of participants. My original intention was to focus specifically on therapists working with concerns of

emotional abuse and/or neglect; however, recruitment seemed impossible as no participants came forward. I wondered if people may have had concerns but not necessarily perceived them as strong enough to be classed as “abuse”, and therefore didn't feel they could take part.
It became apparent that the wording used in recruitment was vital in encouraging participants to volunteer. Upon reflection, I realised that the sensitivity of this subject matter may have resulted in people feeling scared of being judged or perceived as doing something wrong. They may have felt that they were opening themselves up to criticism or potential litigation if they were revealed to have had concerns that they didn't act upon. As identified in the literature, the language used to describe child abuse can vary and be very evocative (Waterhouse and McGhee, 2015); I therefore, altered the research question to “*having concerns for a child's welfare*” and participants began to respond. Upon further reflection, I wonder if the term “safeguarding” would also have been an easier terminology, as it feels less threatening and more positive – with the focus on keeping the child safe. These are important considerations to hold in mind for any future research on the topic.

I feel that these hesitations filtered through into the actual interview process, as despite participants coming forward, there still felt an air of uncomfortableness in discussing these issues. I was very conscious of trying to explore the participants' experiences, without being perceived as critical or judgemental of their decisions and in some interviews but not all, there felt a reluctance from the participants about the level of depth at which they were willing to explore. With reflection, I appreciate that I had been asking them to be honest about facing a complex therapeutic challenge, which potentially had very serious consequences. This could also be understood in terms of a parallel process (Clarkson, 2006); a child may experience fears and anxiety when speaking about the abuse they have experienced, and the reluctance for the therapists to explore their concerns may mirror this. I also found it a challenge to manage the boundary of holding the role of the interviewer and not the therapist within the interview process; there was a temptation to move into a therapeutic role and I recognise that in trying to avoid doing this, it may have prevented the depth of my exploration. I found it a difficult balance to hold, as while I wanted to explore the experience of the participant, upon reflection I think I was wary of opening up participants' personal issues that could have been distressing. As a novice researcher, I think I was lacking the experience and knowledge about managing the difference between getting an in-depth exploration into the participants' experience and engaging in actual therapy.

One of the motivations for exploring child protection from this angle was to consider how much the physically absent child (in terms of not being present in the therapy room) is being held in mind in adult psychotherapy. When reflecting on the place of the child in the interviews, while the child

was in mind it was in a very detached manner and it seems that their physical absence does affect the level of emotional connection to their experience. The participants' focus remained on their client and their therapeutic relationship and admittedly the research questions were targeted at this level also. If I was to approach the interviews now, with this insight, I would be inclined to pay more attention to how the participants' felt connected to the child and how they experienced their connection to the child, rather than just their concerns for almost an abstract being.

As I reflect on the analysis process, I feel it is important to acknowledge the difficulties I faced at this stage, as I took a break to have my second son and renovate a house. Again I noticed that taking an extended break from the research, changed my perspective and at this point, resulted in my decision to take a fresh approach to the analytical process.

The developments of a new supervisor and guidance on how to take a different approach to analysis with the use of spreadsheets rather than word documents made the analysis a more efficient process.

One of the most challenging aspects of the analysis was the reduction of data; with over two hundred emergent themes arising in the early interviews, this was an overwhelming amount of data to analyse. However, as the process developed, I became more honed in my technique and the number of emergent themes reduced.

Deciding on the final superordinate themes and corresponding subordinate themes was a painful and heartbreaking process, as some of the poignant quotes had to be dis-guarded; it was a frustrating realisation that I could not just focus on what I felt was important, but there needed to be a representation across the interviews or that issues needed to stand out as a particular dissonance.

Reflecting on the process of the research as a whole, I recognise that it has spanned over many years and as a result, my thinking and development as a person and a practitioner has evolved. I imagine that should I conduct the interviews now, I would approach them in a different way; the analysis process has raised more thoughts and questions that would have been helpful to cover in the interviews. The analysis has enabled me to appreciate the depth and complexity of the topic and I've realised that the “experience” of the therapist, has more facets than I originally anticipated; covering the emotional, professional and relational dimensions.

2.8 Closing Remarks

The aim of this chapter was to provide the reader with a background to interpretative phenomenological analysis and why it was chosen as the research methodology for this project. I

have also detailed the research design and described in-depth the analytical process, while also providing an insight into my reflective processes through this research journey. Now the journey continues into a careful exploration of the findings from the interviews.

3 Findings

Following analysis of the six interviews, a number of themes appeared that were represented across either all or the majority of the interviews. The following table presents an illustration of these themes and how they are connected. Attention is also given to those participants whose experience didn't fit with the norm and highlights the occasional sense of dissonance among the interviews.

Superordinate Theme	Subordinate Themes
1 Emotional Experience	*1.1* The Fear Factor
	1.2 Personal Bias: Need to protect
	1.3 Ambivalence
2 Professional Experience	*2.1* Experience of child protection: The Exact Line of It Isn't Clear
	2.2 Use of Supervision
	2.3 It's Not Just Me
3 Relational Experience	*3.1* Avoidance: The Elephant in the room
	3.2 Directness: I Had To Check It Out

What follows is the story of my findings; a discussion of verbatim quotes interweaved with my own interpretations of how the participants understood their experiences, thus illustrating the double hermeneutic (Smith et al, 2010). Some minor alterations to the verbatim quotes have been made to improve readability; for example, minor hesitations and repetition have been removed, as has any identifiable information.

3.1 Emotional Experience

The first superordinate theme encapsulates some of the emotional experience of the therapist; focusing on the power of fear, the influence of participants' own personal biases in responding to the dilemmas they were facing and the confusion of experiencing conflictual emotions towards the clients.

3.1.1 The Fear Factor

Across all the interviews the most powerful emotions that arose through discussion were of anxiety and fear; as participants expressed their worry and concern about their clients and the safety of their children. However, this fear also extended to worry about the consequences of taking action based on these concerns, fearing that they would make things worse, be getting things wrong or

suffer professional implications.

Lynn described feeling very worried because she "*hadn't got a good handle"* on her client and as her client spoke about locking her child in her room and wanting to get rid of her daughter, Lynn's worry increased and made her think, "*ok, I, we need to do something now*". It feels for Lynn that her anxiety was one of the driving factors that made her feel like needing to take action.
Sarah became alert to the risk for the children following a disclosure that her client's boyfriend was being aggressive towards her; this raised the question *"If this guy was you know being very aggressive and you know displaying that in sort of physical ways to her, what he was doing to the children?".* This uncertainty prompted Sarah to be more mindful about what was happening in the family and to explore her concerns within supervision.

Vicki states *"I think I was worried"* when talking about her client, and how she was "*really concerned*" when she learned that her client was allowing his thirteen-year old step-daughter to look after his young baby at night. While Vicki's initial concern was for the older child having to cope with such responsibility, through the interview she also reflected on the impact on the baby, in being cared for by another child.
Sue spoke about her anxiety when she realised that her client was well involved with other peoples' children and also had the veneer of middle-class respectability around him: *"it appeared to me that the whole family was in difficulties of one kind or another. But I'm sure nobody thought that because he lives in a village, a well-to-do kind of situation, in with the church, in with his own local interests, the children go to school and other people's children… well, at that point, I was getting really panicky".* Sue's anxiety seems to be driven partly by the idea that her client's behaviour was going unsuspected and I wonder whether this increased the pressure on her as potentially the only person who knew. However, there also seems to be an anxiety about the possible risk to other children outside of the family, as Sue reflects on her client's involvement in the wider community.

Interestingly for Kate and Simon, most of their anxieties focused on the impact on their clients; Kate spoke about her concern for her client in relation to her supervisor's response to the matter: *"I also felt enormously concerned for my client and in some ways felt that this was another form of bullying of him".* Kate was also able to reflect on the potential impact of making the decision to report concerns on her client's life and reflects on the importance of certainty - *"I suppose taking the decision and responsibility to actually disrupt somebody's life in that way, without knowing, you've got to be jolly sure, that something's happened or more than just an intuition or an*

inference, or my own level of anxiety". What Kate seems to be saying is that reporting concerns isn't a decision to be made lightly and that it needs to be based in fact and certainty rather than an anxious reaction or panic. While I agree with this, I am also mindful of the concerns raised about lack of clarity and definitions of abuse and wonder if it is always so easy to be so sure.

Lynn was very aware of the consequences of her actions and was particularly concerned with making a mistake: she states *"I think the fear factor, was, the fear factor was something that people could really relate to, whether you could make a mistake, whichever, you know the mistake go either way and how big that could be for somebody's life, the effect on their life".* She describes the experience as "*frightening*" and like "*walking on a tightrope*", recognising the "*massive potential for damage either way, either not reporting something or reporting something*". For Lynn the fear of "*not knowing*" was also very important; she questioned "*would some other damage be done?*" and describes "*the fear of not knowing full stop really, not knowing what the outcome is, not knowing whether I'll be able to do something".* But ultimately, for Lynn, "*the biggest fear was that the child and the mother would be separated when they didn't, when the child would then suffer more damage";* fear that the child might be sent away but not necessarily to somewhere better.
Similarly, Vicki described her fear that "*you might cause more problems*". These were views echoed again by Sue, who said *"my fear was if I start interfering and social services come clattering in with their size 10 boots, then this family is… and I might make it all worse".* Sue also reflected on her own personal experience of being misunderstood and how the impact of this can be "*very devastating*". Sue clearly described her dilemma: *"I know that if I don't do it right something will go wrong, but I don't know what is right here".*

Another common thread within the theme was around the potential impact on the therapist personally and professionally. Lynn acknowledged that she had some fear about the possible effect on her as a "*negligent therapist"* and particularly her fear of failing, partly on a "*grandiose*" level for not being able to "*sort it out*", but also in terms of "*failing her and the child, particularly the child".*
Kate was also in training at the time of working with her client and had some real fear about the consequences of the situation on her being able to qualify. She said, *"I can remember being extremely worried from my own stance as a professional, of how it would impact on my work, also before I finished my training, so whether it would impact, prevent me finishing my degree".* So Kate's concerns were very much about the risks to her "*own living*" and that she would be "*asked to leave*" her training institute.
Simon had similar concerns and was worried about the professional risks from his client's

husband; he describes him as "*the kind of guy that could come after me...Not my personal safety, I mean more in being litigious or something".* He recognised the possibility that "*he could pursue me mischievously".* Simon's worry seems to have been that he could have faced legal action which can obviously have serious professional consequences. Similarly, Vicki was also worried about the consequences for her as a professional, she describes a scenario:

"I mean if you look at it another way, that, a psychologist didn't report something, and then it came back to bite them later, that they stood up in court and you heard that you know this mother was going out every night and you know, to nightclubs or on the game or something, leaving her child at home, and you knew that she wasn't getting up in the morning to give him breakfast, and he was walking to school on his own and he was eight on an empty stomach, and you didn't do anything? I mean that could really, damage someone's career professionally, and probably personally as well".

Within the interview, I got a real sense of Vicki's anxiety as she reflected on this dilemma; while she initially spoke about the risks to herself professionally, she progressed to thinking about the risk to the therapeutic alliance with her client by reporting them to Social Care, reflecting specifically on the sense of betrayal: *"your client's going to feel you betrayed them, I mean there's a lot at stake isn't there. Betrayal of your client, dealing with how your client's going to react to that, breaking, I mean they trusted you and for them, you've broken that trust, you may have overreacted and something worse might come of it".* For Vicki, the potential damage to the therapeutic relationship by the client feeling betrayed seems a really important consideration; I wonder if Vicki's anxiety here is about the client disengaging from therapy as a result of feeling betrayed; and what implications this could have for the child.

Sarah had a slightly different experience and rather than being preoccupied with what would happen if she didn't take action, she stated, *"I'd be more afraid of not doing something".* This acknowledges the potential danger of not acting on concerns; and for Sarah, this risk was more important than other risks to the therapy by reporting.

This leads to the next theme, which considers how participants' personal values and morals around child protection, affect their experience.

3.1.2 Personal Bias: Need To Protect

This theme focuses on the participants' personal experiences that influenced their feelings and beliefs on issues around child protection, paying specific attention to their experience of being a parent and their own childhood. An important part of the therapeutic process is being able to recognise your own personal limitations around being able to hold unconditional positive regard in response to certain behaviours and to be mindful of what you are able to work with and what would

feel emotionally too challenging.

Sarah spoke at length about how her own experiences of feeling "*unprotected*" as a child, have most likely influenced her strong tendency to feel "*protective towards children*". She states, *"it's a very personal, you know, ethical, moral priority";* she clearly points out that she will "*believe the child before I'll believe, you know whatever"* and describes her "*default position*" is to protect the child. She also admits that *"I'm likely to be more biased towards the child".* This links back to the previous theme in which Sarah reflects on how she would be worried about not acting on her concerns, this connects with safeguarding being a key priority for her.
Sue also reflected on how her own experiences with smacking her children, impacted how she was able to explore her client's use of physical punishment. She states *"But I suppose I had my own guilt about smacking, so I didn't immediately start confronting him about the smacking".* It seems that for Sue, she found herself colluding with her client because of her own guilt from her past; I wonder whether this was one of the reasons for using supervision so frequently.

Four of the participants reflected on how becoming a parent could have influenced their feelings on child protection; however, there was a general sense that it was an inherent priority regardless of parenthood. Perhaps rather than this desire to protect children being influenced by parenthood, it is more connected to the inherent personality traits of people that train to become therapists – the desire to care and help others. Lynn reflected on how being a parent means that she knows what it is like to be "*concerned about a child's safety*" and wonders if this might be felt "*stronger by somebody who has children as opposed to somebody who doesn't, but I'm not sure about that, but maybe we can identify more with it, I don't know*".
When reflecting on the influence of being a parent, Kate states that she " *would hold those principles whether I did or didn't have children";* but then continues to reflect "*it might heighten my repulsion, the thought of abusing a child, I can't imagine that it would because I can't imagine that it could get, that anything for me could be more repulsive that than, hurting another human being, a defenceless child, in that way".*
Simon acknowledged that his feelings changed when he became a parent, and how from that point he developed more of an interest in "*who we are with children and how it affects them"* and how he now feels "*quite protective of children".* Simon also notices how sensitive he is to "*adult behaviour towards children and how it might affect them*"; and reflects how perhaps he is "*over-sensitive*" to this and wants to "*step in*" and protect them.
Vicki also reflected on how she has always been impacted by seeing " *someone vulnerable being treated badly",* whether this is an animal, the elderly or the sick. She describes how she "*would*

want to try and help" and feels this is simply part of her personality. She continues to acknowledge though how she "*always er on the side of worry when it comes to children"* and how she's always "*got an antenna out, probably from being a mother of small children".* However, Vicki also spoke about how knowing that she can be "*very protective and sensitive where children are concerned",* makes it hard for her to judge whether she is over-reacting to concerns. Vicki seems to be saying that despite having an innate part of her that wants to protect children, she feels her role as a parent has increased her sensitivity to issues concerning children's safety. I wonder whether her difficulty in knowing whether she is overreacting is linked to the feeling of a lack of guidance from the law.

While Vicki seemed to be struggling with feeling confident about the boundaries of what to report, Kate, on the other hand, was very clear on her personal boundaries around what she will and won't work with. She explained how she won't work with alcoholics or with paedophiles because she states "*there's a part of me that believes I could not find the empathy to do so".* She acknowledged that she would "*find it very hard to keep neutral on that score"* and could not work with anybody if she knew that they were a paedophile. Kate also offered an opinion on why her clinical supervisor had such a strong reaction to the situation with her client, wondering if her supervisor's "*own background and what the trigger had caused for her and it just made me, sort of hypothesise, if a similar scenario had happened in her world, in some form or another".* Kate appears to be wondering if her supervisor's reaction was influenced by her own personal experiences with abuse and it feels important to acknowledge that child abuse is a sensitive topic that people may feel strongly about, but perhaps more so if they have a personal experience.

An important part of recognising your own personal biases as a therapist is being able to recognise when you would find it impossible to hold unconditional positive regard for your client, something that can be challenged when you experience conflicting emotions for your clients.

3.1.3 Ambivalence

Across all interviews, the feeling of empathy was identified; For example, Kate expressed empathy towards her client when she pondered how he reacted to her telling him how she would have to deal with her concerns: *"I suppose there was a part of me that when I told him what I would do, what I would be forced to do, you know, I can still see him in my mind, you know the way he recoiled and the pain of that".*

Sarah spoke about how she felt it was important to assure her client that she was there to support her: *"reassuring her that I was there to help her if there were you know, if there were concerns for her children that I'd be there to help her with that".* She reiterated her role as "*helping and*

supporting" her client. I wonder if this was easier for Sarah to do as it wasn't her client who was the perpetrator and she was failing to protect her children rather than being the one to directly harm them.

However, across four of the interviews, participants not only demonstrated empathy for their clients but also spoke about holding other conflicting emotions; although the dilemma of this conflict wasn't necessarily identified as part of the interview process.
For example, Simon spoke about his desire to rescue his client from her difficult, abusive situation: "*my favourite thing would be to dislodge her, dislodge her from the domestic setting".* He recognises this is "*naive*" and how he "*can't get her away from her own crazy".* However, he has a strong empathic reaction to rescue her and "*get her out of the evil dragon's castle".* Simon also spoke about how he liked his client; he could recognise her positive qualities, describing her as "*smart, she's creative, she's musical and artistic*", continuing to say " *she's likeable, she's personable".* Yet he also explained his anger towards her about her inability to stop her abusive situation, *"I feel quite angry at the way she continually rationalises what she does".* Simon reflects on how he wishes he could say to his client, "*this is absolutely appalling, I'm going to take these kids and get out of here"*. For Simon, it seems that he had a positive working alliance with his client, possibly aided by his like of her, and this allowed him to explore the more difficult emotions that arose.

Like Simon, Lynn also spoke about how she liked her client and described her as someone she would "*probably become friends with*"; yet at the same time, she also reflected on how she felt "*pissed off with her*" because she was "*really messing up*". Lynn describes how she recognised the "*very funny, humorous side*" to her client, which could also be "*very tender*"; however in the early stages of the work she also felt "*quite frightened of her*" and initially met the "*very harsh side*". Lynn continued to reflect on how she had to manage her "*irritation*" with her client's behaviour, while also feeling empathy because she knows "*how hard it is to be a parent*". She continues to reflect on how she was "*dysregulated*" by her "*ambivalence*" towards her client. In spite of these contradictory feelings, Lynn described how "*I re-found my empathy for her"* and how this was an important part of the therapeutic process as she was able to " *bring it into the therapy";* prior to this, Lynn was concerned about appearing "*judgemental*" by her client; but once she was able to find empathy for her, she explains *"I knew I got something right with her, that she was gonna, she, well I think it was that I described before, I think she felt that I was empathising with her".* Lynn was also able to reflect on her fear for her client and how she realised how important it was for her client to "*do something different, her needing to be a good enough mother*" and hence Lynn's

concern for her client was very present; which can also be interpreted as empathy.

Sue had quite a different experience and took an instant dislike to her client; she described her first reaction when meeting him as "*I really hope that's not my new client*". However, despite experiencing her client as "*just so heavy and reachable, and, to me, an unattractive kind of individual in every sense",* she was also able to see within him a " *vulnerable small child"* to empathise with. It seems that regardless of her initial negative reaction, Sue was able to identify a more vulnerable part of her client, which appears to have enabled her to hold unconditional positive regard for him.

During the interview, I felt that Sue found herself more in touch with her client's sadness, stating, *"I suppose I'm getting really in touch with that feeling of heaviness which he must feel and never really admitted to in his life really..It's shit really, isn't it?".* She was able to identify with how damaged his "*inner child*" was and her desire "*to have helped him*". Sue also reflected on how her client was simply "struggling with the everyday" and distinguished him from "*these young mums with social services all over them, worrying, rightly, about whether they're competent";* she reflected on how it was such a " *sad, sad situation".*

Vicki spoke openly about having "*mixed feelings*" towards her clients; she describes feeling "*disgusted and annoyed*" by her client who was violent towards a woman, yet at the same time "*quite liking this man*" and seeing him as "*very charming*". Vicki seems to tussle with the dilemma of worrying that she is being "*taken in*" by his charming side and her role as a therapist to "*listen to him and empathise with him*". She also spoke about another client who had a violent past but was remorseful now; she described him as "*likeable*" and "*nice*" but also worried " *maybe he's got a nastier side that I'm not aware of";* she concludes this by saying "*it can be quite confusing*". Vicki seems to be raising an interesting point about how one of the key aspects of the therapeutic relationship is trust and how hard it can be when we know our clients have different sides to their personalities to develop that trust.

Vicki spoke at length about the pain she felt when hearing some of her clients stories: *"the agony of this poor client of mine"; "it was heartbreaking"; "I really felt his pain"; "it was horrible, just wanting to get his child back for him, knowing that I couldn't, it was really upsetting".* Vicki also speaks about her role as a counselling psychologist and how "*well, you realise your opinions and your views aren't necessarily the right ones and learn to empathise with other people".* Here, Vicki is acknowledging that being empathic is a vital part of being a therapist; however, this can also be connected back to the previous theme on personal bias, as we also recognise that some people will have boundaries and limitations to who they are able to feel empathic to.

Clients can evoke a range of emotions in their therapists and this can be confusing; this is often something that will be discussed within clinical supervision, which leads us into the next superordinate theme, professional experience.

3.2 Professional Experience

The essence of this theme focuses on the aspects of the participants' experience that are related to their confidence around handling child protection issues. The theme brings together the participants' feelings that they have limited knowledge and experience in dealing with safeguarding concerns, the importance of having good clinical supervision to help them manage their concerns and boost their confidence and the value of having the involvement of other professionals.

3.2.1 The Exact Line of It Isn't Clear

Participants were asked about their experience and knowledge that helped them in working with the child protection concerns that arose in their work. Within their responses, there was a strong feeling that there was inadequate coverage of child protection within core professional training courses; there was also a sense that they personally as practitioners did not have enough experience in working with these issues and for some of those that did have experience, they described it as negative.

In four of the interviews, there was a feeling that child protection issues were insufficiently covered in their professional training. Sarah, who was quite protective of her training and did not want to appear critical of it, stated: "*I don't remember child protection being a huge part of it".* She continued to say that while ethical dilemmas were covered in relation to managing the therapeutic relationship, "*the legal requirements and you know, actually what you do and why, I don't think that side of it was well covered"*

Lynn was also reluctant to criticise her training and wanted to acknowledge it's "*good points*", but also identified that "*there wasn't enough training for what really really does happen".* She stated that *"we hadn't really done very much on that in our course"* and *"I kind of wish I'd known more myself rather than find out as I went along";* indicating a desire for more knowledge.

Similarly, Kate spoke about how her training was from the "*adult stance*" and how she "*didn't see the course as working with children...it was all very much from the adult stance"* therefore implying that child protection issues were not considered as relevant. Kate continued to state*"I think you've highlighted something that I don't feel we have really covered very much".*

Simon also spoke about his lack of knowledge of child protection procedures saying: *"I'm probably not very good on police procedure or social services procedure, I'm not one of those people who*

could quote the relevant text at you".

Vicki spoke about how she felt that it was inevitable for anyone working as a psychologist or counsellor to be faced with child protection issues at some point in their career stating "*at some point in their career they're going to be faced with a situation when they'll have to decide whether to call social services"* and her view that "*I don't think we're well trained for that".* It seemed important to Vicki to acknowledge that despite working with adults, facing child protection concerns feels unavoidable and she continued to speak about how not knowing how to manage these concerns leaves therapists professionally vulnerable; this links back to the fear experienced in theme 3.1.1.

Vicki continued to reflect on her lack of confidence, wondering about the impact of this; she states, *"I don't think I did feel that confident about stuff with children before actually, and I don't know if you don't feel confident that you're more likely to just think, well it's probably OK".* What Vicki seems to be saying here, is that having less confidence around child protection, possibly means that people will be more dismissive of their concerns; Vicki explains that she feels this is because involving social services is so scary. For Vicki, this appears to be connected to her fear of the consequences of reporting (discussed in theme 3.1.1). This is quite contradictory to the other findings, as what is implied throughout other interviews is that participants seek advice and support in these situations, in order not to feel alone; thus illustrating a similarity between superordinate themes 1 and 2.

For a couple of the participants, they looked past the experience they received in their core training and reflected on the experience gained in their clinical placements and workplace.

Sarah reflected on how she felt that through her employment within the NHS when it came to knowing the procedures to follow, she says "*I like to think I've got adequate knowledge of that".* However, Kate had quite a contrasting experience, having "*never worked in the NHS*" felt that this was therefore, a "*weakness*" for someone like her, who has "*only really ever worked with adults".* The contrast between Sarah's experience of working within the NHS and Kate's experience of working privately, suggests that working for an organisation such as the NHS provides a certain level of basic training that is potentially missed for those working in other sectors.

I also find Kate's use of the word "weakness" interesting here as it implies that not having any experience in working with children puts her at a disadvantage in relation to managing child protection issues; I wonder why she feels this way as it feels there is an assumption that working with children would automatically provide experience in child protection. Kate continued to speak specifically about her lack of experience in working directly with children, stating *"I've really only ever worked with one client who was sixteen because I've always said nobody under sixteen";* it

seems that Kate has chosen to focus her work with adults and that there is an expectation that this will avoid safeguarding concerns being raised. Within the discussion chapter, consideration will be given to the idea that child protection should be on everyone's agenda, regardless of whether they work with adults or children.

Another factor connected to participants' lack of confidence is the general vagueness and lack of clarity around defining child abuse. Lynn expressed her frustration over this, stating "*the exact line of where it is, isn't clear"* and *"I think it says something like, where you leave a mark or psychological damage, well how can you prove psychological damage?".*

This view about the vagueness of child protection guidelines was echoed by Vicki and Sue, both of whom wished that the area was clearer. Vicki expressed strong views *"I think people should be taught when they're training, more clearly, what categories these things fall into";* later reiterating this point, saying, *"I think it needs to be spelt out more clearly, what needs to be reported and what doesn't".* Vicki's concern was that without adequate training and knowledge about what constitutes abuse, therapists may struggle to identify abusive behaviour within their clients' dialogues.

Sue acknowledged that the child protection trainer she had was " *really, really experienced"* however, this didn't change the fact " *that it was actually a much more grey area than you'd like it to be really".*

There was however, some recognition that certain aspects of child protection are more clearcut than others; as Vicki points out "*if someone said you know, something about violence or paedophilia or sexual abuse, you know alarm bells would go off immediately";* she continues to emphasise her sense of duty about reporting physical abuse, stating that *"I'd feel it was absolutely my duty to report it, and deal with it".* What Vicki seems to be saying is that some behaviours are deemed as clearly unacceptable and that she would immediately recognise that they need reporting. However, when it comes to emotional abuse and neglect, Vicki describes more uncertainty and instead of having a definite reaction that something needs reporting, instead states, "*you might listen and think that's not on, but would you immediately think I've got to report that?".* Vicki continues to state, "*there are kids out there who are not being fed, who are sleep deprived, who are being abused psychologically, and a lot of this gets missed, because it's not so easy to see";* Vicki's concern appears to be around how many children are not being protected from abuse because it isn't so visible; this links to Lynn's earlier comments about the lack of clarity around what constitutes psychological damage and how this is difficult to prove.

When asked about their experience in child protection, half of the participants spoke about their experience with social services, either in a professional or personal capacity. Lynn described her

conflicting experiences of Social Care, in one case where Social Care had been involved she describes "*there was not very much help that we were getting really, from having that child flagged up by Social Services",* despite " *a number of serious concerns".* And in another case, feeling that there was an overreaction from Social Care: "*I had been brought in to work with the child who had been flagged up to Social Services and it was all a little bit of a...it was overdone".* Understandably, this left Lynn feeling "*a bit ambivalent actually about what might help*". She described her feeling of stuckness with such contrasting experiences, *"I had seen you know where I thought social services really needed to step in, not to, and where you know, they did need to investigate well they didn't really investigate very well and it was blown out of proportion. I was stuck with that".* The impact of this for Lynn was to be left in a position of uncertainty, as she described not knowing what would happen if she was to involve services in her current case. It seems that this also links into the fear of consequences, as she could see what could go wrong and how by making the decision to report her concerns, her fear was that she could potentially make things worse rather than better.

Vicki reflected on seeing the negative impact of social services involvement as she discussed the emotional turmoil of a client who had an on-going court case trying to get contact to see his son. In theme 3.1. Vicki explores the emotional reactions response she had in reaction to this and this makes more sense why she may have a negative perception of involving social care.

Sue's experiences of social care spread across both her personal and professional life; on a personal note, she spoke frankly about her frustration with social care's lack of response in dealing with concerns about a family member, saying "*it's not that I won't contact them, but I think that they haven't responded in some situations".* Given the fear of the consequences of reporting, which is discussed in theme 3.1.1, I wonder if there is a sense that there is no point risking damage to the therapy, when social care may not even respond. In addition to this, on a professional level, Sue had experience of working within a family systems team and found this work "*very frustrating*" and " *it didn't appear to be achieving anything at all".* In this sense, it seems that for Sue, even when professionals are involved, she found that it was hard to make any positive difference to families.

3.2.2 Use of Supervision

Across five of the six interviews, supervision emerged as a crucial factor in managing child protection concerns, either in terms of being able to share their anxiety or in having the support of an experienced supervisor. There are two examples of dissonance with this, with one participant having a very negative experience of supervision and the other experiencing conflicting messages.

Clients with whom there were child protection concerns seemed to be a regular topic of

conversation in supervision settings; Sarah described her concerns as *"something that I took to supervision a lot".* She also explained how supervision is "*great*" to help manage concerns. Similarly, Sue reflected on how her client with the child protection concerns dominated her clinical supervision, *"my other clients didn't get a look-in in supervision".* She describes "*always talking about it in supervision because I found him so difficult".* Simon also acknowledged his frequent use of supervision for his client, which he linked to his lack of confidence around child protection; "*not very confident, you know, she's a constant subject in supervision".* In relation to her initial concerns, Kate spoke about how she "*flagged it up with my supervisor".* It appears that people are using supervision in the manner in which it is intended, to explore difficult issues and areas of concern.

Lynn acknowledged that supervision helped her think about her emotional reactions to her client; she spoke specifically about her anger towards her client in relation to how she was treating her daughter and said *"I really thought you fucking bitch, you know I got very cross...that's what I thought, and I took that to my supervisor".* Lynn later reflects on how supervision enabled her to explore her emotional responses and enabled her to find empathy for her client. Lynn continues to reflect on how she used supervision to explore her "*gut feeling*" that there was something wrong and recognised her own reactions as unusual - *"I took that part to supervision because that's, that's something I don't find happens very often. So I thought this is interesting".* We can assume that Lynn has a positive relationship with her supervisor, in which she feels safe enough to discuss her strong personal emotional responses to her client's behaviour.

Simon also uses supervision to manage his feelings, saying *"I'll respond to my unease and I'll talk to my supervisor and I'll say I just want to run this by you, I feel uneasy".* He also discussed how he used a variety of supervision settings to manage his discomfort and to have a conversation around his concerns, he describes *"If I've got concerns about somebody or about something, I like to spread it around".* He continues to explain how he practically uses supervision by asking questions to gauge colleagues views on his concerns: *"what do you think about that? Is there anything, any anomalies, in that? Have I missed anything? What do you think?".* He describes feeling "*quite comfortable about expressing my uncertainty or the likelihood that I'm unaware";* this is interesting as despite earlier expressing his lack of confidence in managing child protection concerns, here he is illustrating a level of confidence in his role as a therapist, by showing his uncertainty. This feels important that therapists feel able to use supervision openly to explore their concerns, without fear of being dismissed or reprimanded for not noticing things. Simon again demonstrates this when he states:*"I can tell you that if I'm concerned about somebody, or I'm concerned about work, what I like to do in supervision, in a group or individual, is to say I'm going to tell you what's been happening and I want you to tell me if you think I've missed anything".*

Simon illustrates how he uses supervision to get other's views on whether he might have overseen any important points.

Sarah emulated this as she spoke about using supervision to "*get a little bit more clarity"* recognising that by sharing things "*we become more curious around it".* Sarah continues to speak about how she appreciates having the space in supervision to "*just sort of spurt it all out"* and "*dump it on the table"* with "*someone else that you know is thinking in a similar way, you know also questioning, challenging me, what else could this mean?".* For Sarah, it feels important that she is exploring these issues with another therapist, and that together they can dissect the concerns.

Half of the participants reflected on the importance of having a good, experienced clinical supervisor. Lynn appreciated how her supervisor, who was "*very experienced*", helped her uncover ways in which she identified with her client, which was impacting her ability to explore her concerns. Lynn also inferred a state of togetherness with her supervisor, as they thought about "*what should we do with it*"; showed a level of support from the supervisor as they made the decision together, rather than the therapist being alone with it.

Simon also spoke about the importance of a good supervisor: *"very very, essential, indispensable, you've got to get a good supervisor".* He also continued to discuss the role of trust within supervision and the importance of this across different supervision settings: *"all the supervision positions I'm in, I think are populated by experienced people whose experience I explicitly trust".* This level of trust seems crucial in Simon being able to be as open with his concerns as previously mentioned.

Vicki acknowledged that she uses peer supervision groups, however, she expressed her concern that she wouldn't have had the same response from them and feels "*fortunate that my supervisor works in child protection".* Vicki continued along this line, saying *"if I'd taken it to a supervisor who doesn't work in child protection, who's only had the training that you get on the counselling psychology courses, who knows if they'd be able to clarify for me like that, there might have been more uncertainty and vagueness about what should be reported and what shouldn't".* In comparison to other participants, Vicki seemed to feel very strongly about this and reiterated her point, arguing that *"supervisors should have to have certain experiences to take";* concerned that if they don't, "t*here's no guarantee that they're going to pick up on it is there?".* Vicki seems to be proposing that all supervisors need to have a certain level of training or experience in relation to child protection, fearing that if they don't, concerns may still get missed. I wonder what implications this could have in terms of training requirements and will explore this further in the next chapter.

Vicki described having a positive experience of supervision; she spoke about how supervision enabled her to feel more confident and while reflecting on the enormity of the decision about whether to report concerns, stated: "*I don't think it's one that people should ever have to make on their own".* For Vicki, the support provided by supervision seemed invaluable.

For Kate, however, it seems unfortunate that she had a negative experience of supervision, in which the supervisor took the concerns very seriously and reported them to Social Care, without Kate's consent, because "*she felt that this case needed to be, they needed to be made aware of it".* Kate spoke about how she felt her supervisor's "*concerns were quite extreme*" and actually "*over the top*". This led to Kate feeling "*very unsafe with her"* and "*extremely anxious".* It is unclear whether the supervisor's "*extreme*" reaction, was due to a lack of experience in dealing with such concerns causing her to take such impulsive action; or whether the supervisor could have been influenced by her own personal experiences, as Kate later hypothesises.

Sue also described getting some mixed messages from colleagues in her supervision group, which left her feeling confused. She explained how the advice changed from one week to the next - *"Well, i thought, this is all very well, you know, but last week you were saying, 'oh, you know, just poddle along; nobody's going to do anything about this' to 'oh, this is terrible. These poor children,'".* Sue's experience points to the idea that "too many cooks, spoil the broth", as she seems to be more confused by conflicting advice than reassured.

3.2.3 Involvement of others – "it's not just me"

This leads into a discussion around the final subordinate theme around having other people involved in cases where child protection concerns were present; this seems key to the idea that therapists were not alone in managing their concerns.

Across all the cases, the involvement or influence of other professionals, or in one case, other family members, was discussed. Half of the participants sought advice from colleagues; in Sarah's case this was through an "*anonymous call to Social Care"; w*hereas Lynn " *took some advice from a couple of colleagues in CAMHS".* Lynn continued to explain that *"the advice that I was looking for was what are the rules around smacking for example. You know, I didn't know what that was".* Sue turned to her service manager for advice: *"I went to see the service manager, who's very good about any kind of ethical issues and so forth, about smacking particularly, and he looked it up and said, "oh well, it's not illegal." You know, that was his take on it".* It is interesting to notice that therapists sought out advice from colleagues rather than just relying on clinical supervision; my sense is that this is connected to the lack of certainty about defining abuse, driving people to seek as much reassurance and opinion as possible, to try and solidify their concerns.

Two of the participants had numerous other professionals involved with their client, due to the complexity of the cases. Simon's client had a number of professionals involved and aware of her difficult situation; "*the police are aware, the GP's aware, there's a circle of, the psychiatrist's aware".* He continues to say, *"I do know that there is a circle of people that know about them and know what's going on, so it's not just me";* later emphasising his point: *"it's not that I'm the only person who's party to this".* Simon's client was particularly risky, not only from a child protection perspective but from a mental health stance, hence the involvement of so many professionals. This was obviously important for Simon in not feeling alone in holding such a risky case; however he also points out *"that they're not able to act, also makes a difference to me".* It seems that what Simon is reflecting, is that simply having other professionals involved doesn't mean that they are able to do anything to change or help the situation, although this can offer reassurance in not being alone with such a risky case.

Vicki echoed Simon's sense of reassurance by having other professionals involved, she said: *"I think we both felt more reassured that it was in court, she was living in sheltered housing, social services, there were obviously people involved, she wasn't living with him at the time and I think the last time I saw him the daughter was with the mother anyway, so I sort of felt like, well actually you know, they're not all living under the same roof, people are involved, things are OK".* Vicki's sense of reassurance seems to come not only from having other services involved but also in knowing that the risk was reduced as the perpetrator was no longer living with the child. However, Vicki also raised some important questions as she wondered, *"do we make the mistake sometimes of thinking, well other people are involved so I don't need to do it? Maybe those other people don't know as much as you know, because they're not telling them".* The issue Vicki is raising seems to be about communication and responsibility; what do people know and who is going to take action?

Kate's experience differed slightly, rather than seeking advice from professionals, she became aware that her client's wife knew about some of his concerning behaviours: "*She was also on occasions in the room when they were all together and he was on the sofa with her playing with the daughter's feet".* Because Kate had met the wife of her client, she "*unconsciously assessed that I didn't think she was a woman who'd put her daughter through that".* This is an interesting point to consider, I wonder how many therapists have contact with other members of their clients' family, to have the opportunity to assess their awareness of certain behaviours. I wonder if there is also a danger here in assuming that other people are conscious of the risks, particularly family members who may be in denial or not even contemplated that those risks exist in their family.

3.3 Relational Experience

This final superordinate theme explores the relational experience of the participants'; exploring the impact of the clients' avoidance in addressing the issues and how this contributed to the participants' need to become directive in their therapeutic approach.

3.3.1 Avoidance: "The Elephant in the Room"

Across four of the interviews, participants spoke about how their clients were quite avoidant of speaking about the issues around their children and their own potentially risky situations and were potentially in denial about the reality of their situations; it is likely that this avoidance was driven by fear, as clients' were also fearful of the consequences of the situations.

In the first couple of the interviews, it was noted that the clients were hinting at unacceptable behaviours but were unable to name this. Sarah said "*it was just a sort of sense that there was something unspoken you know, elephant in the room",* as she noticed things that her client had "*hinted at*". Sarah continued to speak about how as the therapy progressed, she "*started to get the sense that actually what she was shedding the tears over wasn't about perhaps what she was talking about".* However, as Sarah also explained, the client "*never actually even bought the idea of him harming the children".* Sarah ultimately felt the need to directly ask her client about her concerns, as she reflected that it seemed too much for her client to say; this is explored further in the next subordinate theme on directness.

Lynn had a similar experience and spoke about "*the clues my client was giving me, quite subtly";* she also reflected on how sometimes it was unclear whether her client was talking about what she was doing or what she *felt* like doing. She also spoke about the "*little hints*" her client was giving her and how she had to make a "*foray into whether she had concerns about herself, and whether she was asking me for something".*

Returning to Sarah, she was able to reflect on how difficult it was for her client to be able to voice her concerns, partly because of her own tendency for avoidance: *"it would be very easy for her you know to close the door and run which was part of her pattern".* She describes how her client was very "*cloak and dagger*" about so much of her life and therapy was another area in which she "*had to hide so much*". In Sarah's situation, the client wasn't the perpetrator of the abuse, it was the client's boyfriend where the concerns were raised. Sarah spoke about how her client "*depended on him being there to look after the children"* and consequently how her client "*didn't want to confront or look at that".* It seems that the implications for Sarah's client were complex, not only in terms of the relationship but also in respect of financial, emotional and potentially safety. Not only

was avoidance a pattern of this client, there was the added complication of the client's feeling of guilt about what was happening to her children; Sarah found herself reflecting "*was she withholding something?"* and how she needed to loosely hold her concerns in mind for a long time and listen to what her client was saying.

Simon's situation was quite different; his client was very mentally unwell and he spoke about how his concerns centred around how his client might commit suicide and the impact this would have on her children, but how his client "*doesn't like to think about that, she puts that sort of stuff out of her mind".* He continues to describe his client as "*deeply resistant, you know there's an enormous and not very unconscious resistance to taking that on board".* Simon felt her avoidance was reflected in her attendance at sessions, which had recently reduced to fortnightly, making him question how tolerant she was and increased his concern for the children.

Sue also struggled with an avoidant client, who "*wouldn't engage with anything"* but would focus on "*intellectual things*" and she recognises her "*counter-transference weakness*" was to get "*pulled into talking about intellectual things*". Sue reflected on how she feels her client "*used every unconscious mechanism he had to keep me out",* even to the point of not allowing her to talk and to be "*dismissive*" of anything she had to say. Interestingly, with Sue's client, her attempt to discuss her concerns, his response was to shut down even further; she explains: "*I think he really closed up once I flagged up my concerns. He started to put it in a different way. "no, I only ever smacked them occasionally, but in a controlled and disciplined way," not as he'd said before in anger".* As previously mentioned, it seems that for both Simon and Sue, there were some concerns about the clients disengaging from the therapy as a result of concerns being raised. There appears to be a risk associated with challenging the clients' avoidance, that they will change their story and pull away from the therapy; I wonder what the underlying fear is here; is it that the therapeutic alliance is damaged and the client leaves the therapy, therefore leaving the child at further risk?

3.3.2 Directness: I Had To Check It Out

A strong theme that emerged across all the interviews was a sense that participants needed to be direct with their clients about their concerns; despite this going against their usual therapeutic practice, which was to work in a person-centred, non-directive way.

The way in which participants framed their directness varied slightly, with four of the participants reflecting explicitly on their honesty with their clients in terms of their duty of care and responsibilities in respect of confidentiality; at times also advising their clients about contacting Social Care. Lynn explored with her client how she "*had wondered whether she would find it useful to get support from social services; I didn't say I'm going to grass you up! And her being a*

bright woman, knew what that meant". Lynn continued to say that she did want her client to get support but also reflected that the underlying message to her client was that she was serious in her concerns and that her client was "*bright*" enough to understand this.

In good practice, clients are informed at the start of therapy about the therapist's duty of care and need to act on issues of concern; while this is often only mentioned at the start of therapy during the initial contracting phase, two participants discussed their need to remind their clients of this duty throughout the course of the therapy. Sarah spoke about how she "*constantly reminded her about that*". Sue's client was also a therapist and spoke about how he knows *"what my duty is if I think children are*..." and she also repeatedly reminded him about the situation and her duty. For Sue, it seems that her hope of reminding her client of her duty, was that he would accept the support and come on board with the idea, rather than it being something she had to do against his wishes; however her client was very resistant to this and continued to claim that everything was ok. Kate, however, was very clear about how direct she would be if she had significant concerns about her client's behaviour; *"I actually advised him, that if he told me anything was inappropriate, then I would be forced, to take some sort of action".* She continues to say that if she did have concerns,*"I would have to have told him you know that my thoughts that this child is in danger and I need to report it to social services, and at that point I would not feel it appropriate for me to work with him and try help him find somebody who, who could or would".* It seems that Kate was fortunate and that this situation did not arise and she was able to explore her client's behaviour and felt able to continue working with him. However, this does connect to theme 3.1.2 around personal bias and therapist's own boundaries about what they are willing to work with. Kate is very direct in stating that she would not be able to work with someone behaving in a sexually abusive way towards children and would not shy away from ending the therapy.

However, managing the concerns directly was not solely about being honest and reminding clients about the duty of care; it was also about how participants were able to facilitate conversations about their concerns and elicit more details, to enable them in making clear and informed decisions.

Sarah spoke about how she "*had to be quite in a way quite challenging with her in terms of asking her about this man who was in her life";* her client would say things that indicated that her partner was emotionally unkind but "*never ever disclosed that he hit her".* Sarah stated, *"I had to actually ask her that directly at one point";* she spoke about how it felt too much for her client to name but that she " *had to check it out".* Sarah also reflected on how hard it was to be directive and find a way to mention the unmentionable: *"I think the most difficult part of the process was actually in a way directly asking you know posing it";* especially as she explained, *"I'm more non-directive".* For

Sarah it seems that not only was it difficult in terms of changing her style, but it was also a challenge in practically knowing how to find the words to raise her concerns.

Lynn also acknowledged that she is usually non-directive, *"I don't normally as a rule if the client is starting to say something I don't normally bring in my agenda";* however, she goes on to illustrate how in this case, she needed to be: *"she came in, very much kind of like she usually did. And she started talking about her training and this essay she had to write, and blah blah, and I really kind of stopped, I kind of stopped the nonsense if you like, at that point".* Lynn seems to be saying that her client was avoiding the issue by talking about irrelevant matters and that she felt the need to challenge this and "*stop the nonsense*" so that they could address the concerns. This links with the earlier theme around avoidance, as many clients found it difficult to face their issues directly; Lynn had to challenge her client's avoidance in a very direct way.

Kate also spoke about how in "*one session I did actually ask him, this was session four or five, whether he had a sexual interest in...";* from this intervention, Kate was able to establish that the concerns were more based in fantasy rather than behaviour, which enabled the work to progress.

Similarly, Simon spoke candidly about how he confronts his challenging client: *"I was very direct and engaging, and probably said what I thought right from the off".* He describes how he can be "*quite ruthless*" in his interventions and how he uses his emotional reactions and will say to her, "*I feel like just telling you to pack your stuff, put it in a car, drive away, just drive away, go somewhere"* and at times uses his anger to say to her "*I have a strong sense that you shouldn't do that, madam".* Luckily Simon also describes having a strong working alliance with his client and feels she is able to tolerate his direct interventions.

Sue described feeling under pressure to change her usual "*person-centred*" approach, thinking *"god, I've got to go in there and I've got to have this agenda. I've got to see if these children are in danger".* There is a strong sense in this statement that Sue felt she needed to change her style and to check on the children's safety and that she wasn't able to be laid back; this need to have an agenda resulted in Sue beginning "*to ask these much more direct questions".*

Lynn also spoke about having an agenda, which she wasn't initially aware of; as the work with her client progressed, she realised that she did have an agenda, which was "*to keep an eye on her daughter*". She also reflected on how it was difficult to get her client to "*come round*" to her agenda and how at one point she ended up confronting her client, saying " *I'm beginning to get concerned".* This illustrates how Lynn's concerns (fear) influenced how she interacted with her client and how she altered the direction of the therapy so that she could assess the level of risk to the child.

Vicki spoke about how she was "*very direct*" with her client, where there were some cultural issues

around his views on women; she felt that "*he needed to understand that women can have strong opinions about things*" and felt it "*was really important that I was quite upfront with him about how I felt about things*". Part of the risk to the children, in this case, was around the client's (step-fathers) attitude towards the mother and his expectations of her, which were largely influenced by cultural factors. Vicki described her need to be direct with her client about her views on things, partly as a way of gaining his respect but also in challenging his attitudes towards women. When her client told her about leaving thirteen-year old child in charge of his baby at night so that he could sleep, Vicki made her views very clear and said to him, "*I, think it's absolutely unacceptable that you would even consider putting a young baby in a room with a thirteen-year old. I said you're not to do that".* As Simon spoke about the importance of a strong working alliance in being able to challenge his client, Vicki also described having a positive relationship with her client that enabled her to speak so candidly.

It seems that having concerns about the safety of children feels so risky and important, that therapists are willing to or feel the need to change their usual practice to gather more information. Some of this seems to be connected to their sense of duty and possibly the fear of what would happen if they didn't; however there is also a sense that some of the participants were avoidant of acknowledging the concerns, it feels, leaving the therapists with no choice but to become more directive.

3.2 Closing Remarks

Having presented the dominant themes that arose through the course of the interviews, in the coming chapter I shall consider how these themes are interconnected, look at the issues that arise in more depth, and pay attention to the implications these findings have in the field of psychological therapy.

4 Discussion

"What was your experience of working with a client where you had concerns for their children?"

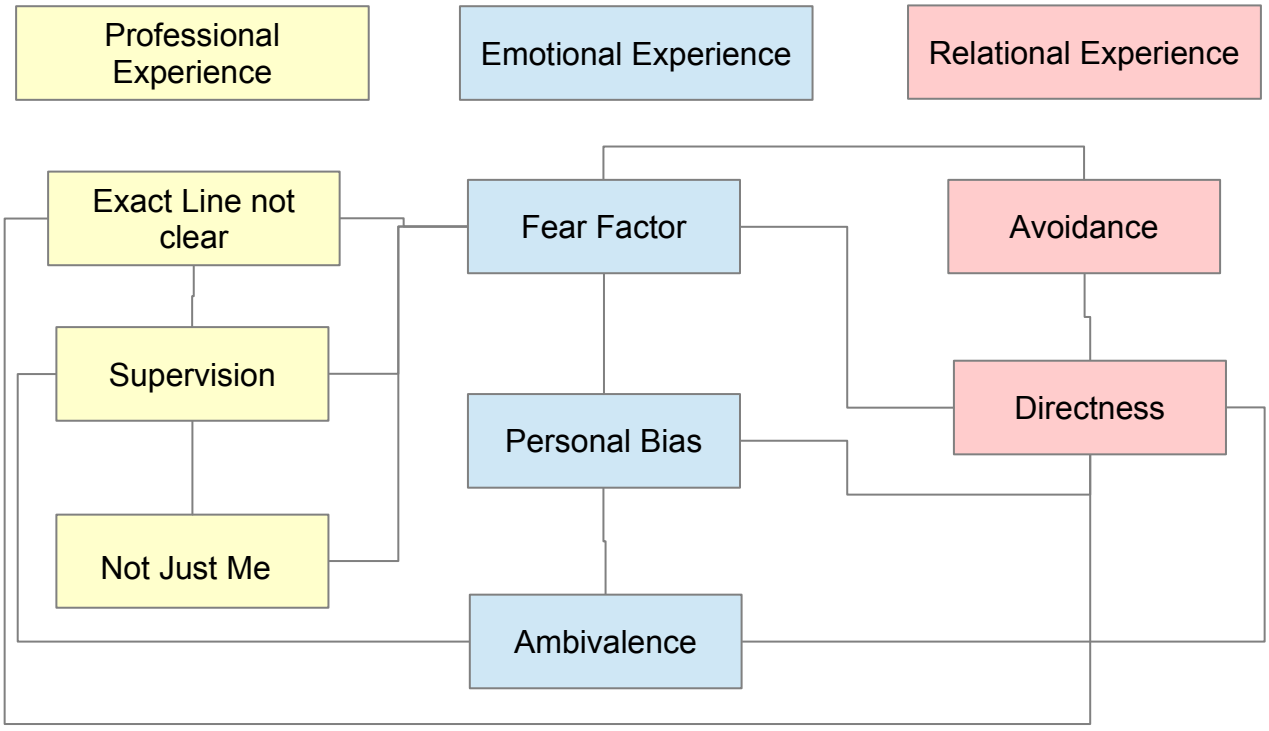
4.1 Overview

This chapter aims to provide a more detailed exploration into the superordinate themes and to illustrate how the subordinate themes are interconnected. I shall then move on to consider on a higher meta-theme level, how the superordinate themes are interconnected and how this relates to implications for the research.

4.2 Relationships Across the Subordinate Themes

I have created the diagram below as a way of providing a visual illustration of the relationships between the subordinate themes.

Diagram A



There are many connections between the subordinate themes and the diagram above illustrates the complexity of these relationships. Deciding how to group the themes was a difficult and subjective task, which may have been approached differently by others; for example, "Ambivalence" has been placed within the emotional experience of the participant, as it

encompasses the confusion and mixed emotions that affected participants; however it could be argued that this could also have been placed within the Relational Experience superordinate theme, as these feelings will affect the therapeutic relationship. This is a good demonstration of the double hermeneutic; the themes have developed not only from what the participants said but on my interpretation of what the participants said; which means that others may make other interpretations.

The emotional experience of the participant was central to the findings; in particular the fear factor, which refers to the feelings of fear and anxiety experienced by participants', particularly when considering the consequences and implications of how they respond to their concerns. One element of this was the negative perception of the social care system and participants' wariness of involving them. As illustrated in the above diagram, this experience of fear is also a driving force in the need for supervision and for wanting other professionals involved in the cases so as not to feel alone and to seek reassurance. Likewise, not feeling supported can feed the feelings of anxiety, thus creating a mutually dependent relationship.

The findings additionally indicate that the feelings of fear contribute to the participants' sense that they need to become more directive in their approach and to have an agenda to check on the welfare of the child. This change to a direct approach also appeared to be fuelled by clients tendencies to be avoidant of talking about the difficulties they were facing, placing participants in the dilemma of risking the relationship by naming the concerns themselves, or by colluding with their clients' avoidant behaviour.

When reflecting on the overall experience of the participants', one of the central themes focuses on their sense of feeling ill-equipped and unprepared to manage child protection concerns. "*The Exact Line of it isn't Clear*" refers to the sense of vagueness and uncertainty about how to define and identify abusive behaviour; it was connected to a general sense of a lack of training and being inexperienced to cope with such matters.

Leading on from this, there was a clear sense that participants' felt a strong need for support in order to manage their insecurities. Here it was evident that having the space to reflect on concerns in clinical supervision was crucial, as participants described their cases as a "*constant*" topic of supervision. In addition to this, participants also reflected on their experience of not being alone in their concerns and the influence of having others involved, such as other professionals, colleagues and family members.

4.3 A Meta-theme Level of Analysis

Analysis of the findings can be taken to a more abstract level. All three superordinate themes have an interconnected relationship, in which each affects the other; for example, there is a two-way relationship between the emotional and professional experience; practitioners need help to process and manage their emotional responses to child protection issues (importance of professional supports such as supervision and getting advice from others) and their level of experience and feelings of confidence are likely to influence how they feel and potentially reduce the sense of anxiety and fear.

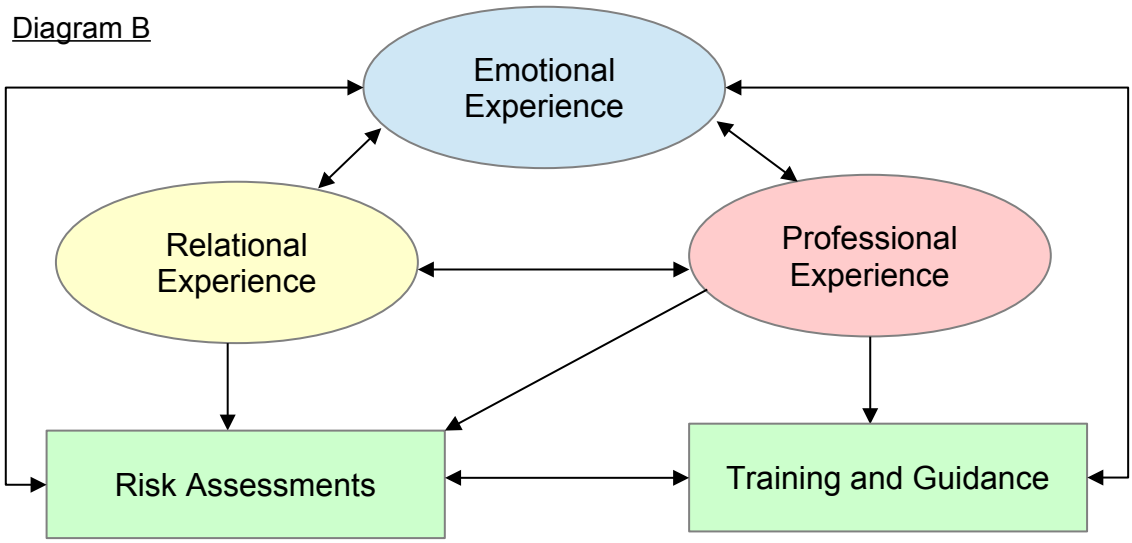
The professional experience of the therapist may influence their relational experience in terms of their decision to become directive and how they explore their concerns within the relationship; similarly, the way the therapist interacts with the client (countertransference or type of intervention for example) may lead them to require additional professional support.

Finally, the emotional responses experienced by the therapists will influence how they relate to their clients and this will, in turn, affect how they feel within the relationship.

Moving on from these themes, the *"Relational Experience"*, the need to challenge avoidance and become directive, could be understood as participants trying to find ways to assess the level of risk connected to their situation. *"Risk Assessments"* will also be influenced by both the therapists level of training and their ability to manage their emotional responses to the work.

The *"Professional Experience"* superordinate theme can be understood in relation to "*Training and Guidance*"; based on the interpretation that participants were driven to seek advice and reassurance as a result of feelings of a lack of experience and training. The feelings of fear and ambivalence will also have fed into this need and will potentially be reduced with sufficient guidance and experience.

Diagram B



4.3.1 Emotional Experience

4.3.1.1 Ambivalence and Personal Bias

The subject of child protection evokes a range of powerful emotions, which interweave and interact in a complex web. This was demonstrated across the interviews as participants expressed feelings of fear, anxiety, empathy and confusion.

Participants spoke openly about their conflicting and mixed feelings towards their clients; describing finding clients both funny and likeable yet also being scared of them. This awareness of client's dark sides while also feeling empathy towards them raises some confusing dilemmas. The complexity of this feeds into the importance of supervision (link to professional experience) and it is positive to see how participants have described using their supervision to explore this.

An important part of the therapeutic alliance is about holding unconditional positive regard for your client (Rogers, 1995); accepting them no matter what. This seemed important to the participants as they reflected on how despite being aware of their clients' imperfections, they had a capacity for empathy and a desire to help them.

There is a strong overlap here with the subordinate theme on personal bias; as while the therapeutic ideal is that therapists hold unconditional positive regard for all clients, the truth is that everyone has their own personal limitations, finding certain behaviours or attitudes harder to work with than others. This was reflected within the findings, with one participant particularly expressing clear boundaries about working with certain client groups because she didn't feel able to empathise with them. Interestingly, although the other participants described strong feelings about wanting to protect children (as explored within the personal bias subordinate theme), they did not explicitly state that they would not work with the issues. This is a dilemma for therapists as while to a certain degree they can influence the type of clients they work with by choosing particular settings, they cannot influence the issues that arise within the context of the therapy. When faced with issues that they find difficult, the quandary is whether they are able to continue working with the client and find some compassion, or whether their feelings are too strong and they need to cease the therapy. Again, use of clinical supervision and personal therapy become crucial to work through this.

There are many ways in which therapists' own personal experiences could influence how they respond to child protection dilemmas and how they perceive risk. Some people may approach things more cautiously, thinking about the risks; whereas others may be more impulsive. One issue raised within the interviews was how participants own experiences within their childhoods,

affected their sense of responsibility towards children; with one participant clearly reflecting on her experience of feeling unprotected as a child and how this has affected her desire to put the child first.

One of my curiosities at the start of this project was whether being a parent influenced how people felt about child protection concerns; my interest in this grew particularly after becoming a parent myself. Earlier I referred to some research conducted by George (2010) who identified some of the challenges for trainee psychologists who were also parents and worked in child and adolescent mental health. George (2010) acknowledged that parents face a complexity of emotions, both being able to empathise with the struggles of being a parent, but also finding the child abuse work very emotive and painful; which resonates with the ambivalent feelings identified by the participants.

Interestingly though, the participants hadn't really thought much about how being a parent influenced them in dealing with child protection concerns. Some of the participants felt that their desire to protect the vulnerable was an innate quality that they had always felt, even before having children. One can hypothesise that this quality may have been part of their motivation for entering the field of psychological therapy and wanting to help others. Despite this natural inclination to protect, some participants did acknowledge that becoming a parent may have heightened their repulsion.

This does feel a difficult belief to accurately measure; if people haven't consciously reflected on their attitudes towards child abuse before having children, it may be hard to think back to this once having had children, to assess the difference. From personal experience, having worked in child and adolescent mental health services, both before and after having children, I am aware that I am more emotionally disturbed by some stories of child abuse since becoming a parent. Partly because things become more real and you can't help but imagine "*what if that happened to my child*", which is a chilling realisation. I would concur with what my participants said, that I have always felt passionate about protecting children, even before becoming a parent, but having my own children made the subject matter more emotive and distressing. I wonder whether there is scope for further research to explore this dynamic in greater depth, as I feel it was only touched upon in this study.

While there was a sense amongst participants that it was indeed their duty to report their concerns, the dilemma of betraying their clients was also acknowledged. It raises the question about whose needs do we place first – our clients' or the child? The idea of child abuse was naturally uncomfortable for the participants, however so was the idea of breaking their clients' trust and confidentiality. It feels that this is a very personal decision, grounded in individuals values and

ethos. As illustrated in the literature by Maddocks (2010), some hold the belief that it is not their job to know about child protection concerns, instead prioritising their adult client. While this attitude was not clearly evident in the findings of this research, the concern about betraying the client is suggestive of it; it would be surprising to find there are no psychological therapists who hold this view. The potential introduction of a new mandatory reporting system could, therefore, have serious implications for this population; some may argue that this is positive as it would force people who don't see it as their duty, to make reports, or face legal consequences.

4.3.1.2 Emotional Experience: The Fear Factor

One of the most poignant themes that arose was around the fears experienced by therapists about acting on their concerns; more specifically the fear of the potential consequences. The consequences ranged from betraying clients' trust, damaging their own professional career and doing more harm to the child. This falls in line with what was found in the literature, particularly Bunting's (2010) discussion around reasons that prevent professionals from reporting their concerns.

The decision about whether to report child protection concerns was clearly a dilemma for participants, as they grappled with the lack of certainty and evidence to support their suspicions. As explored within the literature, Munro (2008) reflects on how abusive behaviour rarely presents clearly and while suspicions are often raised through an accumulation of information, she also accepts that uncertainty is an inevitability.

Rather than having the security of solid evidence, participants reflected on their gut instincts and intuition that something was wrong. As the literature highlighted, intuition can be a useful tool in assessing risk, but it can also be misleading and needs careful thought in supervision. As previously discussed, supervision was incredibly important to participants, which is reassuring as it illustrates that they were responding to their emotions appropriately, by exploring them within a supervisory context. So while Munro's (2011) report suggests that intuition can lead people to take their assumptions as truth and fail to focus on the bigger picture, this doesn't appear to be true for the participants of this study. In fact, it seems that given the seriousness of the potential consequences of reporting concerns for participants, intuition alone wasn't deemed good enough.

Not only were participants worried about making false allegations, but they were also influenced by their negative experiences of the social care system. As already identified within the literature, social care doesn't always have a good reputation in the eyes of the public; widely publicised child abuse cases such as Victoria Climbie and Baby Peter, have also done damage to their reputation as negligent. Social workers have been portrayed in the media as “child snatchers”, accused of

removing children unnecessarily and breaking up families without due cause. Involvement of social care can be associated with fear rather than relief; an attitude that was unfortunately echoed by participants. Participants spoke about Social Care not taking action when it was felt necessary and interfering in cases when it wasn't felt necessary. Participants expressed their views that social care involvement was not perceived as a positive opportunity to get families the correct support but instead connected to a fear that children would be removed and further damage would be done. It is truly sad that this has become the perception of a service that is primarily targeted at supporting vulnerable families; however, with these beliefs firmly in place, it is no wonder that professionals may, therefore, be reluctant to involve them and families are terrified at the prospect of them being contacted.

In reality, the role of social care is about supporting families who are struggling and at risk of breakdown; assessment of parental capacity and risk assessment of child abuse is only part of their remit. If their reputation could be improved and people made more empathic to their role, this may reduce some of the fear of involving them. As indicated in the literature, the use of social media to explain the social worker's role to the public could be helpful, yet it is hard to promote a service that is constantly struggling, due to financial cuts and limited resource.

It appears that fear is a double-edged sword, with participants expressing their fear at involving social care, but also their fear of what might happen to the child or the professional consequences for them by not reporting, there is a real sense of “dammed if you do and dammed if you don't”.

Should the UK government decide to undertake a mandatory reporting system, I wonder how this would impact the levels of anxiety among professionals. On the one hand, it could be argued that it should reduce anxiety as the decision-making process is being taken out of their hands; they will have no choice. However, the fear verbalised by participants doesn't so much focus on whether or not to report, but is about what will happen as a result of reporting; in reality, the consequences will be worse from a professional perspective with the mandatory reporting law, as it will impose sanctions to those that don't report. With this in mind, it is possible that the change would increase therapists sense of fear and anxiety, rather than offer reassurance and a sense of removed responsibility.

4.3.2 Professional Experience

4.3.2.1 The Exact Line Of It Isn't Clear

The subordinate theme, “*The Exact Line of it isn't clear”*, highlights participants' feelings of a general sense of a lack of guidance and training around child protection issues; which links to an apparent lack of confidence in identifying and defining abusive behaviours.

In Chapter One, the literature revealed how the definition of abuse is subjective, influenced by numerous factors; lengthy definitions have been provided by the Government in an attempt to provide more clarity. However, despite these in-depth definitions, the participants' experience reinforces this sense of ambiguity, as they struggled to feel confident in knowing exactly which behaviours needed reporting. Individuals' boundaries can vary considerably about what behaviour they deem acceptable and unacceptable, depending on their gender, age, culture or religion; which leaves space for confusion and uncertainty.

Participants expressed more certainty in relation to behaviours of a violent or sexual nature; other research, such as that of Crensaw et al (1995) supports the sense that there is more confidence in reporting sexual and physical abuse. Linked to this, literature also reveals that emotional abuse and neglect are under-reported and under-recognised (Glaser, 2002), as professionals struggle to define the behaviours and have confidence in being able to prove it legally.

The experience of the participants supported this idea that psychological abuse is hard to prove, with the quotes "*the exact line of it isn't clear*" and *"how you can prove psychological damage?",* clearly illustrating this. The impact of physical and sexual abuse can sometimes be proven more easily with the potential for physical evidence such as bruises, broken bones or DNA evidence; something not available for emotional abuse. The lack of visibility of neglect and emotional abuse was raised as a concern by participants, with a scary realisation that so much can be happening out of sight. There have been long-standing assumptions that emotional abuse and neglect are not as serious as physical or sexual abuse (Vachon et al, 2015); in terms of having such dangerous outcomes such as potential death or serious physical injury; however positively these assumptions were not evident in the participants' thinking. This could be understood in relation to the nature of psychological training, which has an emphasis on child development and attachment; and thus provides psychological therapists with a good understanding of how damaging emotional abuse and neglect can be. So rather than these concerns not being regarded as important, it seems more likely that participants' hesitation in reporting is related to the difficulties in proving harm, but also concerns about whether reporting will make a helpful difference to the family. The lack of certainty and the danger of making a false allegation are connected to the later theme around the feeling of fear experienced by participants.

These are really difficult issues: proving emotional abuse is complicated as it is often not a single incident, but an on-going process of verbal put-downs and mind games (Vevers, 2008). However, what is clear from participants' experience, is there is a difficulty in linking the professional definitions of abuse to the behaviour/dialogue presented in the therapy room. The information available on how to identify signs of emotional abuse tends to focus on what you might notice in the child's behaviour (as listed on the NSPCC website for example). While it could be argued that

there are clear guidelines in the definitions about what constitutes emotional abuse (e.g. yelling, bullying, ignoring). I wonder whether participants were finding it hard because they don't witness this, but instead hear how their clients speak about their children in ways that perhaps they don't agree with, but are unclear whether it meets the threshold of being emotionally abusive.

A potential risk highlighted by one participant is that a lack of confidence and knowledge about child protection may lead to concerns being dismissed and unreported; increasing the risk to the child.

When reflecting upon where therapists might access this guidance, the ethical guidelines of professional bodies would seem to be a logical place to start. However, while there is an acknowledgement of the duty to report child protection concerns, within the ethical guidelines of organisations such as the UKCP and BPS; these are broad, non-specific statements that offer no clear guidance to members about how to manage their concerns. While it was not explicitly explored with participants about their views on the usefulness of the ethical guidelines, it was equally not mentioned by any of the participants; suggesting that the guidelines are not necessarily being used and experienced as helpful. It is perhaps unreasonable to expect that such guidelines go into specific details, as this would make a lengthy document dominated by the topic. There could, therefore, be scope for an additional document focusing more specifically on outlining duties in relation to child protection. As expressed in the findings, there is a desire from participants for more clear direction and for things to be "*spelt out more clearly*".

Leading on from this, the lack of confidence and certainty is linked to the deficit in training around child protection, which was another key area raised by participants. The findings suggest that participants felt that child protection was not sufficiently covered by their core psychological training courses, which left them feeling ill-equipped to manage their concerns. With the sense that issues are only being briefly addressed in professional training, attention then moves to the provision of continued professional development and mandated training of organisations. The NHS requires all employees to complete basic safeguarding children and vulnerable adults course as part of their induction programme, which needs regular refreshing; for those working more directly with vulnerable groups, there are additional courses required which go into greater depth.

However, it needs to be noted that the focus of this research was on therapists working in non-NHS settings; as such, they were not necessarily mandated to complete any safeguarding training in the workplace. This raises an interesting issue about the requirements of different organisations and the impact of this.

Participants were not explicitly asked about whether they had experience working within the NHS, but through the research, a contrast was noticed between the experiences of participants who had

worked within the NHS and those who had not, in terms of their satisfaction with their training. One participant spoke confidently about her experience of working with the NHS and the level of training she received which helped her feel adequately trained in child protection; this stood out in comparison to another participant who reflected honestly on her lack of NHS experience and viewed this as a "*weakness*".

This raises a point for further consideration – how does the nature of the organisation in which therapists work, influence how they deal with child protection concerns? This will be addressed later in the chapter when exploring the importance of support. However, focusing back on training need, the issue remains that child protection training is not a specific CPD requirement and is only mandated by certain organisations; meaning that those working privately, for example, are not required to undertake it or be likely to have it easily accessible.

The BPS (British Psychological Society) has stressed that safeguarding children is the responsibility of everyone, regardless of whether they work with adults or children (BPS, 2014). Within the HCPC guidance, it advises that registrants need to keep up to date with laws and regulations (HCPC, 2016). However, while child protection could be classed within this, there is no specific requirement and those working outside the realm of children's services, may not be alerted to new developments or the need for updating their training. They may not also consider it to be relevant to their roles if they work predominantly with adults.

As part of the BPS Continued Professional Development Programme, there are workshops offered on managing ethical dilemmas, which is positive as it provides a space for psychologists to take difficult issues; however, as this is not specifically focused on child protection, it is unclear how much support people would receive on particular issues; and again, this is an optional programme.

Participants reflected on how despite having good and experienced child protection trainers, they continued to find the area too "*grey*"; casting doubt on the helpfulness of existing training. While I wonder if participants are craving something that simply cannot exist, namely a definite, black and white handbook on what and what not to report; it is possible that more targeted training to bring the definitions of abuse to life by connecting the definitions to what the therapists might see in the therapy, could be useful. As I reflect on this I wonder if more guidance to help therapists think about how their clients speak about their children, might be useful; some questions that came to my mind were: do clients speak negatively of their children - criticising them, putting them down? Do they describe the punishments they use or describe how they manage their behaviour? Do they talk about going out frequently, with childcare arrangements being unclear? Are you aware that their partner is being violent or aggressive towards them and the children are in the house? What do therapists notice in relation to the tone of voice and body language their clients use when talking about their children?

Training that takes this focus, may help therapists notice more subtle clues and behaviours within their clients' dialogues and enable them to reflect more clearly on whether this translates into an abusive situation.

As previously mentioned, the UK government are currently exploring whether to follow the actions of other countries and to introduce mandatory reporting laws. It is unfortunate that the interviews took place before these developments, as it would have been interesting to explore participants' views on this. However, I anticipate that this could be an entire piece of research in itself. So while I have not directly looked at views on mandated reporting, I still feel that some of the findings can be considered in the context of it. For example, one of the consequences of a mandatory reporting system is that people feel required to report everything, meaning that there is an increased number of false allegations (Gilbert, 1997). This has serious implications for social care services as they become flooded with even more referrals and unmanageable demands for assessments. The findings of this study illustrate that uncertainty and anxiety is already a huge concern for participants in the absence of a mandated reporting system; the introduction of such a system is likely to raise anxiety and result in over-reporting. This has direct implications for training need; by improving the training of psychological therapists, hopefully, they will be more informed and skilled in identifying appropriate referrals, to prevent the flooding of social care that has been experienced elsewhere.

4.3.2.2 Professional Experience: Use of Supervision

It is evident that participants feel ill-equipped in managing their concerns; a natural consequence of this is feeling an inflated need for support, reassurance and guidance.

It was acknowledged in the literature that there is no clear definition on the purpose of clinical supervision; however, Proctor (2001) has suggested that one of the functions of supervision is restorative, in which supervisees are made to feel emotionally supported and contained. From the findings, it seems that this function is particularly important for the participants of this study, as it emerged that clinical supervision and support from other professionals was incredibly important; partly as a response to the feelings of uncertainty and lack of confidence, but also due to the levels of fear and anxiety. It emerged that participants spoke frequently about their clients with whom they had concerns in supervision, with these clients often dominating the supervision process.

Participants described one of the main driving forces for using supervision was to explore their feelings of "*unease*" and their "*gut feelings*" that something was wrong; with a sense that clients

were alluding to things but there was no solid evidence. This created a sense of uncertainty and contributed to the feelings of fear and anxiety that participants also expressed so clearly. The role of gut instincts was discussed within the literature and it was highlighted that supervision is a crucial space to explore these feelings and to challenge them (Munro, 2011). It is reassuring that for the majority of participants (with only one exception) that they experienced supervision as a safe place in which they could explore these difficult emotions.

However, as participants reflected on how the guidance of their supervisors was so helpful in managing their concerns, it became apparent that it wasn't only about having supervision, but that the quality of supervision was vital. Participants spoke about how having experienced supervisors was important; with it being suggested that supervisors should be required to have certain levels of experience. This is an interesting suggestion; particularly in light of the negative experience of supervision discussed by one participant. In this example, it was felt that the supervisor took inappropriate action without the consent of the participant or their client; however, it is unlikely that this situation arose due to a lack of training. In this instance, it was hypothesised that the supervisor was influenced by their own personal biases and possible personal traumatic history, which led to the inappropriate handling of concerns.

A couple of issues arise out of this; firstly it highlights the issue about the supervision of clinical supervisors – are practitioners sufficiently supported within their role as clinical supervisors? Milne (2007) suggests that this is an area that is greatly neglected.

I also wonder about the relevance of personal therapy for therapists and feel that it emphasises the need for individuals to have dealt with their own personal issues. In this instance it is suggested that perhaps the supervisor had unresolved issues that affected their handling of the concerns; this raises the issue of not only therapists training and support but also that of clinical supervisors. I would argue that it certainly stresses the value of personal therapy and development for all psychological therapists.

One concern raised in the literature (Kirkbride, 2016) was that therapists working privately, may feel less supported than those in wider organisations; this research hasn't been able to clearly assess this as it has only focused on those working more independently. One could hypothesise that such importance is placed on supervision and having other professionals involved because the participants are working more in isolation. It suggests that working independently places greater responsibility onto the therapist, whereas when working as part of an organisation or team, the risk can be held more collectively.

4.3.2.3 Professional Experience: It's Not Just Me

The findings also indicate how participants extended their reassurance-seeking beyond clinical supervision; with some participants seeking guidance from managers and peers, and others being aware of other services such as the police being involved with their clients. This illustrates the high levels of anxiety the participants experienced through managing this delicate topic. Unfortunately, seeking advice from others was not always experienced as helpful, with participants sometimes receiving conflicting messages about whether to take action or not; this only increased participants' sense of confusion and further illustrates the subjectivity of the issue. Interestingly, the option of anonymously contacting social care for a consultation was scarcely mentioned by the participants; this option is available and can allow individuals to seek advice about what action to take and to find out what might be likely to happen if a formal referral is made. This is a potentially useful strategy, although it is unclear whether therapists are actually aware of this option.

One observation from the findings is that only two participants spoke about being aware of other professionals being involved with their clients' families; their experience of this was also completely contrasting, with one finding it reassuring and the other finding that there was increased pressure on the therapy because the other agencies couldn't take any action.

This didn't arise in the other interviews and it is unclear whether this is because it wasn't explicitly asked, however, if this is the case, it also suggests that participants didn't feel it was an important enough topic to raise. This raises the question whether other agencies were not involved with the clients' families or whether participants were not aware of it; it makes me wonder whether this is something that therapists routinely ask about in assessments. The nature of the setting may again be influential here, with organisations such as the NHS, perhaps more likely to gather this information.

However, it feels important for therapists to have this knowledge; as participants have expressed, there is some reassurance felt by knowing that there are other people helping the client, perhaps a sense of sharing the responsibility. It is important to acknowledge that knowledge alone is not enough; knowing that others are involved can be worthless if the professionals are not communicating and sharing their concerns. The therapist may be holding just one piece of a puzzle; alone, their concerns may not be enough to warrant child protection proceedings; however, if that information is put together with what other professionals know, accumulatively there may be a stronger case. Literature supports this, as investigations into child deaths have shown how lack of communication between key professionals was one of the unfortunate factors that contributed to the death of Baby Peter in 2007. A report by the Care Quality Commission (2009) focused on how poor communication between social care, the police and the NHS was crucial in the lack of

assessment and action around Peter's protection. What is even more devastating is that years before, similar failures were uncovered in the tragic death of Victoria Climbie:

> *"it is very frustrating to read that ... a long way before that happened, a pattern of things emerging, but knowing that at the time ... separate agencies held those bits of information. So GPs will be seeing things, accident and emergency will be seeing things, the police may be dealing with other aspects of what is going on in that child's life, and nobody is bringing it together." (Lord Laming, 2003:9)*

So by not communicating or sharing our concerns, others may not be in a position to act due to a lack of evidence. One of the major learning points from these serious incident reviews has been about improving communication among professionals, including psychological therapists. While participants spoke about their awareness of other professionals involvement, it was unclear about the level of communication they had with them; my assumption is that this is a delicate area concerning confidentiality and that communication is, therefore, likely to have been limited. However, studies show that sharing information is crucial and therapists should be encouraged to do this and not carry their concerns alone.

There is, however, also a danger in knowing that other professionals are involved; Vicki highlighted a very important point, "*do we make the mistake sometimes of thinking, well other people are involved so I don't need to do it?".* The reassurance of others' involvement may lead to the assumption that they don't need to take any action because someone else will. This may also feel appealing if the therapist has worries about disrupting the therapeutic relationship by breaking confidentiality. However, if everyone has the same thought that someone else is going to act, there is a risk that no one will act and abuse continues unreported.

4.3.3 Relational Experience

4.3.3.1 Relational Experience: Becoming Directive

Fear is a powerful emotion; as indicated in the findings, it can paralyse people, stopping them from taking action and instead pushing them into avoidance (a theme that shall be addressed shortly). Fear can also create panic and mobilise people into acting on their concerns. What has been noticed within the findings, is that while participants did not panic and make hasty decisions in light of their concerns, they did change their behaviour by becoming more directive in their therapeutic approach.

It was identified that generally, participants are non-directive in their psychotherapeutic practice, allowing clients to bring their issues of concern at their own pace; something that resonates with

my own clinical practice. However, when child protection concerns came into the work, participants expressed their feelings that they needed to have an "*agenda*", to find out more information and to challenge their clients. This links to the earlier ideas about certainty; Ling and Luker (2000) alerted us to the idea that our intuitions can be used as a "*silent alarm*", to alert us to the idea that something is wrong and might warrant further exploration. This feels very relevant to this study as participants noticed their feelings that something wasn't right and became more directive and inquisitive with clients as a result; they started looking for evidence to support their intuitions, a natural instinct showing careful consideration rather than rash, panicked reactions. Reflecting on this, participants seemed reluctant to make reports based on their gut instincts but instead used them to try and gather more information to get more certainty on what was actually happening – looking for facts. Of course, as identified earlier, hard facts are unlikely to emerge, but the strong feelings of fear of the potential consequences meant that participants were reluctant to act on instincts alone.

There was one example of dissonance with this trend, with one participant holding to her non-directive stance, allowing information to flow naturally throughout the course of the sessions, without her actively seeking it out. She believed that information is shared when the time is right and didn't seem to feel the need to have an agenda, like the other participants. I am curious what led to this difference in experience; was it simply that the participant feels so strongly about her therapeutic approach that she will not stray from it? Or was it because her concerns weren't strong enough to feel the need to explore them straight away? I also wonder if there is a connection to the participant's level of experience; this participant has worked in the NHS and had also described feeling well-equipped to deal with child protection issues from past experiences; could this confidence have made her less anxious? While I can only speculate about the reasons for this, it does suggest a potential avenue for future research, focusing more on how levels of experience influence reactions and management of child protection concerns; this could have implications for clinical training.

Participants were not only directive in asking their clients for more information about their concerns, but they were also direct in informing the clients about their duty of care around confidentiality. Usually, as part of initial contracting with clients, therapists give information about their responsibilities and duties around confidentiality; this is considered an important part of establishing the boundaries of the therapeutic relationship (Clarkson, 2006). The findings show that it was important for participants to be clear about their duties and in some cases to regularly remind their clients of this throughout the work, not just to discuss it at the beginning. The literature supports the importance of contracting; Steinberg (1997) found that if a therapist was

explicit about their reporting duties within their therapeutic contract, clients had a more positive emotional response. The study also indicated that being more explicit may result in clients being more likely to remain in therapy, although this wasn't statistically significant. Some have expressed fears that clients will become more secretive and less trusting within therapy if therapists are explicit about their duties; that it will "chill" disclosures (Steinberg, 1997); however this hasn't been supported by research nor in the findings of this study. In fact, one could argue that by being honest and upfront from the onset, it improves trust and the robustness of the therapeutic alliance and can also provide the client with a sense of containment.

4.3.3.2 Relational Experience: Avoidance

An important factor in participants feeling the need to become directive was a sense that clients often found it too difficult to raise the issues about their children and in fact could be very avoidant about facing it. Consequently, therapists were faced with the dilemma of either colluding with the clients' avoidance or becoming directive and challenging the behaviour.

Avoidance can be defined as "*a chosen (non) activity whereby the individual does not do something (which may be a behaviour, thought, or feeling) in order to avoid some kind of perceived discomfort*" (Widdowson). It is understandable that if a client is doing something that could be deemed as unacceptable or their partner is behaving abusively, the client may find it difficult to speak out about it. The "perceived discomfort" may be feelings of shame and guilt about their behaviour, it could be their fear about what the consequences might be in terms of the law or having their children removed from their care; or in the case of a partner's abuse, fear of what the partner might do or losing the stability and support of the relationship. While fear appeared to be mobilising for participants and a driving force in them becoming more directional in the therapy, it seemed to have the opposite effect for their clients, paralysing them and preventing them from facing the issues.

While many clients were avoiding talking explicitly about issues of concern, participants spoke about their clients alluding to certain things, giving hints. I wonder whether these were unconscious invitations to be challenged, with clients finding it too difficult to name themselves, but on some level wanting to talk about it. Some may see that challenging clients' avoidant behaviours is part of the therapeutic process, however, this is a delicate process and will be influenced by the strength of the therapeutic alliance.

Some participants expressed their fear at raising their concerns with their clients, fearing they may rupture the therapeutic alliance. A rupture to the working alliance can be defined as "*moments of interpersonal tension between patient and therapist"* (Safran and Kraus, 2014). This fear that the

therapy may breakdown was particularly pertinent for one participant who expressed his concern that should his client disengage from therapy, the implications for her children could be very serious. His client was experiencing complex mental health difficulties and he spoke at length about the delicacy of balancing the therapeutic relationship with challenging her "*crazy thinking*". This links back to the literature discussed earlier around the importance of therapy for parents with mental health issues; it was highlighted how therapy can be effective in helping parents to become more mindful of their children and identified how parents engaging in therapy can provide a valuable opportunity to facilitate a change in their abusive behaviour. However, should the therapeutic alliance be ruptured due to breaking confidentiality, it could potentially break down irreparably and this could place the children at greater risk of harm. This is a big risk, but it is important to note that if a rupture can be successfully repaired it can be instrumental in progressing the therapy. Being able to challenge clients is a much "safer" risk if there is a strong therapeutic relationship as it increases the chance of repairing any potential ruptures (Steinberg et al, 1997). Research has shown that there are better outcomes in terms of clients remaining engaged in therapy, if they have a strong therapeutic alliance prior to reports of abuse being made (Steinberg et al, 1997; Watson and Levine, 1989). This was evidenced within the interviews, as the strength of the therapeutic relationship was identified as allowing the participant to challenge his client's behaviour in a tolerated way.

Another issue identified within the interviews was that therapists may not always feel able to challenge their clients' avoidance and actually end up colluding with the avoidant behaviour. This was either because of their fear o f taking action and not wanting to have to deal with that or possibly as a result of their own past histories and experiences with child abuse. It is important for therapists to reflect upon their own personal biases, how they perceive child abuse, their loyalty to their clients and their own desires to protect the child. If they hold protecting the vulnerable as a key value and part of their responsibility, it follows that they are going to prioritise taking the appropriate action to ensure this.

4.4 Considering the implications of my findings

Reflecting back on Diagram B, which I introduced at the start of the chapter, there are important implications that need to be considered around risk assessment and training and guidance. Two of the key elements of participants' experience are around a lack of certainty about managing child protection concerns and fear about what could happen. It could be argued that by improving training and support structures for psychological therapists around these issues, that anxiety could be reduced and therapists would feel more confident. This may also have a knock-on effect on how therapists approach risk management.

4.4.1 Training and Guidance

4.4.1.1 Required Continued Professional Development on Child Protection

Regulating bodies are in agreement that child protection should be on everyone's agenda and would probably argue that they currently encourage registrants to stay informed and adequately trained under their general guidelines. However, the findings indicate that there is a need for more specific requirements around training on child protection, whether this is part of core professional training and/or within a continued professional development programme.

The following points should be considered:

- The introduction of a dedicated session on managing child protection concerns in the context of the therapeutic relationship as a compulsory part of all psychological and psychotherapy training courses.
- A one-off introduction to child protection/safeguarding, which covers the definitions, legal and ethical issues as a mandated training for everyone regardless of their employment setting.
- Required yearly update session on developments in relation to child protection for all qualified psychologists and psychotherapists, regardless of their employment setting (e.g. NHS or non-NHS).

By introducing a more dedicated element in core psychological training courses, this would immediately equip trainees with skills about handling these difficult issues. It would be within this training that the focus could be more about the therapeutic issues in dealing with such concerns – how to repair ruptures that might occur, how to deal with your counter-transference responses to such issues, dealing with the sense of betraying your client.

The one-off introduction to child protection is a standard requirement of those working within the NHS; however, there is no guaranteed provision for those working outside the NHS unless perhaps the post is specifically in working with children and families. By making this a standardised

requirement for psychological therapists, it would ensure that no one falls through the gaps and that even those working in private practice, are adequately informed.

The regular update session could be provided by an organisation such as the NSPCC, who could advise with updates in respect of changes in the law/regulations and recent research developments relevant to psychological therapy. There could also be the option of online training, to make this more accessible.

My recommendations are in line with those made by Bunting et al (2010) who also identified that training needs to extend beyond helping professionals identify signs of abuse, but to help them deal with the more intricate aspects of the dilemma.

4.4.1.2 Clinical Supervision

There is also an implication around clinical supervision and training or experience in child protection. Supervision and support from others played a key role in participants experience of managing their concerns. Some participants suggested that supervisors should be required to have certain experiences in child protection – this seems perhaps an idealistic view and is probably unrealistic. However, it does raise the question about training requirements for supervisors and whether there needs to be an extension of their training to focus on how to help their supervisees handle child protection concerns. I feel it is important to recognise that while child protection courses are useful in providing definitions of abuse and guidance about whom to contact and so on, they seem to lack the therapeutic angle – what does it mean for the therapy to report concerns? These are delicate issues that are unique to the fields of psychology and psychotherapy; we look to our clinical supervisors to guide us on these issues, and if they are not adequately informed, how can they?

4.4.2 Risk Assessments

As demonstrated in the findings, participants are making their decisions about whether to report their concerns based on limited information, gut instincts and hints from their clients that something is wrong. It is unlikely that solid, indisputable evidence of child abuse is going to be revealed within therapy; therapists are therefore left with the uneasy job of deciding whether there is sufficient cause for concern to report to social care. It could be argued that part of this decision-making process involves undertaking a mini-risk assessment – is there really a risk to the child and how serious is it?

However, it is not the role of psychological therapists to make risk assessments on child protection;

risk assessments in psychological therapy tend to focus on self-harm, suicide or violent/forensic behaviours. It is also important to recognise that therapists working with adults will only have access to limited information, that which their client chooses to share with them; they are unlikely to have direct contact with the child or the home situation, making it almost impossible to get a holistic picture of what is really happening.

The role of assessing parental capacity and whether a child is experiencing abuse is the role and duty of social care, who are specifically trained in this arena and have the access to fully explore the situation. Yet, the decision to involve this service is a serious one and understandably therapists are reluctant to proceed without good reason.

In order to manage this, participants have reflected on becoming more directive to gather information; however, I also wonder whether therapists could be provided with more guidance here. Initially, I deliberated on whether therapists should undertake specific risk assessment training on child protection; I then realised that actually this is the role of social care and would be a huge responsibility and task for therapists to take on.

With further reflection, I would like to propose the development of a guide sheet, which prompts therapists to consider certain questions and guides their thinking and understanding of their concerns. Some of these questions may be discussed as part of clinical supervision, but I feel there may be some benefit to having a crib sheet which may aid conversation within supervision or can be used independently. The questions may help focus thinking, which can easily become fractured and confused in such complex situations; even in supervision, it can be easy to get distracted and lose focus.

For instance, the following questions could be considered:

- What is the nature of your concerns?
- What evidence or factual information do you have to support these concerns?
- What has led you to having these concerns?
- What are you worried about happening?
- Are other services already involved with the family?
- What would you hope to happen by reporting the concerns?
- Are there any other concerning factors that need to be taken into consideration? For example, mental health, history of criminal behaviour, drug and alcohol use,

Having a set of guidelines that could help a therapist pull together a multitude of factors and help them look at the wider picture might help them feel more confident in the decision-making process. It may highlight areas that the therapist has little knowledge about, which can inform the therapy

and direct the therapist about what further information they need to know before making their decision. For example, unless we routinely ask about what other services are involved with our clients, we may not be aware that the client is already receiving support from social care. We might assume that this information would be discussed in the course of therapy, but if clients are avoiding the issues, this may not be the case. Being aware that our clients are already receiving support from social services or have frequent involvement with the police can be helpful to assess the level of need within our clients' families.

Some of these questions could also encourage self-reflection and provoke the therapist into thinking about the complex issues around cultural and personal attitudes on what constitutes abusive behaviour. For example, what does abuse mean to you? How could the role of culture or religion influence this situation? How do your own experiences impact how you are relating to this case?

Another interesting point that was discussed by one participant was their awareness that another family member knew about their client's concerning behaviour; the therapist had met this family member and made an unconscious assessment that they didn't believe they would tolerate the behaviour, which influenced the action they felt they needed to take. This is an interesting point to consider, I wonder how many therapists have contact with other members of their clients' family, to have the opportunity to assess their awareness of certain behaviours. It also concerns me that further assumptions are being made without clarification; child abuse is very common within families, "*66% of child sexual abuse takes place within the family or its trusted circle*" (Children's Commissioner, 2015). It is therefore quite risky to make assumptions about the role other family members may or may not play within this, particularly as some people find it so difficult to believe that such things could be happening in their families.

4.5 ***Limitations of Current Study and Reflections on Possible Future Directions***

As with any research, there are limitations to how widely the findings can be applied and particularly with the use of IPA methodology, the aim is not about having generalisable findings but to focus on the specific experience of the participants; meaning a small sample size is inevitable. A consequence of this is that the sample was not very diverse. As I reflect on the homogeneity of the participants, one of the striking weaknesses is in gender representation, with only one male participant. However, one could argue that psychotherapy is a largely female-dominated field, meaning the gender in-balance is actually reflective of the therapist population. From the findings it is unclear whether gender plays an important role in how having child protection concerns are

experienced by therapists, but this can only be determined through further research.
I also notice that participants were all white British, meaning that the role of ethnicity and cultural differences hasn't been covered. This may be an interesting area for further research, given the subjectivity in the definitions of abusive behaviour, it would be interesting to explore whether therapists have different views about what they would report and how this is impacted by their cultural backgrounds.

I think it is important to reflect that participants would have only volunteered for this research if they were conscious that their concerns were of a child protection/safeguarding nature. I still ponder the question of how many therapists working with adults are actually thinking of their client's behaviours in the context of child protection and how many concerns may be going undetected. I wonder whether this contributed to the difficulty in recruiting participants, although I sense that this may be influenced by participants fear of being discovered negligible. Future research would need to pay close attention to the recruitment process, thinking carefully about the terminology used and any potential implications for participants in taking part.

An aspect which I would be interested in exploring further is in the difference between the experiences of those working privately to those working within large organisations or the NHS; a factor that the nature of this study was unable to explore. Further research could focus on a comparative study to consider how the support, training and experience of different settings affect how concerns are managed; working on the hypothesis that organisations provide more support and guidance. The findings of this study highlight the sense of anxiety and lack of confidence in managing child protection concerns amongst those working in non-NHS settings; I am curious whether these feelings are still experienced in those working within larger teams – does the support system make a difference or are those feelings an inevitable reaction to such work?

The findings additionally gave an indication that gut instincts and counter-transference reactions of anxiety and worry play an important role in participants decision making processes. While this has been touched upon in this research, there is scope for further exploration into the relationship between therapists desire for solid evidence, the importance of certainty and the role of instinctual feelings. Do we restrain from reporting concerns until we have sufficient evidence – but what is considered evidence? Particularly when thinking about neglect and emotional abuse. I can reflect on cases in working with young people where I have felt uncomfortable when they tell me how their parents speak to them, but also feel there aren't sufficient grounds to involve Social Care. How do we decide when we have enough just cause to take things further?

Following on from this, there is also potential to develop more practical guidance and training on child protection, aimed specifically at those working within the therapeutic fields. Quantitative research could focus on surveying therapists to gauge whether structured guide sheets would be welcomed and to clarify the details of what therapists would find helpful.

4.6 Final Conclusions: Bringing It Together

Trying to write the perfect ending to a study that has been part of my life for over six years feels an impossible task. Over this time the research has shifted form, evolving with the developments in my thinking and changes in my life.

There is no doubt that talking about child protection concerns within psychological therapy is uncomfortable; sometimes it involves challenging clients' avoidance on obviously unacceptable behaviour, sometimes it is about listening to the subtle clues being given and the silent cries for help. What this research has aimed to achieve, is an insight into the lived experience of psychological therapists who are faced with the reality of these issues.

What I have found resonates with my own experience; that participants feel inadequately trained and lacking in confidence in identifying and knowing how to respond to concerns over a child's safety. There is a distinct lack of guidance that takes a therapeutic angle and considers how to handle concerns in the context of a therapeutic relationship.

I hope that through this research I have raised the profile of child protection within adult psychological therapy and encouraged therapists to question the behaviours and stories of their clients with a more mindful approach to the impact on their children. I also hope that the recommendations will be taken into consideration by academic bodies and appropriate adjustments made so that therapists have the confidence and the skills to tackle their concerns.

"Don't turn your face away.
Once you've seen, you can no longer act like you don't know.
Open your eyes to the truth. It's all around you.
Don't deny what the eyes to your soul have revealed to you.

Now that you know, you cannot feign ignorance.
Now that you're aware of the problem, you cannot pretend you don't care.
To be concerned is to be human.
To act is to care."
— Vashti Quiroz-Vega

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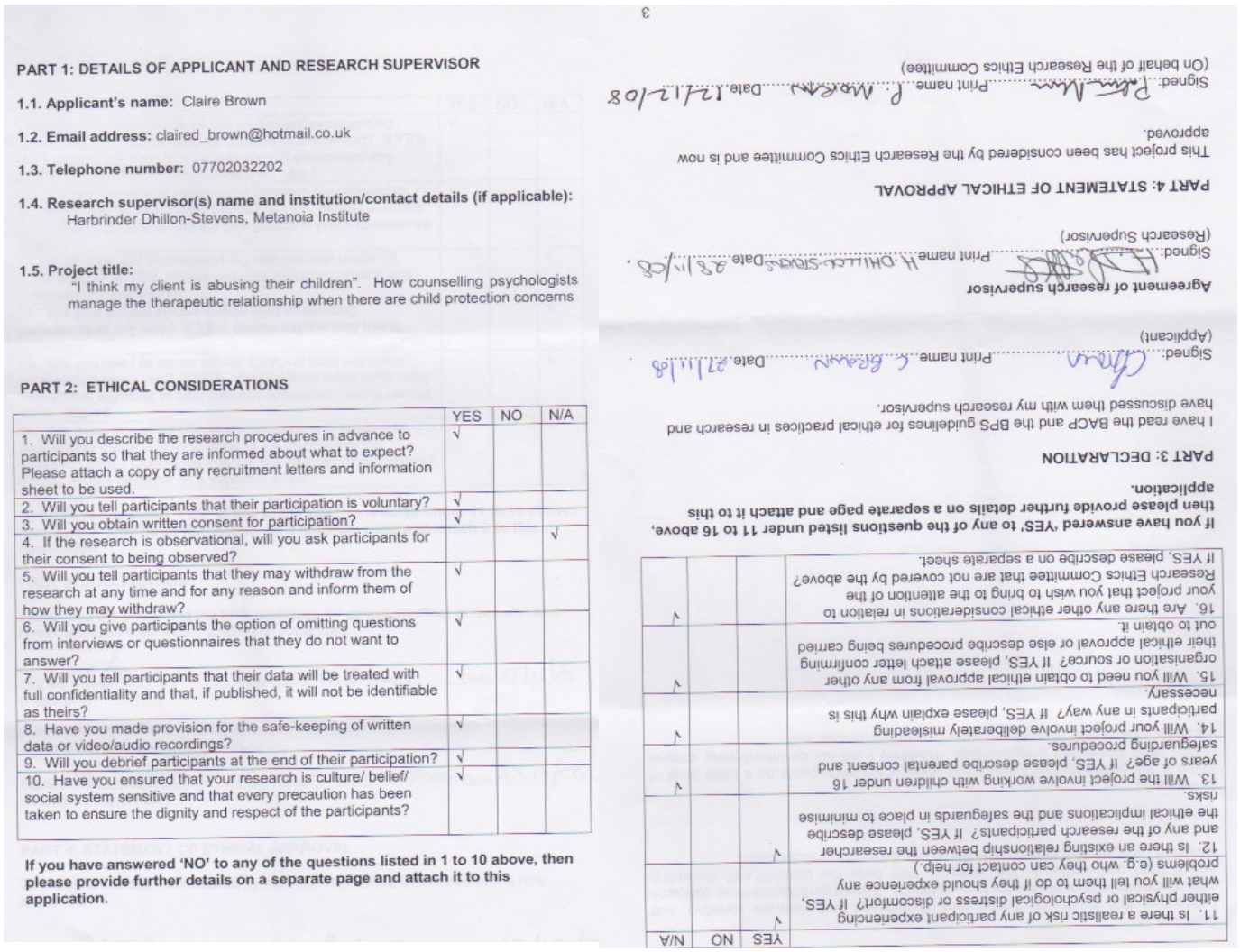
Appendix 1 – Ethics Approval Confirmation



PART 1: DETAILS OF APPLICANT AND RESEARCH SUPERVISOR

1.1. Applicant's name: Claire Brown

1.2. Email address: claired_brown@hotmail.co.uk

1.3. Telephone number: 07702032202

1.4. Research supervisor(s) name and institution/contact details (if applicable):
Harbrinder Dhillon-Stevens, Metanoia Institute

1.5. Project title:
"I think my client is abusing their children". How counselling psychologists manage the therapeutic relationship when there are child protection concerns

PART 2: ETHICAL CONSIDERATIONS

	YES	NO	N/A
1. Will you describe the research procedures in advance to participants so that they are informed about what to expect? Please attach a copy of any recruitment letters and information sheet to be used.	√		
2. Will you tell participants that their participation is voluntary?	√		
3. Will you obtain written consent for participation?	√		
4. If the research is observational, will you ask participants for their consent to being observed?			√
5. Will you tell participants that they may withdraw from the research at any time and for any reason and inform them of how they may withdraw?	√		
6. Will you give participants the option of omitting questions from interviews or questionnaires that they do not want to answer?	√		
7. Will you tell participants that their data will be treated with full confidentiality and that, if published, it will not be identifiable as theirs?	√		
8. Have you made provision for the safe-keeping of written data or video/audio recordings?	√		
9. Will you debrief participants at the end of their participation?	√		
10. Have you ensured that your research is culture/ belief/ social system sensitive and that every precaution has been taken to ensure the dignity and respect of the participants?	√		

If you have answered 'NO' to any of the questions listed in 1 to 10 above, then please provide further details on a separate page and attach it to this application.

	YES	NO	N/A
11. Is there a realistic risk of any participant experiencing either physical or psychological distress or discomfort? If YES, what will you tell them to do if they should experience any problems (e.g. who they can contact for help.)	√		
12. Is there an existing relationship between the researcher and any of the research participants? If YES, please describe the ethical implications and the safeguards in place to minimise risks.	√		
13. Will the project involve working with children under 16 years of age? If YES, please describe parental consent and safeguarding procedures.			√
14. Will your project involve deliberately misleading participants in any way? If YES, please explain why this is necessary.			√
15. Will you need to obtain ethical approval from any other organisation or source? If YES, please attach letter confirming their ethical approval or else describe procedures being carried out to obtain it.			√
16. Are there any other ethical considerations in relation to your project that you wish to bring to the attention of the Research Ethics Committee that are not covered by the above? If YES, please describe on a separate sheet.			√

If you have answered 'YES' to any of the questions listed under 11 to 16 above, then please provide further details on a separate page and attach it to this application.

PART 3: DECLARATION

I have read the BACP and the BPS guidelines for ethical practices in research and have discussed them with my research supervisor.

Signed: ..... Print name: C. Brown Date: 27.11.08
(Applicant)

Agreement of research supervisor

Signed: ..... Print name: H. Dhillon-Stevens Date: 28/11/08
(Research Supervisor)

PART 4: STATEMENT OF ETHICAL APPROVAL

This project has been considered by the Research Ethics Committee and is now approved.

Signed: ..... Print name: P. McKenna Date: 12/12/08
(On behalf of the Research Ethics Committee)

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Appendix 2 - Research Interview Schedule

"What was your experience of working with a client where you had concerns for their child's welfare?"

Main topics

1. Setting the scene: background of case e.g. length in therapy, presenting problems, how did concerns arise, nature of concerns
2. Impact on therapy: how did they manage concern, therapeutic alliance, transference reactions, cultural factors
3. Personal Impact: emotional impact, counter-transference, parental role, learning, confidence, experience,
4. Professional Support: use of supervision,

Introduction:
Thank you for agreeing to participate in my research; the interview will last approximately one hour. So, we are here to talk about your experience of having concerns for one of your clients' children.

1. **Perhaps you could start by telling me firstly, in what setting you were seeing the client and a little about the background of the therapy.**
   - *a)* What was the clients' presenting problem?
   - *b)* How long had you been seeing the client? At what point in the therapy did concerns arise?
   - *c)* How were your concerns initially aroused? What was the nature of your concerns?
   - *d)* Where there any cultural factors that were influential in this case?

2. **What was the impact of having these concerns on the therapy?**
   - *a)* What did you do with your concerns? Did you discuss them with the client?
   - *b)* How did the client respond to you bringing this into the therapy?
   - *c)* Did you need to involve external agencies? What was the impact of doing this? How did you involve the client in the process?
   - *d)* Were you able to work with your concerns in the therapy and if so, in what way?
   - *e)* How would you describe the therapeutic alliance with this client before the concerns arose? How did having these concerns influence the therapeutic alliance?
   - *f)* If there was a rupture in the alliance, how did you work with this? Were you able to repair the rupture?
   - *g)* Did the nature/focus of the work shift as a result of having these concerns, and if so how?

3. **How would you describe the impact of this experience on you personally?**
   - ***a)*** I'm wondering if you are a parent yourself? Do you think this influenced how you managed this experience and in what ways?
   - ***b)*** What did you notice in terms of your counter-transference reactions to this client
   - ***c)*** What was the emotional impact of working with such issues?
   - ***d)*** How confident did you feel in knowing how to deal with these concerns?
   - ***e)*** What do you think you learned from working this case?

4. Professional Support/Clinical Experience:
   - ***a)*** **How did you make use of the professional support available to you?**
   - ***b)*** What role did supervision play in managing your concerns?
   - ***c)*** How supported did you feel by your colleagues?
   - ***d)*** **What knowledge and experience, do you feel helped you in working with these**

concerns?

e) Have you had any previous experience in child protection that informed your practice with this client?

f) Have you undertaken any specific training courses that you feel helped you think about or work with this case?

Appendix 3 – Participant Information Sheet

Title of Research:
Between A Rock And A Hard Place: The Therapists' Experience Of Managing Concerns For Their Clients' Children

Introduction:
Thank you for your interest in taking part in this research.
Please be aware that participation in this research is entirely voluntary; the aim of this information sheet is to explain the purpose of this research, why you have been asked to participate and the risks or benefits in participation.
Upon completion of reading this information, you are welcome to ask any further questions. Assuming you agree to participate, you will be asked to sign a consent form.

Purpose of the research:
The aim of this research is to explore the phenomenological experience of the therapist who has concerns for their clients' children.
This research will also serve to fulfil criteria for a Doctor of Counselling Psychology and Psychotherapy by Professional Studies degree at the Metanoia Institute in collaboration with Middlesex University.

Why Me?
The reason you have been asked to participate is that you are a qualified counselling psychologist or psychotherapist, who has experience in the research area and are willing to share this.

What is being asked of me?
I would like to meet with you for one interview, which will last for approximately one hour. I will ask you to talk in detail about a specific case example where you have had concerns for your client's children.
I can be flexible in finding a location suitable for us both to meet, I do have a base in Thame, Oxfordshire, and Reading, however am willing to travel, within reason.
Participation in this research is entirely voluntary and so there will be no payment for taking part.
I will audio-record the interview, so that it can be transcribed; however the file will then be destroyed. After the interview I will provide you with a summary of the key themes that arose in our discussion for your agreement.
I will be publishing the results within my doctoral thesis, which shall be published following submission.

Confidentiality:
Confidentiality is very important so that you feel able to speak freely.
The interviews will be audio-recorded and will be stored on a password protected memory stick, which will be stored in locked storage, to which only myself will have access. There will be no identifying information attached to these recordings. These recordings will be destroyed once they have been transcribed.
The transcripts will not be identifiable by name, and will remain anonymous. My supervisor, Dr. (from Metanoia Institute) will have access to these transcripts in order to help me analyse the data, however they will not be able to identify you.

When the data is published, as part of the doctoral research project, the information will be unidentifiable and will be treated as confidential.

Potential Risks/Discomforts:
There is a possibility that participating in the interview may cause some discomfort, as child protection and welfare is a sensitive issue. Should any clinical issues arise as a result of the interview, I would direct you to your clinical supervisor for further advice. If you feel you need any further support on a more personal level, I would be happy to assist you in finding a suitable therapist to explore this further.

Potential Benefits:
The results of this study will provide valuable insight into the complexities of working with delicate child protection issues and I hope will be both interesting and helpful to other practitioners who may face such difficulties.
I also hope it will help raise awareness about the need to be mindful of child protection issues in work with adult clients.

Right to withdraw:
If at any point throughout the research you wish to withdraw from the project, please contact me and I can remove the data gathered in your interview. If there are any questions during the interview that you do not wish to answer, you have the right to omit these questions.

Individuals to contact:
Dr. will supervise this research; she can be contacted at the Metanoia Institute, 13 North Common Road, Ealing, London, W5 2QB.

Appendix 4 - Consent Form

Title of Research:
Between a Rock and a Hard Place: Research into the therapists' experience of managing concerns for their clients' children.

Researcher Name:

Participant Name:

- I have read the information sheet and have had the opportunity to ask any questions
- I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason
- I understand that the interview will be audio-recorded and then transcribed
- I understand that my name will not be used in any transcripts or data analysis
- I know that if I have any concerns following participation in the research, I am able to contact either the researcher or my clinical supervisor
- I agree to take part in the above named study

Participants signature
Date

Researchers signature
Date

Appendix 5 – Validity Check
Colleagues Notes:

emes	Interview 6 Transcript	Initial Notes
	So, at what point did you become concerned about his children?	
	I suppose I was listening to what he was telling me about the family, but it was just bits and pieces. And maybe about session 12, and I was always talking about it in supervision because I found him so difficult. He would tell me that he was disciplining his children and then he started to tell me that he'd only smack them if they'd been really, really naughty. At that point, he was kind of admitting that he smacked them in tandem.	
	Just out of anger?	
	Yes. So, I took that to supervision and we sort of looked at... Because I have smacked my children, and I remember going to therapy when my children were little and the therapist talking to me about it. It's not something I feel at all proud of, but at the time I was in a very Evangelical Church where smacking was promoted.	
	Okay, so there was religious...	
	Yes, sure, the rod and spoil the child' sort of attitude. The mentor I'd been given in this church, I actually was... I can't believe that I did it, to be honest, because I was her	
	smacking her children, before I had mine, with a wooden spoon. A wooden spoon was	

considered to be better than a hand for some reason I can't understand now, and I just found it so distressing to see her smacking her child with a wooden spoon. But I suppose I had my own guilt about smacking, so I didn't immediately start confronting him about the smacking. Because he was very difficult to work with and he was very avoidant, so it became obvious, two or three sessions on maybe, that anger... He started to talk about his wife and how she was pleased that he was coming to therapy and how his anger was lessening. So, we then started to talk a bit about his anger. Meanwhile, of course, all this time he's been telling me about his childhood, which was terribly, terribly abusive. His father was clearly, as I can say now with hindsight, very traumatised by things that had happened in his life in the war and so on and was very brutal to the client's mother. The client witnessed a lot of violence to his mother, he experienced a lot of violence himself, he'd had experiences when he'd tried to kill his father, and I think the first time I tried to talk to him about his children might be experiencing it was to ask him how it was compared to what it was like for him as a child. And he just said, "Well, you know, by comparison, they live in heaven. You know, it's nothing compared to what I experience." So, he couldn't see that maybe he was doing any...

He was doing any harm?

Any harm. Shall I just go on talking or do you want to ask me some more questions?

Carry on.

Appendix 5
Researcher's Notes

Themes	Transcript	Initial Notes
Therapist's use of listening Therapist's use of supervision to manage stuckness Client's use of physical punishment with kids Therapist's identification with client's behaviour Therapist's personal experience influence of religion on therapist's experience therapist's experience of smacking as distressing therapist's guilt limiting their ability to challenge the client Client difficult to work with Client had abusive childhood Therapist intervention to assess client's empathy for kids client's lack of insight	So, at what point did you become concerned about his children? I suppose I was listening to what he was telling me about the family, but it was just bits and pieces. And maybe about session 12, and I was always talking about it in supervision because I found him so difficult. He would tell me that he was disciplining his children and then he started to tell me that he'd only smack them if they'd been really, really naughty. At that point, he was kind of admitting that he smacked them in temper. Just out of anger? Yes. So, I took that to supervision and we sort of looked at… Because I have smacked my children, and I remember going to therapy when my children were little and the therapist talking to me about it. It's not something I feel at all proud of, but at the time I was in a very Evangelical Church where smacking was promoted. Okay, so there was a religious…? Yes, 'spare the rod and spoil the child' sort of attitude. The mentor I'd been given in this church, I actually saw… I can't believe that I did it, to be honest, because I saw her smacking her children, before I had mine, with a wooden spoon. A wooden spoon was considered to be better than a hand for some reason I can't understand now, and I just found it so distressing to see her smacking her child with a wooden spoon. But I suppose I had my own guilt about smacking, so I didn't immediately start confronting him about the smacking. Because he was very difficult to work with and he was very avoidant, so it became obvious, two or three sessions on maybe, that anger… He started to talk about his wife and how she was pleased that he was coming to therapy and how his anger was lessening. So, we then started to talk a bit about his anger. Meanwhile, of course, all this time he's been telling me about his childhood, which was terribly, terribly abusive. His father was clearly, as I can say now with hindsight, very traumatised by things that had happened in his life in the war and so on and was very brutal to the client's mother. The client witnessed a lot of violence to his mother, he experienced a lot of violence himself, he'd had experiences when he'd tried to kill his father, and I think the first time I tried to talk to him about his children might be experiencing it was to ask him how it was compared to what it was like for him as a child. And he just said, "Well, you know, by comparison, they live in heaven. You know, it's nothing compared to what I experience." So, he couldn't see that maybe he was doing any… He was doing any harm? Any harm. Shall I just go on talking or do you want to ask me some more questions?	Justifying hitting them with level of naughtiness use of supervision influence of religion own issues affecting therapy collusion of avoidance client experienced horrific child abuse client been a risk to others? Client's lack of insight

Appendix 6 - Master Table of Themes

		Participants					
		Sarah	**Lynn**	**Kate**	**Simon**	**Vicki**	**Sue**
1 Emotional Experience	1.1 Fear Factor	x	x	x	x	x	x
	1.2 Personal Bias	x	x	x	x	x	x
	1.3 Ambivalence	x	x	x	x	x	x
2 Professional Experience	2.1 Exact Line Isn't Clear	x	x	x	x	x	x
	2.2 Use of Supervision	x	x	x	x	x	x
	2.3 It Isn't Just Me	o	o	x	x	x	x
3 Relational Experience	3.1 Avoidance	x	x	o	x	o	x
	3.2 Directness	x	x	x	x	x	x

X = theme present, o = theme not present