

DClinPsy Thesis

Experiences of Ending Psychological Therapy: Perspectives of Young People
who are Looked After

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ABSTRACT

Background: According to the existing evidence base, the experience of ending therapy, from the perspectives of adolescents who are looked after, is substantially under researched. Moreover, the ending of therapy is highlighted as an important phase of the therapy process and previous research into ending therapy indicates this as a valuable area of research. The available literature indicates that those with a history of loss may find the ending phase particularly challenging. It was hoped that the research findings may assist Clinical Psychologists and other therapists to make sense of how young people experience ending therapy, and may also highlight ways in which therapists can support looked after young people through this transition.

Aims: The study aims to provide an in-depth understanding of the way in which young people who are looked after make sense of ending psychological therapy.

Methodology: Semi-structured interviews were conducted with six looked after adolescents who had recently ended psychological therapy. The transcripts of the interviews were then analysed using Interpretative Phenomenological Analysis (IPA).

Results: Four master themes emerged from analysis: inextricable link between therapy and therapy relationship, ambivalence, means of coping and moving on from therapy.

Implications and Conclusion: This study highlights the need for careful and on going consideration of the ending phase of therapy with this population. It also gives further support to the significance of the therapeutic relationship and consideration of this at the end of therapy. Areas for future research are highlighted, notably the value of conducting further research with looked after young people, to explore factors such as culture and gender on the experience of ending therapy.

INTRODUCTION

With regard to principles of qualitative research, I wish to begin my thesis by introducing myself, the researcher, and convey to the reader my interest in the topic of ending therapy from the perspectives of adolescents who are looked after.

Following this there will be a review of looked after young people and their mental health difficulties, including a discussion on attachment relationships and loss. I aim to introduce the reader to the topic of 'ending psychological therapy', including the experiences associated with this process and psychological theories which have been applied in this field. The relevant concepts will be discussed, including developments in the field. I aim to draw attention to the importance of focusing on ending therapy from the perspective of young people who are looked after. The chapter will conclude by introducing the aims of the current research.

Reflexive considerations

Reflexivity refers to awareness of how the researcher and the research process may have influenced the data and consequently the interpretation and analysis (Willig, 2001). By being transparent about my position, describing my beliefs and what I bring to this research, I hope to be clear about my influences and approach to this field. Furthermore, Elliot, Fischer and Rennie (1999) argue that being aware of one's own position and making this available to the reader, is an important aspect of qualitative research.

Me as a person.

I am 26 years of age and live in a small town where I have lived since childhood. Other than moving away to university, I have remained with the familiar, maintaining friends with old school friends and living close to family. I continue to form new relationships as my personal and professional life continues but as I form new connections, I don't tend to end or break other connections. Perhaps this is the beginning of my reflection of endings, change and connections.

My personal experience of ending relationships has been limited. On those occasions I remember a sense of loss and difficulty, adjusting to a life without those people around me. I continue to hold people in my thoughts. Through observing others' experiences of ending, I am intrigued as to how they manage and give meaning to the experience. Over time, I have observed how people experience relationships with people, both personally and, in my clinical practice, specifically how people end relationships.

I have always found myself interested in other people's experiences and what it must be like to live in the shoes of another. I have spent many hours people-watching, imagining what was happening in their lives and what brought them to where they were in life. I reflect that I have always been a curious person and feel this is a contributing factor to my interest in qualitative methodology.

My theoretical and epistemological position.

I have worked for the NHS in the field of psychology for six years. I am influenced by clinical training, work experience, family beliefs and values, all of which inform my theoretical orientation. I recognise that with the passage of time, experiences and meanings may alter and change, yet no one story is more valid than another.

During my Clinical Psychology training I have been influenced by social constructionist approaches, taking value in a multifaceted, fractured worldview, consisting of individual stories and constructions (Burr, 2003). Consequently, I tend to disagree with the tenets of positivism or realism. I align myself with ideas that consider there to be multiple, fluid and changing truths, which are construed as relative to different historical, cultural or social factors (Burr, 2003). In line with such an approach, I view research as an active process of exploration in which researchers are not detached observers. This research has therefore been approached in this manner.

I describe my theoretical orientation as eclectic and tend to draw on a wide range of models and theories in my thinking, principally systemic and narrative approaches. I value approaches that attempt to identify strength and resilience,

rather than a problem orientated focus. I tend to look for exceptions to difficulties, akin with narrative approaches.

How I came to this study

My interest in ending psychological therapy began on my first placement on the Doctorate of Clinical Psychology course. Coming to the end of my first placement, I felt overwhelmed by the process of ending therapy with a number of clients at once. I was struck by the range of responses that clients expressed, both verbally and in their behaviour. My interest continued to develop throughout clinical training and I became increasingly aware of the impact of psychological and social factors in the response to therapeutic process and engagement.

In my second year of clinical training, I worked on placement in a child and adolescent mental health team, which had links with a looked after children's service. This experience led me to realise that a large proportion of therapeutic work with looked after young people was establishing a therapeutic relationship and fostering attachment relationships. I was intrigued to consider how a young person comes to experience the therapeutic relationship and, after the process of developing such a relationship, how they then experience the ending of that relationship. Consulting relevant literature revealed that little was known about how looked after young people experience therapy generally, and very little was known about how they experience ending therapy. This also revealed that there was much therapist speculation about what it was thought the young persons' experience, but the views of young people themselves were often neglected.

I approached this subject with curiosity about what it was like for looked after young people to end therapy. I wondered how their life experiences and constructions impacted on their experience of this phase of therapy.

My interest in looked after young people and ending therapy therefore led me to develop this study. I hoped to draw attention to what can be learnt from hearing young people's experiences. I hoped that this study would reveal ways in which therapists may work with young people to maximise gains of therapy, in which is guided by the young people themselves.

BACKGROUND

A systematic literature search was conducted over an 18-month period ensuring comprehensive coverage of the relevant topics and minimising the potential for bias. The search comprised a number of stages ranging from a generic search of the literature using key terms, to a more specific search according to inclusion and exclusion criteria (See Appendix 1 for details). This formed the basis for the succeeding chapter.

The term 'Looked After Children' (LAC)¹ refers to children and adolescents who are provided with substitute care, either on a voluntary basis to assist parents, or as the result of a court order (Children's Act, 1989). It covers all young people living in public care, including those in foster or residential homes and those still living at home with their parents, but subject to care orders (Polnay & Ward, 2000). According to a recent survey, there are 65,520 LAC in England, with the majority of them aged ten or over (Department of Education, 2011).

Children are looked after for a variety of reasons, and are considered for placement in care when their parents are unavailable or unable to meet their needs for safety, care and control (Carr, 1999). However, the main starting points for 54% of these children are abuse and neglect (Department of Education, 2011). Abuse can be physical, emotional and/or sexual. Other reasons include breakdown in family support, behavioural difficulties and family dysfunction (Department of Education, 2011). These findings highlight the varied and challenging early experiences for many LAC.

The most common care option throughout the UK is foster care, with 74% of LAC in foster placements (Department of Education, 2011). Sixteen percent of young people in care have had experience of three or more placements during one year, with placement breakdowns more typical of older children (Ford, Vostanis, Meltzer & Goodman, 2007). Such statistics indicate that many LAC, particularly adolescents, will be subject to periods of instability and subsequent disruptions to caregiving relationships.

¹ The abbreviation 'LAC' will be used from this point forward to describe 'looked after young people', including children and adolescents.

LAC and attachment relationships

As the research in attachment theory has been extensive, it will not be possible to provide a comprehensive summary of all the available literature. Instead, this section gives a brief overview of the main ideas relevant to this research. For a comprehensive understanding see Cassidy (2008). Attachment theory has been cited to account for processes associated with ending therapy, and this will be discussed later.

Attachment theory focuses on the child as part of a dyadic relationship, emphasising the mother-child relationship. Research has suggested that early interactions in the dyadic relationship impact on how individuals understand, react and relate to others, shaping the formation of mental representations of attachment-related interactions (i.e. internal working models: IWMs) that guide future attachment interactions (Ainsworth, 1989). Attachment theory therefore posits that the earliest years of a child's life are critical for later development.

Bowlby (1988) claimed that human beings have a biologically based attachment system and consequently, the theory directs us to understand relationships as affecting all humans, encompassing all cultural boundaries, and/or ethnic child rearing practices. While it is accepted there are nuances of attachment relationships which might differ across cultures, and some attachment concepts might have some cultural bias, overall, attachment theory appears to have significant applicability across cultures (Music, 2011).

Attachment classification in children was pioneered by Ainsworth, Bellar, Waters, and Wall (1978) whom reported evidence of secure and insecure attachments using the Strange Situation. They explored the response of 12-month old infants to novelty and to separation from and reunion with the mother (i.e. an attachment figure). From this, Ainsworth and colleagues identified three attachment styles; (A) insecure-avoidant, (B) secure, and (C) insecure-ambivalent. An insecure-avoidant style was noted in children who explored the environment without referring back to the caregiver, and were unperturbed by their parent's

exit and return. By contrast, secure children used the parent as a secure base when exploring the environment, became distressed at separation and sought contact with the parent on their return; they were easily comforted by the parent and returned to exploration. Insecure-ambivalent children focussed on the parent; they were unable to explore, became distressed when the parent left and were not easily comforted by the parent on their return, appearing angry or passive. A fourth attachment style was later identified as (D) insecure-disorganised (Main & Soloman, 1990), attributed to infants who failed to show a repeatable pattern of behaviours. Children in this category were typically assigned to one of the other categories also (Lyons-Ruth, & Jacobvitz, 1999).

An insecure-disorganised attachment is the pattern most associated with poor psychosocial outcomes and is more prevalent in LAC (31% compared with 15% of non-adopted: Van den Dries, Juffer, van Ijzendoorn & Bakermans-Kranenburg, 2009). However, a similar number of LAC also showed secure attachment. One of the major criticisms of attachment classification in relation to LAC is the subjective nature of assessment, which can lead to the over-diagnosis of attachment disorder² in this population (Barh, Crea, John, Thoburn & Quinton, 2005). Given the debate regarding the taxonomy of categories, this introduces important questions for attachment typologies and the validity of specific attachment styles associated with groups of people such as LAC (Fraley & Spieker, 2003). Variation in attachment patterns is therefore seen as continuous, not categorical (Fraley & Spieker, 2003).

There is growing research in the field of neuroscience to indicate that early relationships don't just affect our behaviour, but shape our brains in the process

² There is broad consensus that the disorder results from inadequate caregiving environment and encompasses two clinical patterns, an emotionally withdrawn inhibited type and an indiscriminately social/disinhibited type.

(Gerhardt, 2004). Evidence has indicated that the newborn baby is an ‘external foetus’ in which physiological and chemical systems are still being formed (Gerhardt, 2004). This is now a commonly accepted standpoint in early development literature and provides empirical support for the significance of attachment relationships. In relation to the current research, this highlights how LAC may come to learn what to expect from others in close relationships, such as the therapy relationship, from early experiences of abuse and neglect.

Whilst attachment difficulties are not an inevitable consequence for LAC, many are likely to have greater exposure to weak or broken attachments characterised by rejection (Howe & Fearnley, 2003). It is believed that many LAC may experience issues with attachment to some degree (Guishard-Pine, McCall & Hamilton, 2007). Regrettably, once in care, some LAC experience a variety of placements and professional input, resulting in further disruption to their attachment relationships. Attachment relationships are seen to play an important role in the aetiology of mental health difficulties (Bowlby, 1969, 1973).

Howe and Fearnley (2003) demonstrated the clinical applicability of attachment theory and understanding relationships in LAC. They drew on a growing body of knowledge (empirical, theoretical and clinical) to propose that LAC take different pathways to relationships, which are dependent on the type of early experiences they have endured (Howe & Fearnley, 2003). An interesting concept they discussed is that, when children have experienced a world of unpredictability and violence, they tend to avoid being cared for – for them, care implies danger, abandonment, rejection and hurt. They suggested that many LAC will have developed strategies such as control and avoidance when forming new relationships, resulting in them aiming to control and not engage with people (Howe & Fearnley, 2003). This highlights an association between attachment experiences and how young people may come to experience the therapeutic relationship.

Attachment theory is a broad theoretical model, which has long been debated in the literature. Early tenets of the model have received considerable criticism and have therefore been subject to review and modification. Notably, the legacy of early experiences on development has long been debated (Fraley,

Roisman & Haltigan, 2012). In 1976, Clarke and Clarke published a noteworthy account demonstrating that early experiences do not necessarily leave an immutable mark on people's lives. Contrary to traditional psychological perspectives, the authors argued that the effects of early experiences are just the first steps in an on-going and complex life path, on which the shaping or re-shaping of development can occur in any period (Clarke & Clarke, 2000). Furthermore, evidence has indicated that shifts in attachment classification are related to corresponding changes in mother-infant interactions and/or other key factors such as separation, loss and the development of other attachment relationships, such as romantic partners (Shaver & Fraley, 2008).

This reinforces the position that people can learn new ways of relating, reflecting a limitation of focusing exclusively on the early attachment experiences. However, such conclusions have been challenged, with researchers citing evidence that, in fact, the legacy of early experiences can be observed in many domains (Sroufe, Egeland, Carlson, & Collin, 2005). This is consistent with recent neurodevelopmental research, which would seem to suggest that early experiences can- and do- play an enduring role in human development (Gerhardt, 2004). Fraley et al. (2012) have concluded that the notion that early experiences may play an important role in human development is just as controversial today as it was decades ago. This acknowledgment may be particularly important for the current investigation as it demonstrates that early experiences may or may not play an influential role in how young people experience the therapeutic relationship, and specifically, the ending of that relationship.

Despite major limitations, attachment theory, with an emphasis on recent developments, may be helpfully applied to the understanding of therapeutic relationships and has formed a foundation for novel therapeutic interventions, particularly within the LAC field. As Schofield and Beek (2005) comment, attachment theory continues to offer a scientifically rigorous and yet practical framework for making sense of children's troubled and challenging behaviours.

LAC and experiences of loss

Many people are exposed to loss or potentially traumatic events at some point in their lives (Bonanno & Kaltman, 2001). Not only are LAC likely to have exposure to weak or broken attachment relationships, they are likely to have experienced a number of losses and separations both pre and post care, for example, the experience of loss of parents, siblings, extended families, carers and professionals.

Lee and Whiting (2007) proposed that our work with LAC should be guided by a focus on loss. They highlight that foster care is rife with circumstances where the losses are not clear-cut and final, with a lack of information creating uncertainty and anxiety for young people (Lee & Whiting, 2007). In support of this view, Many (2009) identified a link between loss and ending therapy, claiming that traumatic loss histories make the task of ending therapy more challenging. It may be possible to argue here that the experience of ending therapy for LAC may be a valuable area for research. Specific models of loss, in regard to ending therapy, will be discussed later.

The vulnerability of LAC towards developing mental health difficulties

LAC share many of the same health risks and problems as their peers, but often to a greater extent (Department of Health, 2009). McAuley and Young (2006) identified that this is because the difficulties faced by LAC are the result of a complex interaction of past and present experiences, including their childhood experiences (e.g. abuse, loss, neglect and lack of adequate parenting), disruption of attachment relationships and their experience of being in the care system (Tarren-Sweeney, 2008; Ward, Jones, Lynch & Skuse, 2002).

Bentovim (1998) argued that there are three core areas of children's development affected by abuse; (1) the development of attachment, (2) the regulation of emotional states, and (3) the development of an adequate sense of self and relationships. Such difficulties could precipitate a need for referral to services, but also impact on the young person's relationship to help. Furthermore, LAC are less likely to benefit from protective factors such as a secure and stable

home and a sense of connectedness. All of these can buffer a person against mental health difficulties (Carr, 1999).

Concept of resilience and LAC

It is important to highlight that attachment disruptions, loss and vulnerability to mental health difficulties are not the case for all LAC. In regard to research which debates the impact of early life experiences on later development, the concept of resilience may play an interesting role. Resilience refers to a person having the capacity to resist or 'bounce back' from adversities (Gilligan, 2000). It is the ability to remain positive in face of adversity, which is not the same as not having distress. Such research underscores central themes of the positive psychology movement (Seligman & Csikszentmihalyi, 2000). This approach has gained considerable support in recent years and is defined as the science of positive subjective experience.

Rutter (1985) proposed that resilience should be understood in terms of processes and mechanisms rather than focused simply on lists of factors or characteristics. It is thought that the same variable may appear protective in one situation, but become a source of risk in another. Mechanisms that predict resilience are not only within-child factors (for example, high levels of cognitive ability), but also include within-home factors (for example, high parental socio-economic status and education), and outside-home factors (for example, high levels of support and high teacher expectations) (Fonagy, Steele, Higgitt, & Target, 1994).

On the one hand, evidence seems to suggest that LAC may lack resilience because of the high levels of need and poor outcomes often associated with this population. However, on the other hand, recent research has demonstrated that LAC hold more positive self perceptions than non-LAC; which is suggested to be a protective factor linked to resilience (Honey, Rees & Griffey, 2011). Furthermore, developmental psychologists have shown that resilience is common among children growing up in disadvantaged conditions (Masten, 2001). A longitudinal study revealed that, independent of adverse early experiences, a range

of factors and processes appear to enhance or threaten the stability, progress and resilience of children in long term foster care (Schofield & Beek, 2005).

The available research therefore indicates a complex interplay between LAC and resilience processes, demonstrating the potential for multiple and varied pathways to development. The value of this research, together with other reports on resilience, is hopeful and demonstrates that not all LAC experience these damaging patterns of development. This position seems to suggest that their resilience may protect them from the adverse experiences of ending therapy, which may prove challenging for other people. This leads me to a position of curiosity as to how they may experience ending therapy, and seems to oppose the viewpoint that typifies ending as a challenging experience for LAC.

Prevalence of mental health difficulties for LAC

It is recognised that LAC are more likely to be at risk of developing mental health problems (Golding, 2003; McCann, James, Wilson & Dunn, 1996; Rodrigues, 2004). An extensive study by the Office of National Statistics (ONS) (Meltzer, Corbin, Gatward, Goodman & Ford, 2003) gathered information on more than 1000 5 – 17 year-olds looked after by 142 local authorities in England. The findings revealed that 45% were assessed as having a mental disorder; a four-fold increase compared to children living in private households (Meltzer et al., 2003). This survey was the first national survey of its kind and demonstrates a new field of understanding and recognising the mental health needs of LAC nationally.

There is a slight gender bias in the research with 55% of 11 – 15 year old boys in care experiencing mental health difficulties, compared with 43% of girls (Meltzer et al., 2003). Such a variation could be explained by recent research which has identified that girls tend to have more protective factors than boys and may therefore be more resilient to the development of difficulties (Honey et al., 2011). Outside the UK, similar rates of heightened risk of mental health difficulties for LAC are reported in Europe, North America and Australia (Tarren-Sweeney, 2008). Such findings demonstrate that, whilst a large number of LAC

do not experience mental health difficulties, the vulnerability to difficulties is fairly consistent cross-culturally.

The likelihood of developing a significant mental health difficulty is greater during adolescence than at other stages in the life course (Goodman & Scott, 1997). This is consistent for LAC (Amsden, Pecora, Payne & Szatkiewicz, 2000). However, this apparent age effect could be confused by the ages at which children enter care. Children who have entered care at an older age will probably have poorer pre-care mental health, a greater number of placement moves and are less likely to be adopted from care (Tarren-Sweeney, 2008). The increase in the number of people reported to be experiencing mental health difficulties and the heightened vulnerability in adolescence highlights the need to consider the quality and efficacy of mental health interventions for this age group (Audit Commission, 1999).

Mental health services for LAC

Despite their vulnerability and high levels of need, only a small percentage of LAC access mental health services (Mount, Lister & Bennun, 2004). Promoting their mental health and emotional well-being continues to be a key priority for the Coalition Government (House of Commons, 2011). Emphasis has been placed on the need for dedicated services for children and young people. This is reflected in the policy perspectives and guidance in the National Service Framework for Children (NSF, DoH, 2004), Care Matters (DfES, 2007) and Every Child Matters (DfES, 2005). The NSF (DoH, 2004) proposed that although progress has been made in providing appropriate, accessible Child and Adolescent Mental Health Services (CAMHS) for LAC and their carers, further work is needed to ensure this progress is maintained and extended.

Tarren-Sweeney (2010) proposed that it is time to re-think mental health services for LAC. In their paper, they proposed ten key principles to guide the design of mental health services. A key principle they outlined is the need for specialised practice in this area, including the need for appropriate conceptual frameworks for formulating complex attachment and trauma-related disorders that determine the mental health of children with a history of care or maltreatment. To

support their proposed principles, further research is needed for LAC and the kinds of adaptations that may need to be considered when working therapeutically with this population. This reinforces my argument for the potential value of further research with LAC and their experiences of therapy, including ending therapy.

Psychological interventions used with LAC and the therapeutic relationship

The Cocker (2004) review highlighted that services for LAC are mostly provided by Social Workers and Clinical Psychologists. The most common type of therapy, as described by the clinicians surveyed, was the use of non-specific therapeutic techniques, followed by family therapy. This review failed to explore the views and wishes of LAC, namely if this approach to therapy was useful and positive. Furthermore, the term 'non-specific therapeutic techniques' did not appear to be clearly defined by the researchers.

Outcome research has shown that the majority of children and young people undertaking therapy make improvements (CORC, 2009). Research obtained using qualitative approaches demonstrated that LAC consistently reported positive therapy outcomes (Davies & Wright, 2008). Despite promising outcomes, understanding of how people experience therapy and, in particular, ending therapy has been limited, especially from the perspective of LAC.

Attachment interventions are commonly associated with LAC because of the prevalence of attachment disruptions in this population. Bowlby (1988) emphasised the importance of constructing or reconstructing working models of self and attachment figures. More recently, researchers have identified adolescence as a crucial period at which to target intervention, as developmental changes may allow internal working models to be revised and consolidated (Crittenden, 1997). The value of this research is that it highlights the importance of ensuring that relationships formed during this stage, such as therapeutic relationships, are considered and thoughtful.

Dan Hughes (2005) has pioneered the use of attachment focused treatment specifically for foster and adoptive families; Dyadic Developmental

Psychotherapy (DDP). Similar to Bowlby's aims, this approach emphasises facilitation of a safe secure environment in which the child can begin to explore the world. Hughes (2004) proposed that LAC have possibly experienced clinicians as inconsistent, abusive, uncaring and not to be trusted. Therefore attempts to engage may be met with resistance. The role of the therapist is highlighted as pivotal to this approach; adopting an attitude of playfulness, acceptance, curiosity and empathy (Golding & Hughes, 2012). There has been some evidence in support of this approach, demonstrating that for those who received DDP there was significant improvement in difficulties (Hughes, 2005).

Attachment focused interventions typically emphasise the importance of the therapist-client relationship. The development of the therapeutic relationship is common practice among many treatment models and empirical research supports how it benefits the process, particularly with individuals who experience trauma in their lives such as poor early social relationships (Paley & Lawton, 2001). In support of this view, Mann (2005) conducted an in-depth qualitative study using IPA methodology to explore how LAC experience mental health services. Amongst a broad range of findings, this study revealed that LAC reflect on the uniqueness of the therapeutic relationship, which seemed to offer a degree of consistency often lacking in other areas of their lives. This study demonstrates the importance of the therapist relationship with LAC. Although this study is unique in that it explored the views of LAC exclusively, the focus on the therapy process itself, such as ending therapy, was not within the scope of their study. Furthermore, this was an unpublished thesis and although it has been examined it may not have been extensively peer-reviewed and therefore its quality may not be assured. To ensure therapy adequately addresses the needs of LAC, it is argued that further research is needed to explore their experiences of the therapy process itself.

The concept of the therapeutic alliance has developed great emphasis in recent years as the important ingredient in the therapeutic process of psychotherapy for different patient populations (Paley & Lawton, 2001). Many treatment models for LAC, such as DDP, focus heavily on developing a strong therapeutic relationship with clients to facilitate change. This is also the aspect of therapy valued by LAC themselves (Mann, 2005). This leaves me questioning

how therapy, based on activating attachment relationships, and developing strong therapeutic relationships, is negotiated and ended for this population. From an ethical standpoint, I wonder what consideration is given to how this is managed and facilitated to support the young person through the transition of ending therapy.

There has also been concern about the potential for psychotherapy to harm children and young people in care. Fonagy and Bateman (2006) postulated that, for adults with borderline personality disorder, psychotherapy might be harmful, due to the impaired mentalisation capacity and the activation of attachment systems within a therapeutic alliance. Tarren-Sweeny (2010) concluded that if this speculation is true, then a sizeable proportion of young people, who have complex attachment related difficulties, could be vulnerable to experiencing harmful effects from common psychotherapies. From an ethical standpoint, this emphasises the need for further research into the effects and impact of psychotherapy on LAC, including a need for better informed treatment planning for these young people.

Ending therapy

Therapy involves the paradox of building authentic relationships with service users, with the relationship also having a defined ending. Termination of therapy is a transition in which therapist and client must move from working together to going their separate ways (Gutheil, 1993).

The ending phase of therapy has been well researched, with findings highlighting its paramount importance. Friestein (1974) found a distinct, qualitative difference between the termination phase and the rest of the therapy process. Weddington and Cavenar (1979) proposed that therapy termination is the most important phase of therapy and has the greatest potential for mastery based growth. Furthermore, Coltart (1993) suggested that it is the suffering caused by ending which most fully tests the value of therapy itself. These findings demonstrate the complexity associated with this phase of therapy, highlighting the need for specific research on this topic.

Psychological theories used to understand processes of ending therapy.

The literature reveals a relatively vast account of psychological theories and models, which have been used to account for the processes of ending therapy. Due to the breadth of available literature, only those deemed relevant to the experiences of LAC will be discussed. It is recognised that other accounts are available. It is important to mention a body of research which will be excluded from this review, relating to existential theory. Although I acknowledge existential theory as a potentially relevant addition to this literature review, my rationale for its exclusion is based on the little available research which has focused specifically on how this theory helps to understand the processes of ending therapy for LAC.

Although it is recognised that there may be overlap between the following perspectives, they have been delineated for ease of reading.

Psychoanalytic perspective.

Much of the early literature on ending therapy is from a psychoanalytic perspective. The traditional view is that ending therapy is a powerful, intense and particularly painful experience. Early theories focused on clients' emotions as defensive reactions and this belief is evident in the recent approach of cognitive analytic theory. For example, it has been theorised that if ending of therapy were approached with the absence of anxiety and disappointment, this would suggest the reality of the end is not yet felt by the patient (Ryle & Kerr, 2002). Theories of psychological defences and regression seem prominent in these accounts. Much of the earlier literature was heavily based on descriptions of negative client reactions to ending therapy, describing a difficult, if not traumatic experience. However, Kramer (1990) proposed that, if we are taught that the ending of therapy is significant, this is portrayed to clients. It is the legacy of psychoanalysis and may not necessarily be relevant to current therapy approaches.

Cobb (2007) attempted to address some of the early assumptions and sought to elicit the clients' perspective of the process. Data was gathered from questionnaires completed by therapists and client dyads immediately following

their final session. This research demonstrated that ending therapy can involve positive experiences for the client, and the process of ending therapy was not usually the traumatic struggle suggested in traditional literature.

Cobb (2007) has critiqued their study for the method of data collection, recognising that by inviting therapists to consider this prior to the end of therapy, may have led therapists to subconsciously attend to the therapy termination, hence changing the nature of experience. Although this research is not without its flaws, it challenges traditional psychoanalytic perspectives. Furthermore, this position is supported by research that demonstrates symptom reoccurrence is the least common reaction to treatment termination, therefore challenging older perspectives that clients regress (Fortune, Pearlingi & Rochelle 1992). Therefore, although it seems psychoanalytic theories have received much attention in the ending therapy literature, this position lacks strong support in contemporary literature.

Models of loss.

A number of researchers have drawn on people's experiences of loss to help understand their reactions to ending therapy (Gould, 1977; Many, 2009; Quintana, 1993). Despite the universal nature of the experience of loss, it appears that no one theory, or predicted trajectory for bereavement or grief dominates (Bonanno, 2001). It seems that themes and trends in grief and bereavement are not definitive; a position supported in review papers (Bonanno, 2001; CAH, 2004).

Studies indicate that clients' previous experiences of loss have been found to make therapy termination more difficult (Gould, 1977). In support of this view, Many (2009) proposed that termination of therapy with children who have a history of poor disruptions and losses, provides a unique opportunity for the clinician to provide the child with a new experience of loss, "which is controlled, predictable and paced" (p.23). From this experience, Many (2009) suggested that the child develops a new model for loss, which permits for losses that are a natural part of healthy growth and change. However, it is argued that, if not processed and explored meaningfully, the termination can come to represent another example of

traumatic loss. This raises the importance of ending as a principal part of the therapy process for people who have experienced a number of losses.

Such claims indicate termination as pivotal in supporting the child's development of trust in the stability of future relationships. Despite highlighting the importance of this phase of therapy, this research is based on therapist speculation rather than from the perspective of young people themselves. They argued that further and more extensive qualitative research regarding children's perspectives of ending therapy would be beneficial in order to add to the knowledge base (Many, 2009). This would help to understand the emotional and sense-making processes underlying the experience, which might help to clarify and elucidate the process.

This leads me to be curious as to how experiences of loss may impact on the experience of ending therapy from the perspective of LAC, many of whom are well rehearsed in the process of loss. At present, it appears they may be described as experiencing future losses as challenging and traumatic, unless explored meaningfully by those around them. This seems to neglect the body of research in relation to resilience and LAC.

The discourse of loss seems to have dominated thinking in relation to endings. This seems to be based on the assumption that loss is inherent in all terminations. From a critical standpoint, I question whether other processes are also evident, a viewpoint which is supported by research demonstrating that ending can involve positive experiences (Baum, 2005; Cobb, 2007).

Quintana (1993) attempted to review the traditional model of understanding endings, specifically the 'termination as loss model'. This conceptualisation of endings suggests that clients and psychotherapists experience termination as a difficult process, in which symptom relapse is probable. Quintana (1993) identified that the other aspect of the traditional model that has received little attention is the 'termination as development' component. He argued that this limits our understanding of endings. Quintana (1993) demonstrated that the predictions that termination is inherently a crisis for clients and therapists, namely the component of 'termination as crisis', were not confirmed in research. For example, Marx and Gelso (1987) demonstrated that most clients in short-term

therapy were satisfied with termination (65%), compared to only a small minority (10%) who were dissatisfied.

Quintana (1993) therefore proposed that a review of this model was necessary, concluding that a conceptualisation of ‘termination as transformation’ metaphor seemed a helpful addition. Within this model, termination is seen to serve as a catalyst for growth, crystallising the process of psychotherapy and one’s personal growth. Empirical evidence has been provided for the component of ‘termination as transformation’. This model challenges older perspectives that clients regress and experience this phase as difficult. This conceptualisation of ending is consistent with theories emphasising the process of internalisation. In this view, clients transform real or imagined characteristics of the therapy environment into inner characteristics, which then are available as representations beyond the end of therapy (Schafer, 1968).

The traditional model of loss was therefore revised to include this element of transformation and is argued by Quintana (1993) to incorporate current theory and research, as well as critical aspects of the traditional approach to termination. This assertion potentially highlights an interesting and novel idea in the context of traditional models and demonstrates a multifaceted account of endings. However, the model proposed was based on adults’ experiences of short-term therapy, which therefore limits the transferability to other populations.

Attachment perspectives.

Bowlby (1973) used attachment theory to help explain emotional distress following unwilling separation and loss. Although he was primarily concerned with understanding infant-caregiver separations, he considered other pair-bond relationships within the same theoretical framework (Shaver & Fraley, 2008). Robertson and Bowlby (1952) explored the link between separation and psychopathology and identified a predictable pattern – one of angry ‘protest’ followed by ‘despair’ and eventually ‘detachment’. A limitation of this traditional focus is that it assumes that the relationship with the caregiver served as a source of safety; however, children exposed to abuse or neglect may have alternative processes for separation and detachment. This model is therefore limited in its

acknowledgment of individual differences, which is considered a major limitation within the current research, given the early experiences associated with many LAC.

More recent research has focused on the link between attachment styles and people's experiences of relationships. The work of Bartholomew and Horowitz (1991) is helpful here. They demonstrated that people with attachment difficulties are seen as having an immense fear of losing relationships, once established. In the child's mind, they witness a repeat of the painful rejection, loss and abandonment of relationships. This pattern is determined by their early experiences and formation of internal working models.

Reder and Fredman's (1996) research lends support to the link between early experiences and behaviours in caregiving relationships. They used the phrase 'relationship to help' to describe the concept that clients and professionals bring, to their relationship with each other, beliefs about the helping process which can significantly influence the outcome of therapy. They observed that people's 'relationship to help' could be a repetition of earlier family relationships. They make reference to the 'relationship to help' as occasionally interfering with termination of treatment. A value of this research is the acknowledgment of a broad range of factors contributing to the experience, rather than focusing on the early attachment experiences exclusively. This research reinforces the utility of exploring people's relationships and the impact of this on the therapy process, including the ending phase of therapy.

Transitional perspectives.

Some researchers (Lanyado, 1999; Pedder, 1988; Wittenberg, 1999) have preferred to conceptualise ending therapy as comparable to a 'weaning process' rather than a 'termination' which implies finality and often irrevocability. Lanyado (1999) likened the ending of therapy to the developmental task of 'letting go'. This is contrasted with the process of 'holding' the child in mind which is central to the therapeutic task. The balance of loss and gain is seen as a transitional experience intrinsic to many life transitions and it is advocated that ending therapy is therefore seen as such, rather than stark beginnings and endings.

Whilst there is much to be learnt from literature on adult patients, Lanyado (1999) identified that many of the processes are not comparable to the child experience of ending therapy. This demonstrates a need to think specifically about ending therapy from the child and adolescent perspective. This research points to the positive gains made possible during ending therapy, which can be seen as a 'transition' rather than 'event', alongside the challenges of this phase.

Systemic perspectives.

Ending therapy has long been considered in the systemic literature. Boscola and Cecchin (1980, cited in Campbell, Draper & Huffington, 1992) postulated that ending therapy arises when clients recognise that they may continue to have problems, but that these are no longer psychiatric problems, but problems of living. Building on this concept, Campbell et al. (1992) wrote that within systemic therapy the end of therapy is considered when "either party begins to feel there is no problem, or that the problem will not be solved with this approach" (p.71). This approach recognises the influence of the therapist on the ending process. From a narrative therapy perspective, White and Eptson (1990) view ending therapy as a rite of passage and consequently have adopted approaches such as prize giving and letters to mark the end of therapy.

More recently, Fredman and Dalal (1998) introduced concepts of systemic principles to understand the process of ending therapy. They outlined ideas and beliefs about ending therapy, which they gleaned from the systemic literature, incorporating those ideas described above. They proposed that therapists and clients bring to the therapeutic encounter a collection of stories about endings which are drawn from a number of contexts both professional and personal. They organised these ideas according to different 'discourses', each a cluster of stories about endings which gives meaning to the therapeutic relationship and influences people's actions in the final stages of therapy (Fredman & Dalal, 1998). They proposed five discourses which relate to the therapeutic relationship and activity at the end of therapy: ending as loss, ending as cure, ending as transition, ending as relief and ending as metamorphosis. These discourses represent a range of

narratives about endings which have different implications for the therapy process.

The value of this research is the link between beliefs about endings and how this impacts on the therapy process. They acknowledged that the discourses are not an exhaustive nor mutually exclusive list of approaches to ending, but rather represent a range of themes about endings. This led me to consider the ideas and beliefs which may contribute to discourses of ending therapy for LAC. Given the unique early experiences of LAC, notably the prevalence of experiences of loss, it is unknown how this study relates to the specific population of LAC.

Summary of models.

To conclude, the current literature reveals a number of theories and psychological models which have been used to account for the processes associated with ending therapy. Each theory presents an alternative perspective to the process of ending therapy, and brings different elements of the experience to the fore. Despite this, there continues to be little consensus or comprehensive account as to how LAC may experience ending therapy, particularly from the young people's perspectives. Overall, the research highlighted here presents us with a strong call for further research in this field.

Eliciting young peoples views on therapy

There is currently support for the inclusion of children and young people in the development of mental health services and therapy process. Bassett (2010) argued that in the past, research generally has been conducted *on* children. More recently there has been a move towards research *with* children, engaging them as active participants, recognising their rights, respecting their autonomy, and giving them a voice (Grover, 2004). There is now great emphasis on creating an equal partnership between the users of services and the services themselves. It is argued that eliciting the views of LAC specifically is important because of the complexity and nature of their problems (Mental Health Foundation, 2002). A large-scale review of the literature for LAC identified that young people need to be listened to

and their views kept central to the development of planning and delivery of services (Mental Health Foundation, 2002).

Employing qualitative methodology to explore LAC's views

Traditionally, research with LAC has been limited and mainly based on quantitative methodology and has therefore been unable to provide rich detailed information about the complexity of LACs experiences of ending therapy. Whilst quantitative studies are valuable in their own right, they limit the extent to which participants can express their opinion, so information must be derived from theories rather than young people themselves. The extent to which surveys and questionnaires have been derived from constructs of importance to children rather than clinicians and researchers is unclear. Hennessy (1999) concluded that there is little evidence to suggest that the questionnaires used to establish children's satisfaction with services actually addresses aspects that are salient or relevant for the target group. The extent to which children's views are genuinely represented in these studies must be limited and it is therefore argued here that there is a need for an increase in the use of qualitative methods in order to understand young people's views fully.

Qualitative research, with its focus on shared construction of meaning with participants, and flexibility in design, methods and process, can give participants voice. Qualitative methods should offer children the opportunity to speak freely about their experiences and offer their views; something that they are keen to provide (Mental Health Foundation, 2002). Due to such merits, qualitative methods are an especially relevant approach to the subject matter of LAC.

Worral-Davies and Marino-Francis (2008) argued that if the views of children and young people are to be taken seriously, there is a need to elicit their views using research which is rigorous. They conducted a review to identify what methods had been routinely used and to highlight the best practice methods available to elicit views of LAC effectively. Just one of the studies they reviewed was based on a specialist LAC service; highlighting the substantial lack of targeted research within this field. They concluded that many studies exploring

children and young people's views of CAMHS were poorly reported and that further research was required.

Davies and Wright (2008) reviewed the literature about qualitative studies, which attempted to elicit the views of LAC about their experience of mental health services. No published study appeared to investigate this completely. They reported limited findings that vulnerable people such as LAC tend to be ambivalent about professional intervention, such as feeling wary of professionals and feeling uncared for. This underlined the importance of establishing a therapeutic relationship with young people. Because of the limited knowledge base for this study and others there is a definite need for further qualitative research in this area.

To overcome the lack of service user involvement from LAC, Davies, Wright, Drake and Bunting (2009) attempted to develop a service user feedback system for adopted and fostered children in receipt of mental health services. The results of this study were two-fold. Firstly, through interviews with young people and their carers there was a marked message that therapists are not interchangeable, but rather they represented attachment figures. Secondly, they demonstrated that children with disrupted attachments can be engaged in reflective discussions about mental health services when a methodology is developed specifically for them.

Experiences of ending therapy

Much of the literature on ending therapy is based on therapists' speculations regarding the clients' experiences. This is often related to the adult population, with limited number of studies focusing on children and young people. The current evidence base for LAC and ending therapy is sparse. Given these limitations, it is therefore necessary to consider a wider literature base to include information from other clinical populations and related research.

A casebook of termination in child and adolescent analysis and therapy (Schmuckler, 1991) identified the therapeutic benefits and difficulties encountered in the termination phase of therapy with younger patients. This demonstrated the

difficulties of ending therapy in the adolescent stage of life. This was, however, written from the therapist's psychoanalytic perspective. This demonstrates the need for investigating this important phase of therapy from the client's perspective.

Recent research has indicated that the ending of therapy can produce mixed responses for both the therapist and client (Baum, 2005). Most studies exploring the client's experience indicate feelings of stress, anger, regression, rage, denial, loss, sadness and anxiety. Conversely, some studies identified pride, sense of achievement and a sense of newly gained independence (Baum, 2005). The recent research findings about mixed responses to therapy endings may reflect that the early literature is not relevant to many current treatment approaches. It is possible that the ending is impacted by the treatment modality adopted. Given that attachment focused interventions are commonly associated with LAC, together with 'non-specific therapeutic techniques', further research is needed to examine ending therapy from clients discharged from looked after children's services.

In a study of adolescents' experiences of individual psychoanalytic psychotherapy, findings suggested that the ending of therapy involved feelings of ambivalence, together with issues of separation and loss and of moving on (Bury, Raval & Lyon, 2007). Many of the adolescents within this study reported the ending of their therapy as an important and significant transition, which evoked a range of emotions and for some, a re-emergence of ambivalent feelings. For many adolescents, the ending of the relationship with the therapist was also characterised by a sense of loss. This was an interesting finding as the results were generated by the adolescents themselves and suggests that the ending of therapy is a prominent aspect of their experiences of therapy. It is possible that their accounts were influenced by the adolescent's developmental stage with a tendency to focus on concepts of independence and separation. This study recruited adolescents in general, rather than the specific population of LAC. Further research is needed to consider if these experiences are consistent in the LAC population. Furthermore, this study is limited in ability to generalise about other therapeutic modalities.

LAC have unique experiences of moving from one placement to the next (Guishard-pine et al., 2007). Lanyado (2003) argued that the transitions LAC experience in placements is essentially paradoxical and inevitably fraught. Principally, Lanyado (2003) demonstrated the difficulty for young people to form new attachments whilst also being in the grips of mourning the loss of the foster or birth family. This is particularly challenging for children who have experienced abuse and neglect, for which “daring to try again, to allow a new relationship, is a highly dangerous proposition” (Lanyado, 2003, p.344). There is also the risk of triggering traumatic memories and feelings from the past. Such concepts might be relevant for understanding experiences of LAC ending therapy. One crucial difference remains between transitioning placement and ending therapy; there is no one identified to take over the role of therapist.

Whilst these studies provide valuable insight into LAC’s experience of mental health services and loss, there has been no research to date investigating LAC’s experiences of ending therapy. The research directs us to consider ending as an important aspect of the therapy process, yet indicates further research is required for the LAC population.

Barriers to research with LAC

Historically, LAC has been a difficult group to study. The most dominant barrier to research is due to difficulties in accessing this population because of complex issues including methodology and ethics. Heptinstall (2000) suggested that a major issue in involving LAC in research is the tendency of adults to protect children from the perceived adverse effects that participation in research may cause, meaning some young people are prevented from taking part in research. Heptinstall (2000) further suggested that there are difficulties in gaining consent which can deter researchers from exploring this client group.

Despite these practical and ethical concerns, there is growing support for the inclusion of LAC in research. This is reflected in the increase in studies which incorporate the views of young people. LAC also have the right to participate in decisions about their care, exploring their views about the kinds of help they need. Furthermore, Gilligan (2000) suggested that it is beneficial to hear their views, as

involvement in their care and research is likely to enhance self-esteem, giving them greater control over their lives.

Theories of adolescence

Adolescence is typically viewed as the bridge between childhood and adulthood, and describes the period between the ages of 13 and 18 years (ranges vary). Adolescence involves significant changes developmentally. Cognitively, adolescents start to find a sense of self, become more outspoken and clearer about what their needs are (Fadem, 2008). Socially, a primary task of adolescence is to learn about developing close, supportive and intimate relationships.

Research has historically viewed adolescence as a period of storm and distress with an intense preoccupation with the self (Peterson et al., 1993). The developmental changes associated with this life stage directed some theorists to propose that adolescence leads to psychological difficulties such as identity crises, sexual conflicts, ambivalence and regression (Freud, 1905).

Erickson (1968) viewed adolescence as the most decisive period in the formation of adult personality and believed that successful psychosocial outcomes in infancy and childhood pave the way toward a coherent, positive identity. While the concern of early adolescence is group membership and affiliation the establishment of a clear sense of identity, that is, a sense of 'who I am' – is the major concern of late adolescence. It is often associated with a need for independence and separation. We can infer that their developing sense of autonomy and independence will have an impact on their relationship to seeking help. Although stage theories are limited, because they are based on culturally specific norms and generalisations, they indicate the potential developmental processes specific age groups may face.

Kraemer (1982) viewed the difficulties of adolescence as akin with the difficulties of 'leaving home'. He argued that the difficulties faced during the adolescent years are either a false attempt at independence or an actual refusal to be independent. He concluded that leaving home and, consequently, adolescence, is not simply an event but a process which continues in a rather indefinite way

which is inevitable. Although this research is dated, with assumptions of western culture and independence, it demonstrates the task of adolescence as a period of developing independence and separation. This is supported by research which describes adolescence as a period of becoming less attached and developing autonomy (Allen & Hauser, 1996).

Given the early life experiences, attachment disruptions and altered stages of leaving home, I question the applicability of traditional theories of adolescence and consider that LAC may experience a distinct process. Blain, Thompson and Whiffen (1993) have suggested that attachment experiences have implications of an individual's ability to negotiate the developmental task of adolescence. There remains limited understanding on how developmental tasks such as those experienced during adolescence are negotiated for LAC. Focusing on adolescents in this study is justified, particularly when considering theories of separation and independence and the impact of this on the relationship to help. The general theories of adolescence need to be considered with caution.

Aims of the research

The absence of literature about how LAC experience ending therapy forms the basis of the rationale for this project, which aims to provide an account of the way in which young people make sense of their experience of ending therapy. Research indicates that LAC may have more difficulty with endings, due to experiences of loss and relationship difficulties (Many, 2009; Reder & Fredman, 1996). Conversely, their reported strength and resilience may prove a protective factor for this experience. This study aims to examine this experience from the young people themselves. A qualitative approach is indicated, focusing on the views of service users themselves.

It is hoped that the research findings may assist Clinical Psychologists and other therapists to make sense of how young people experience ending therapy, and may also highlight ways in which therapists can support LAC through this transition.

Research question

With the above aims in mind, the research question was framed as:

How do young people who are looked after experience the ending of psychological therapy?

Related to this main research question, the following areas of interest were also explored:

1. The potential impact of the end (positive and negative)
2. The potential coping strategies that were used

METHODOLOGICAL APPROACH

This study aims to gain an understanding of LACs experiences of ending psychological therapy. Interpretative Phenomenological Analysis (IPA) is a qualitative methodology committed to the examination of how people make sense out of life experiences (Smith, Flowers & Larkin, 2009) and will be used to meet the research aims. This section outlines the procedures and description of the data analysis process. A reflexive account will conclude this section.

Qualitative research methods – Why a qualitative approach?

As reviewed in the introduction, there is little research, both quantitative and qualitative, exploring how LAC experience psychological therapy and, more specifically, the ending phase of treatment. The aim of this study is to capture an in-depth account of young people's experiences. Qualitative methodology was chosen as it attempts to explore areas which are sensitive to context and process and represents people's experiences of specific lived encounters (Elliot et al., 1999). Qualitative research tends to reject positivism, opting for a position based on developing understanding, rather than on testing hypotheses (Bryman, 1988). These methods differ from quantitative approaches in regards to epistemology; the theory of knowledge, especially with regards to its nature, validation and limits (Barker, Pistrang & Elliott, 2002). Rather than attending to observable facts, they rely on a quest for understanding the nature of individual experience.

Qualitative approaches are particularly suited to questions of understanding 'what it is like', to experience particular conditions and situations. Silverstein, Auerbach and Levant (2006) demonstrated how qualitative research enables the enhancement of clinical practice because it is based on the richness and depth of individual experience. This can be applied helpfully to generate information to improve current practices.

A phenomenological approach such as IPA lends itself to the exploratory nature of the research question posed for this study; how LAC experience the ending of psychological therapy. IPA was chosen as the preferred qualitative methodology.

Interpretive Phenomenological Analysis (IPA)

IPA is a relatively new development in qualitative inquiry in psychology. The theoretical foundation of IPA is based on concepts from phenomenology, hermeneutics and idiography.

Phenomenology is a philosophical approach to the study of experience, committed to thinking about how we might come to understand what our experiences of the world are like (Smith et al, 2009). Theoretical theories in phenomenological philosophy claim that understanding of 'experience' invokes a lived process of discovering perspectives and meanings, which are unique to each individual (Smith et al, 2009). This is opposed to obtaining an objective statement of truth about an event or experience.

The second key principle underpinning IPA is the theory of 'hermeneutic inquiry' which is concerned with people as interpreting and sense-making individuals. It draws upon Heidegger's (1967), hermeneutic phenomenology, which highlights that lived time and engagement with the world is accessed through interpretation. Within this theory the complexity of the relationship between the interpreted and interpreter is acknowledged. For one to access another's lived experience depends on the researchers own conceptions and hence requires an awareness of one's own bias and preconceptions (Smith et al, 2009). Thus, reflexivity is considered to be vital in facilitating transparency. Smith et al (2009) describe this process as 'double hermeneutics', whereby the researcher is trying to make sense of the participants trying to make sense of their world.

The third major influence underpinning IPA is 'idiography' which focuses on engaging with a research question at an idiographic (particular) level (Smith et al, 2009). In contrast to traditional nomothetic approaches, which focus on the universal and generalisability of finding, IPA aims to work at the individual level to make statements about those individuals. IPA involves two levels; the commitment to detail and the commitment to understanding lived experiences from the perspective of a small group of particular people, in a particular context (Smith et al, 2009). For this reason, small sample sizes are recruited with the aim to examine in detail the perceptions of this small group.

IPA's theoretical position is that there is no objective reality to be uncovered, but instead invokes a process of discovering perspectives and meanings, which are unique to each individual and are constrained by social constructions (Smith et al., 2009). Thus, the essence of IPA lies in its analytic focus towards the participants' attempts to make sense of his or her own world and the researcher in turn will be trying to understand and interpret this. For one to access another's lived experience depends on the researcher's own conceptions and hence requires an awareness of one's own bias and preconceptions (Smith et al., 2009). Thus reflexivity, attending systematically to the context of knowledge construction, is considered to be vital in facilitating transparency.

IPA was chosen as a suitable methodology for this study for several reasons.

1. The phenomenological foundation of IPA lends itself to the research question, which allows a detailed exploration of how people make sense of their lived experience and attempts to gain an 'insider's perspective' (Smith et al., 2009).
2. It is acknowledged that the population of LAC will be diverse and it is not the attempt of this study to be able to generalise the findings to the population of LAC as a universal group. The participants in IPA are viewed as 'experts' in regards to their experience, and hence IPA is based on an inductive approach to theory building, developing ideas on a case by case basis. The idiographic foundations (the ability to engage with a research question at a 'particular' level) of IPA complement this aim of understanding and exploring in detail the individuals' experiences rooted in context. This has an additional advantage of giving a platform for individuals to voice their experiences, which can be contextualised later within a psychological perspective.
3. The opportunity to explore experiences from the individual perspective by learning from those who are experiencing it, fits well with Government policy which states a commitment to user involvement and pledges to continue greater involvement of and empowerment of service users (DoH, 2009). Furthermore, this fits with the Government agenda of listening to children and young people and including them more readily in research

(DoH, 2003).

4. Despite growing influences, to date there have been no published IPA studies with LAC, regarding the experience of ending therapy. Smith and Osborn (2008) suggest that IPA can be particularly useful where the area under study is a novel or complex one. IPA will help to provide a new account on this topic from those who are experiencing it, rather than based on theories and hypotheses based on different populations.
5. My standpoint on epistemology and understanding of individual experience within a social context fits with the key underpinning principles of IPA.
6. Finally, IPA responds to previous researchers who advocate the need for qualitative research to explore more thoroughly the experiences of LAC.

In summary, given the philosophical foundation of IPA, the existing literature, the nature of the research population, the research questions and my personal stance it was thought that IPA would be the most suitable methodology for this study.

IPA as opposed to other qualitative methodologies

Other possible qualitative approaches were considered in the study design, namely discourse analysis, grounded theory and narrative analysis.

Discourse analysis is concerned with how people use language to construct and negotiate knowledge, meaning and identities. Potter and Wetherall (1987) reject the idea that participants' accounts might be reflecting underlying cognitions and regard discourse entirely as contextual and contingent. I considered this approach as less appropriate than IPA, because my key aim of the research was to seek to understand the subjective experience of ending therapy rather than understanding how language constructs the discourses which operate in the therapy process.

IPA was favoured over grounded theory because grounded theory attempts to allow researchers to move from data to theory in such a way that new theories about social processes could emerge. This is opposed to capturing the individual's personal experience. Grounded theory has also been considered more of a

sociological approach (Willig, 2001), which draws on larger samples to support wider social explanations. IPA also differs from it in its idiographic approach, primarily concerned with the in-depth exploration of personal experiences of a smaller sample (Smith et al., 2009), which was felt to be more in keeping with the study's aims.

Narrative analysis is underpinned by the philosophy that the accounts we give of our lives, to others, and ourselves, are constructed as stories and that the generation of narratives is an intrinsic part of human experience (Cresswell, 1998). A focus of the analysis is given to the structure of personal narrative accounts and employs a biographical type of interview. Narrative analysis was excluded as the chosen methodology, because, in my study of experiences of ending therapy, I am aiming to look in close detail at the actual experience of ending therapy rather than how people make and use stories to interpret this experience.

Strengths and limitations of IPA

A major strength of IPA is the inductive nature of enquiry, allowing for new data to emerge (Smith et al., 2009). This is a particular strength in the area of LAC and therapy process, as the evidence base is currently limited. Following from this, is the focus on the individual level allowing the voice of service users to be heard. Notably, this is something that LAC have advocated.

Whilst IPA is most consistent with the research aims of the study, it is not without criticism. Small sample sizes might be a limitation of IPA studies; however, Smith et al. (2009) considered that reduced participant numbers allows for a richer depth of analysis that might be inhibited with a larger sample.

IPA requires an ability of participants, particularly young people, to communicate the rich texture of experience, which could also be seen as a limitation of using IPA. It is suggested that individuals may not have the language or ability to describe coherently the nuances of their experience in detail. For young people, who are developing their emotional language, it may prove difficult to express what they are thinking and feeling. Consequently, this makes it difficult

for the researcher to interpret their experiences, but not impossible. Furthermore, Smith and Osborn (2008) acknowledge that a key role of the researcher is to ask critical questions about what is unspoken.

Design overview

A qualitative design was employed using a semi-structured interview to explore looked after young people's experiences of ending psychological therapy.

Participants.

Recruitment.

At the planning phase of the research, a number of specialist LAC services in the NHS were considered regarding potential recruitment. Specialist services within my geographical region were limited in number, however, and whilst some showed initial enthusiasm they shared concerns regarding the future of their services due to NHS budget cuts and time pressures. There were also concerns about recruiting all 6 – 8 participants from one service due to the limited number of young people meeting the criteria. It was therefore decided that recruitment for the study would be from two NHS services that expressed interest and confidence about recruitment potential for the coming year.

Recruitment from just two services enabled the development of positive links with the staff. This was important in order to ensure that issues such as ethics and client vulnerability were fully considered. Finding young people who met the criteria and who were willing to participate proved quite difficult. A total of ten young people were identified by CAMHS clinicians for participation in the study. Two young people identified did not want to take part. A further two young people had moved away and could therefore not attend for interview. Interestingly, only three of the participants identified for inclusion were male, one of whom chose not to participate, the other having moved away. A reflection of this is included in the discussion.

Inclusion and exclusion criteria.

To ensure the sample was sufficiently homogenous, participants were LAC aged 13 – 18 years of age. The age band is commonly referred to in the literature for the period of adolescence. They were to have ended psychological therapy 3 – 18 months previously. This time frame was to ensure that the experience of ending therapy was not too raw but within a time frame that enabled the young person to recall events with a fairly high degree of accuracy. To ensure that no young person was discriminated against, participants of any ethnicity, religion, gender, sexual orientation or cultural background were eligible to participate in the study. Inclusion criteria included those young people who are looked after by the Local Authority under a Voluntary Care Order (section 20: Children's Act, 1989) or under a Care Order (Section 31: Children's Act, 1989) and had been looked after for at least one year, in order to ensure that separation from their birth parents was not a new and raw experience. It was also required that confirmation was received from their Social Worker that it was appropriate for the young person to participate in the study.

Those young people who were involved in court proceedings relating to their care and / or previous abuse were not eligible to take part. Such proceedings would possibly impact on the young persons' relationships with professionals. Those who had clear suicidal ideation/ risk identified by CAMHS clinician involved in the case, or the allocated Social Worker, were also excluded from the study. This was to protect the young person from harm. Qualitative research relies heavily on language, therefore non-English speaking participants were excluded from the study as there was a concern that the richness and meaning of language might get lost in the process of translation.

The sample.

Smith and Osborne (2008) recommend that five to six participants is a reasonable sample size for a student IPA project. Participants were six young people, aged between 14 and 17 years of age, who were looked after and recently ended psychological therapy. Four young people were in foster care, one in

residential care and one in kinship care. All of the participants had been looked after for at least two years.

Table 1 Participants

Name	Age	Gender	Ethnicity	Approximate length of time since end of therapy	Ending therapy context ³	Type of care
Chloe	17	Female	White British	18 months	3 years in therapy. Planned ending. Non-directive psychodynamic/ art therapy	Foster care
Jen	17	Female	White British	9 months	Placement move therefore forced ending following 18 months in therapy. Attended 1 session following end of previous therapy.	Foster care
Leila	14	Female	White British	9 months	Six months in therapy. Mutual decision to end. Systemic interviewing and reflection.	Kinship care
Cher	15	Female	White British	18 months	Two years in therapy. Planned ending. Long term psychotherapy	Foster care
Chris	14	Male	Black Caribbean	12 months	Two experiences of therapy. Planned ending. Chris' decision to end following 6 sessions.	Foster care
Janet	15	Female	White British	3 months	Three years in therapy. Janet's choice to end. Integrative approach, psychodynamic orientated therapy and Theraplay.	Residential care

Context.

They were a purposive sample recruited from Psychological therapy services in two NHS trusts. Psychological therapy services were multi-disciplinary services for children and young people aged 0 – 18 years of age who were under Local Authority care. The services which helped to recruit were based in a North London borough (Islington) and in Bedfordshire.

Islington has a disproportionately high number of LAC compared to statistical neighbours. Forty per cent of children coming into care were identified

³ Information captured on brief information questionnaire completed by CAMHS clinician.

as white. Black and dual heritage children were reportedly overrepresented in comparison to the local population. In contrast, black Somali children were underrepresented (Islington, 2010).

Bedfordshire also has a disproportionately high number of LAC compared to their statistical neighbours. Bedfordshire have a higher number of young people coming into care in later adolescence than the average in England (38% compared to 30% respectively). Ethnicity data shows that children from all non-white, black and minority ethnic groups are over-represented in the looked after population when compared to both census data and information from Central Bedfordshire Council maintained schools (Central Bedfordshire Council, 2011).

Ethical considerations

An application for Research Ethics Approval was granted a favourable opinion by South Cambridge Research Ethics Committee in September 2011. Research governance approval was provided by the two NHS trusts. Relevant documentation is provided in Appendix 2.

Informed consent.

Prior to participants agreeing to take part in the research, they and their allocated Social Worker were sent an information sheet outlining the purpose of the research and detailing what participation was involved (Appendix 3 and 4). If considered appropriate by the allocated Social Worker, the young persons' birth parents were also sent information and consent forms (Appendix 5). They were able to consider this in their own time before deciding whether to participate. Oral information, including the reassurance that they could withdraw at any time, was also given prior to the interviews and they were given the opportunity to ask questions. Social Workers completed consent forms and participants signed an assent/ consent form (dependent on age), both of which were countersigned by the researcher (Appendix 6)

Confidentiality.

Confidentiality was clearly outlined in participant information sheets and orally explained to participants and their allocated Social Worker. Participants were informed that all information would be secured either on password protected computers or in locked secure cabinets. They were informed that all personal identifying information would be removed from written transcripts and any quotes used within the thesis would be sufficiently anonymised.

The limits of confidentiality were clearly outlined in information sheets and given orally, prior to interviews. The only circumstance in which confidentiality could be broken was if the young person disclosed information that raised concerns about his or her safety, or that of others. In this instance, it was noted that the relevant allocated Social Worker would be informed.

Interviews took place in environments where participant and researcher were assured of confidentiality.

Affiliation of study.

It is possible that young people may have assumed that the service they received now or in the future from psychological therapy services could be affected in some way by their decision to participate in the research. The information sheets clearly outlined that the research was independent of the service and would not affect adversely their standard of care.

Psychological harm.

For young people participating in the research, the study may be exploring painful emotional experiences, thus making them vulnerable to psychological harm. Young people, who were deemed at risk by therapists or Social Workers, were not eligible to take part in the research. However, for those participating, there could be a risk of increasing their difficulties with ending relationships. As these experiences had already happened within the participants' lives it was deemed unlikely that anything could be more traumatic than the actual events the participant described. Furthermore, by talking about the experiences, it may

enable these experiences to become more explicit for the participants, enabling them to engage in future psychological therapy if required.

As a Trainee Clinical Psychologist I had experience of dealing with people in distress and I endeavoured to conduct the interviews as sensitively as possible. Participants were given the opportunity to debrief with me following the interview and were given contact details of support services available if required. All participants were advised to speak with their allocated Social Worker if they had any concerns or worries following the interview. No young person in this study expressed distress or desire to contact local support services. Conversely, all of the participants said the research was beneficial to them and they were pleased they were able to take part.

Data collection

Materials.

Semi-structured interviews are a common data collection method in IPA (Smith et al., 2009). This process facilitates rapport and empathy and allows the researcher to be responsive and flexible. A structured interview schedule was developed (Appendix 7) covering young people's experiences about ending psychological therapy. The aim was to explore their feelings, experiences and processes of ending therapy. The schedule was developed with reference to the literature on mental health difficulties in LAC, the experiences of other populations about ending psychological therapy and relevant guidance on structuring an interview schedule (Smith et al., 2009). The schedule was also developed in consultation with clinicians working with LAC. The schedule was designed to facilitate discussion regarding the participants' experiences, rather than dictating the interview. This allowed for the same areas to be covered with each young person, whilst allowing them to raise specific issues spontaneously. The sequencing of the questions was flexible and modification to the inclusion and exclusion of questions was possible throughout the process.

Bassett, Beagan, Ristovski-Slijepcevic and Chapman (2008) outline the methodological challenges of interviewing adolescents as research participants.

Despite unquestionable challenges from interviewing this population, it is important to find ways to improve qualitative interviews with adolescents.

McDonagh and Bateman (2011) highlight the importance of designing developmentally appropriate materials to ensure success. Phrasing in interviews was highlighted as particularly important when concrete rather than abstract phrasing is better understood. Rephrasing questions is also indicated as necessary to ensure the young person has understood the question. During the interview itself, Bassett et al. (2008) recommend that the researcher must take steps to make the participant feel comfortable, through appearance, body language and informal speech. The interview itself was therefore more relaxed than what might result from traditional IPA interviews with adults.

Piloting the interview.

The interview schedule was piloted to facilitate its development. Firstly, it was piloted with a Clinical Psychologist working in a specialist LAC mental health service. This allowed for amendments to be made, prior to piloting the interview with a LAC. Through this process, I was able to rehearse the interview procedure and gauge timings.

Secondly, I piloted the interview with a LAC. This highlighted that it was important to understand the young person's experience of therapy in general and then to explore their experience of the ending phase of therapy. This demonstrated the importance of asking precise questions around the last session in order to facilitate greater memory recall of their emotions and thoughts around this time. The interview schedule was amended to include more questions on the overall impression of therapy, as well as the last session in particular. The pilot interview with the LAC was included in the main study.

Procedure.

CAMHS clinicians from the two psychological therapy services were invited to consider young people who could participate in the study. The clinicians were informed about the research through team meetings and also via

email. This was supported by brief and detailed information sheets which were distributed to all team members within the services (Appendix 8).

Potential participants were identified by CAMHS clinicians and their allocated Social Worker was approached to consider their involvement in the project and obtain appropriate consent. Social Workers were asked to explain the research briefly to potential participants. Young people were asked to complete and sign the appropriate assent/ consent form, dependent on their age at the time. At this point, GP information sheets were sent to the young persons' GPs to inform them of their inclusion in the study (Appendix 9). Therapists were asked to complete a brief information sheet detailing contextual information such as length of time in therapy and date of end (Appendix 10).

Interviews.

Participants were given a choice of where they would prefer to be interviewed. Interviews were conducted in the CAMHS building or professional work office. Participants were asked to allow up to 60 minutes for the interviews. The first part of the interview was to ensure the participants were fully informed about the study and had the opportunity to raise any concerns or ask questions.

Interviews lasted between 40 and 60 minutes and were based on the semi-structured interview schedule (Appendix 7). They were audio taped and later transcribed. After each interview the schedule was reviewed to incorporate new areas of interest if appropriate.

Following each interview, I completed a response sheet (Appendix 11) on my thoughts and feelings as well as anything that may have affected the interviews, such as interruptions. This was to facilitate reflexivity and consideration of the interview process.

Transcription.

Transcription is viewed as the first process in gaining familiarity with the data and is viewed as helpful, in order to imagine the voice of the participant, as this assists with a more complete analysis. IPA aims to interpret the meaning of

the content of participants' accounts, and therefore, transcription did not include detailed description of the prosodic aspects of the recordings, such as non-verbal utterances. Social interactions, such as laughter, are noted as important interpretative activity. Any patient identifiable information disclosed by participants during interviews, was not recorded in transcripts, but was instead replaced with a pseudonym. For example, names of clinicians were replaced with pseudonyms.

Three interviews were transcribed by me and three were transcribed by a professional service. A confidentiality agreement was agreed and signed by the transcriber prior to interviews transcribed (Appendix 12).

Data analysis

The analysis was conducted in accordance with the IPA procedure as outlined by Smith et al. (2009). This section will briefly outline the procedure I followed; however, for a more detailed discussion see Smith et al. (2009). Supervision, peer supervision, guidance on quality in qualitative research and consultation with experts in the field of LAC informed this process.

Individual case analysis.

In keeping with the idiographic nature of IPA, each transcript was analysed individually. During this phase the transcripts were read to ensure anonymity (i.e. the removal of all names, place names and other identifying information). Smith et al. (2009) suggest that this procedure allows the researcher to detect new themes, whilst also being observant to repeating patterns. Interviews were read repeatedly, in order to build a coherent narrative of the experience of the participants. Initial annotations were made in the right hand margin on anything significant within the transcript, including paradoxes, contradictions and preliminary interpretations. The transcripts were re-read again and emergent themes were recorded in the left hand margin. This process involved regular checking of interpretations and themes within the text. At this stage, I attempted to 'bracket off' my own preconceptions, as much as possible, in order to facilitate immersion in the data and interview itself.

Clustering of emergent themes.

Emergent themes were listed chronologically, connections between them were made and themes were clustered. Smith and Osborn (2008) describe this process as being like using a magnet; some themes pulled together naturally, in order to facilitate understanding. Each cluster of themes was named to capture the essential quality of the cluster meaning and these then became the super-ordinate themes. To ensure quality of analysis, this procedure involved continual checking of interpretations and themes within the text. Quotations from within the text were extracted to represent each theme and a table of superordinate, subordinate and corresponding quotations was produced. An example of the analytic process is given in Appendix 13.

Cross case analysis.

The above process was repeated for all six interviews. This case by case analysis is in keeping with the idiographic principles underlying IPA and means that the starting point of an analysis is the in depth study of one case before moving on to the next (Smith et al., 2009).

The final stage of analysis involved looking for patterns across the full data set. A final table of themes for the research was produced incorporating the themes from all six interviews. The final list of themes was clustered into superordinate and subordinate themes. Interview transcripts were reviewed to ensure accuracy of the themes. The master list of themes provided a coherent framework to understand the young people's experience of ending psychological therapy. These themes were then expanded into a narrative account which forms the basis of the results chapter.

Quality measures

It is acknowledged that qualitative methods should be evaluated in relation to criteria recognised as appropriate to it, rather than applying the same measures as used for quantitative methods, for example, reliability and validity. A number of researchers offer criteria for ways to establish quality in qualitative research,

including IPA (Elliott et al., 1999; Spencer, Ritchie, Lewis, & Dillon, 2003; Yardley, 2000). Spencer et al. (2003) four guiding principles of quality qualitative research are discussed below, together with the steps I have taken to meet them.

Research as contributory.

Spencer et al. (2003) propose that qualitative research must be contributory and widen the knowledge base and understanding. The relevance of this project has been discussed in the introduction together with a discussion of important implications for clinical practice in the discussion. This supports Yardley's (2000) criteria of demonstrating impact and importance.

Defensible in design.

Spencer et al. (2003) propose that the research strategy adopted should address the evaluative question posed. A comprehensive discussion about the choice of research design is presented earlier in this section.

Rigorous in conduct.

Spencer et al. (2003) propose that qualitative research should involve systematic, transparent collection, analysis and interpretation of data. Yardley (2000) also recommends this as an important marker of quality with an emphasis on transparency and coherence. The procedure and study design have been well documented in earlier sections, giving attention to all stages of study design and procedure.

To ensure rigour, sections of anonymous transcripts containing my initial commentary and emergent themes were provided to the research supervisor and peer IPA researchers. This was to establish whether they felt the themes were plausible and whether they could track the process of analysis to the emergent themes as derived by me. These checks allowed for discussion to consider alternative interpretations and to reflect on personal influences when interpreting the data. The checks revealed that the themes were justified within the text. As a novice IPA researcher, this was particularly valuable. To ensure transparency, I

have included the opportunity to follow the process of analysis in an audit trail of one interview (Appendix 13).

I kept a reflective diary to consider the important relationship between myself and interpretation and dynamics in interviews. To facilitate transparency, self-reflexive sections have been included regarding my motivation and personal perspective. This supports Elliott et al. (1999) guidance of owning ones own perspective.

Credible in claim.

The final principle of Spencer et al. (2003) guidelines relates to the importance of offering well-founded, plausible arguments about the significance of the evidence generated. To aid credibility, interpretations and themes are presented, together with verbatim extracts from the text. The quality checks described above also ensure that the results are credible in claim with professionals in the field commenting on the coherence and comprehensibility of the analysis.

The discussion presents some important clinical implications from this study. These are presented in the context that the results of this study are one possible construction and that other readers may identify other significant themes. Sample characteristics are described to allow the reader to judge the transferability of results.

Reflexive considerations continued

In line with IPA I approached this study with an open mind and with respectful curiosity about the young people's experiences. I hoped to acknowledge my own position, yet try and enter the personal world of the client as much as possible. I am, however, aware that my non-verbal behaviour and my questions and style may elicit particular responses in participants, which might not be evident had another researcher conducted the interviews. In particular, I noticed in some interviews I seemed to adopt a more nurturing role and was wary of probing more challenging, personal questions. I recognise the impact this may have had on the young person and consequently the data collected.

Upon meeting the young people, I was aware that I potentially represented someone from the service from which they had received therapy and some young people may have felt this was a reconnection with their therapist or mental health service. For some, I wondered whether they thought my invitation to research was a way to bring them back into therapy. I recognised that upon meeting the young people I tried to align myself with the University of Hertfordshire rather than from the CAMH services and adopt more of the ‘researcher’ within me than the ‘psychologist’.

RESULTS

This chapter presents the results of an Interpretative Phenomenological Analysis (IPA) of six adolescents who are looked after and their experiences of ending psychological therapy. IPA was used to develop detailed accounts of the lived experience of LAC ending psychological therapy and their attempts to make sense of this experience.

Four key themes, summarised in Table 2, emerged to form the basis of this account. The themes are:

- *Inextricable link between therapy and therapy relationship*
- *Means of coping*
- *Ambivalence*
- *Moving on from therapy*

The master themes and contributing subthemes will be expanded into a written narrative in the remainder of the chapter, illustrated with verbatim extracts from the interview transcripts⁴. This chapter offers one possible account of how adolescents who are looked after experience ending psychological therapy. This account endeavours to highlight the various experiences reflected across the dataset, alongside the similarities and differences indicated between individuals. They do not cover every issue raised, or every aspect of their experience, but were selected due to their salience in relation to the research question. It is recognised that the themes are not entirely separate from one another and are interconnected. This account is subjective and other researchers may have highlighted different aspects. This account should be viewed as socially constructed, partial and incomplete (Gergen, 1985).

⁴ In quotations, repeated words and utterances such as 'erm' have been omitted for ease of reading unless relevant to interpretation. To ensure confidentiality, participants have been given pseudonyms and all personal or identifying information has been either omitted or altered. Significant pauses are indicated using dots, for example '...' would indicate three second pause. Where material has been added it is enclosed within [square brackets].

Table 2**Main Themes**

Super-ordinate theme	Subordinate theme
INEXTRICABLE LINK BETWEEN THERAPY AND THERAPY RELATIONSHIP	Ending highlights the special nature of relationship
	Detachment from vs. attachment to therapist
	Ending means loss of a relationship
MEANS OF COPING	Self protection and disconnection
	Philosophy of acceptance
AMBIVALENCE	Unprepared and out of control
	Positive AND negative
MOVING ON FROM THERAPY	Stepping into independence
	Ending as transition vs. finality of ending
	Therapy as blueprint for future connections
	Understanding why

1. Inextricable link between therapy and therapy relationship

Overview

This theme aims to capture the sense that to conceptualise the ending experience it was important to consider the therapy relationship. For the young people to think about the end of therapy meant to consider the end of a relationship; connection and separation were inextricably linked and consequently there was an overlapping discourse. However, the young people make a clear difference between ending when they had a connection with the therapist and ending when

nothing was gained or they were not close to the therapist. Ending therapy meant ending a relationship, which for some was experienced as loss. Overall, it appeared important for the young people to express their experience of ending in the context of the therapeutic relationship.

1.1 Ending highlights the special nature of relationship

A prominent theme emerging from the interviews was the way in which the ending event helped the young people to recognise the significance of the therapeutic relationship.

Some young people experienced the way their therapist marked the end of therapy as unique and unlike the end of other sessions:

Yeah, usually she'd just take me down to reception and I'd wait for transport. Whereas this session went on a bit longer so she came out that time and gave me a hug and said goodbye which was nice. (Chloe)

It seemed that the therapists went beyond 'normal' boundaries of therapy, which was appreciated by the young people. I interpreted this as being their recognition that marking the end in a personal way demonstrated that they meant something to the therapist, reflecting the special nature of relationship that they held. For Cher, it seemed that the final session was also experienced as a point at which there was a changed status of their relationship:

Well him bringing food and stuff made me feel like he didn't always have, we didn't always have to talk about my anger, he was there to talk about anything and I was allowed to be who I wanted to be and I wouldn't have to pretend to be anyone. (Cher)

Some young people experienced the ending event as a shared venture between therapist and client. The following account from Cher captures this:

In the last couple of minutes I talked about the sessions and how we had got on really well and what we felt during the sessions and how could we improve in our future. And then it was like really hard to say goodbye but then I said goodbye and he watched me go off in my car. (Cher)

Cher's use of words 'we' and 'our' represents a sense of collaboration and togetherness about the ending event. I interpreted this as being that she felt the ending was not only special for her, but that her therapist was also impacted by the occasion, reflecting the special nature of their relationship.

Much like Cher's description, several of the young people remember the therapist placing them in the car and watching them drive off. It was interpreted that the young people experienced this as demonstrating the value of their relationship, much like a parent watching their child move out or go to university. It seemed that the therapists represented someone special to them, perhaps seeing them as a parental figure.

Unlike other participants, Jen did not elaborate on the ending event and often reported 'I can't remember'. However, what she did remember was the physical act of saying goodbye:

Yeah, I said goodbye and gave her a hug. (Jen)

I was struck by the commonality of the 'hug' across the participants' accounts and how this represented the significance of the physical act of separation. The intimacy became a key memory for the young people and was understood as the therapist marking the end with closeness and fondness.

Janet had a unique experience of ending, unlike the other young people, in that her last session was of her walking out. She was therefore denied the opportunity of a planned ending session which she later regrets:

Yeah, I would have liked to have ended in a nice way [...] not with just me walking out. (Janet)

Janet experienced an enduring sense of ambivalence towards her therapist. Her walking out of the session was seen as a defence against the difficulties of managing the conflict in her emotions and as a rejection of the therapist, before she herself experienced this difficult emotion. Without an ending session, Janet was denied the opportunity to reflect on her therapeutic relationship with her therapist.

Although some participants valued the ‘specialness’ of the last therapy session, others seemed to value the simplicity in the ending event.

Um...No I thought it was good the way it ended ‘cos we just talked and then said goodbye and that was it (Leila).

He wasn’t like say “extra”, like “you’re going now”. He wasn’t like that. Just like chilling out still and then when it’s time to go home I just went. I’d say my goodbyes and that... (Chris)

Chris’ use of the phrase ‘chilling out’ implies a sense of comfort and safety indicating that he felt contained by the experience of ending therapy.

Their basic description of the ending event seems to mirror their experience of ending of therapy. I interpreted the appreciation of this simplicity as being that this experience of ending was perhaps unique in their life, compared to other ending experiences which were perhaps more complex and painful.

Leila goes on to describe later that the experience of ending therapy was similar to other endings, such as from her mother, but not on the same level:

I’d say slightly [...] not like dramatic ‘cos when I left my mum that was massive but when I said bye to Roxi it wasn’t so big so [...] similar slightly but not very similar. (Leila).

The simplicity therefore allowed the experience not to become overwhelming and was a contained experience which they felt was ‘good’ and manageable.

Whilst the young people experienced a range of ending events, it seemed that an important aspect was the therapist being attuned to the young person’s needs and managing the event in a way which was helpful for them. This demonstrates the value of the therapeutic relationship, most notably the attunement of the therapist and client, to the ending experience.

1.2 Detachment from vs. attachment to therapist

The centrality of the therapeutic relationship was prominent throughout the young people’s accounts and the connection, present, absent or ambivalent, seemed to be a key factor contributing to the experience of the end. Some young people had

more than one therapy experience and were therefore able to draw on experiences from a range of therapists.

Most of the young people described a sense of connection and attachment with their therapist:

It was always, he was in a good mood, and he was always like happy to talk and even when I didn't have anything scheduled I might as well you know, I just told my teacher I got to see him, can I speak to Philip again, she'd call up Philip and then Philip would just like pick out a time and that would be cool. (Chris)

Chris' account tells us of his sense of safety about someone always being there for him when needed. The therapist seemed to provide a sense of stability and consistency, which was flexible to his needs of developing independence but providing support when needed. Other young people also shared a similar experience of stability and consistency which helped to develop their attachment with the therapist. The following comment from Cher typified this position:

Because he was like a friend to me, someone that would always be there for me and always listen to the way I feel and help me to improve and he cared about me and about how my life was and about how my life was turning out like. (Cher)

Most of the young people described the therapy relationship as central to the therapy experience. The wish for equality and respect which was appreciated by young people is summed up nicely in Janet's account:

Just treat us in how we are supposed to be treated. (Janet)

The use of 'just' in this phrase hints at a sense of not asking for much, that all they want is equality and respect in the therapy relationship.

Most of the young people spoke of the importance of building this relationship over time and the significance of this in feeling contained. Chloe's account captures this:

It it was nice 'cos in the beginning I had a different therapist I can't remember his name but erm when I got Kate it was better 'cos I was able I built up trust with her quicker so we our sessions were a lot better because the trust was there and I could feel like I could tell her anything. (Chloe).

For Chloe, it was of central importance that she was able to build a relationship. Her use of the phrase 'we built' indicates a sense of hard work and collaborative effort in this endeavour. Her comparison between therapists indicates the centrality of the connection with the therapist which facilitated her to open up more.

In contrast, some young people experienced a sense of disconnection with their therapist. Chris's account tells us he did not feel connected with his second therapist and he therefore became detached from therapy:

She wasn't interesting, she wasn't fun and she wasn't really anything to do like, you just have to sit down and talk to her and get bored with her after a while. She wasn't even like cool she wasn't, she was just boring[...] We tried a lot of stuff but nothing was interesting and there was nothing else to do so I just said there is nothing else to do. Let's just stop. (Chris)

Chris' account tells us he felt pressured by the therapist's agenda, which led to a rift in the therapy experience. This eventually led to detachment from therapy.

This experience of the therapy relationship was more challenging for Leila. She persistently described not needing therapy and being bored in the sessions. This was her reason for ending therapy. However, she also spoke about her developing a connection with her therapist. Therefore, although she did not feel she gained from therapy, she did form a connection, something perhaps she was not expecting from therapy. Her relationship to therapy, her therapist and subsequently the end of therapy was confused:

No. Because I didn't think I needed therapy in the first place so [...] not having it any more, I was sad I wasn't going to see Roxi but [...] um [...] at least I don't have to do that 'cos I didn't think I needed it. (Leila)

The attachment with or detachment from the therapist seemed to play a key factor in the young peoples' experiences of therapy and consequently how they experienced ending therapy. The following account from Jen nicely sums this up, and, in a way, captures the whole subtheme:

Well obviously I liked the Brighton one and I was sad when that ended, it was quite sad, but I mean I knew that it had to end at somepoint, er [...]and the other ones, I don't know, er[...] that made me like really have an impact on my life, but all the other ones really I haven't really had that sort of connection with really. (Jen)

Her hesitation hints to a difficulty in remembering the experiences of therapy where there was no connection. When describing an experience of ending with a therapist where she felt no connection she experiences indifference:

I wasn't actually sad to be honest. But I wasn't very close to that one, so I wasn't really very sad or anything, I was just like ok. (Jen)

Jen was able to draw on a number of therapy experiences and therefore her ability to conceptualise endings as dependent on connection may be attributed to her ability to adopt a meta-position and make comparisons across therapists. This was also the case for Chris, Chloe and Jen.

Janet described an unsettled relationship with her therapist, at times describing a positive relationship and at others describing a mismatch and detachment; which in the end became the trigger to her decision to end:

I didn't really wanna end but I'd had enough of her treating me like a baby so...(Janet)

Throughout her transcript she describes experiences of being misunderstood and misheard. She dearly desired respect and equality in her relationship which was often not realised. This disconnection eventually led to detachment from the therapist and eventually detachment from therapy. This was Janet's first experience of therapy, plus she was also living in a residential home. Unlike the other young people, who were all placed in foster care, Janet was expected to form and maintain relationships with a number of different people. It may

therefore have been challenging for her to experience a caring relationship which accounts for the ambivalences in her account of her relationship. The prospect of experiencing connection may therefore have been too difficult to dare to maintain.

These quotes suggest that the young people make sense of the ending experience being dependent upon the therapy relationship. In a way, nothing ventured, nothing gained, nothing lost.

1.3 Ending means loss of a relationship

Five of the young people described a sense of loss at ending therapy, frequently describing a loss of a relationship from their life. This is eloquently captured in Cher's account:

It was quite sad knowing that I probably wouldn't see him again and that I wouldn't be able to come back whenever I felt like it and just talk to him and I wouldn't see him weekly and every time I was angry and upset and shout at my family I couldn't say I was going to see him this week and talk about it and see how I could stop it from happening again. And I would just have to go about it myself. (Cher)

Cher's experience of ending therapy was a journey from a sense of connection to isolation, in which she had to 'go about it' on her own. She connected the emotion of sadness to the loss of her relationship with the therapist. There was also a sense of sadness at the anticipated loss of the relationship in her life, in that she worried about continuing without him. Chloe articulated a similar account of losing part of her life:

It was just a constant ache in a way because because I said it had become my daily routine, it was, it didn't feel normal to me it felt quite strange not going so I missed her a lot and then I felt quite sad 'cos, 'cos of my relationship with her it was just like I'd lost somebody in a way. (Chloe)

In this short phrase, there are a number of connotations of loss; "ache, didn't feel normal, missed, sad and lost". Her powerful use of the word 'ache' points to her physical response to the separation, implying she experienced a 'dull prolonged pain' following the end of therapy. In addition to the loss of the relationship, it

seemed that she had lost a part of her life, perhaps a part of her narrative or the person holding her. She had previously described the importance of ‘building’ a relationship with her therapist and now this was ‘lost’. Her use of the word ‘lost’ also suggests she had been bereaved at the end of therapy.

The phrase ‘wouldn’t see him/her again’ was repeated in a number of the young peoples accounts. Leila’s account captures this:

*I was just thinking I wouldn’t see her again and then I was feeling like sad
(Leila)*

It seemed apparent that this thought triggered the emotion of sadness for the young people and seemed to be related to managing their life without their therapist. Leila repeated this phrase a number of times within her account which points to the significance of this for her. It was interesting that this was the key point which was often associated with sadness and the thing that was lost, rather than other aspects of therapy, such as the techniques of therapy. The significance of the loss of relationship was captured in Chris’ account:

*Well I was feeling sad oh you know, Philip was like a friend and all that
then what can you do you know, the guy’s retired. (Chris)*

Jen was less explicit in her claim of the loss of relationship:

*I really liked her, she was really good therapist, I just felt a bit sad
because it was coming to an end, but I had to, so. (Jen)*

Although she does not make an explicit connection between sadness and loss of the relationship, she describes this sadness within the same phrase as describing her fondness of her therapist. The end of this phrase tails off which hints at a confusion or difficulty in talking about the loss of the relationship.

Unlike other young people, there was an absence of the sadness of loss of relationship in Janet’s account. Conversely, she experienced feelings of anger towards her therapist and this indicates that she was struggling with the end of the relationship in her own way:

Yeah, I'm just angry with her...not the sessions, just her. And I will always be angry with her. (Janet)

Janet makes a clear distinction between the therapy sessions and the therapist, with her anger directed towards the latter. On the surface level, the use of 'just' emphasises that anger is the only emotion she holds for her therapist. However, I interpreted this as a form of defence to other experiences of loss, as this would connect her with painful emotions. Furthermore, Janet had ended therapy just three months previously, therefore it is considered that the emotion of anger is an early experience of loss of the relationship. This emotion might develop as time continues.

1.3.1 Hierarchy of loss

All of the young people were able to recognise that there were different levels of their loss experiences. Each of them had described at least one other experience of loss which they felt was similar to the experience of ending of therapy. Cher's account captures a sense of similarity but disparity of her experience of coming into care:

Well I found it quite hard coming into care, I found it really hard knowing that I wouldn't be in the same place again and I wouldn't see those people there again and that's like the same as I felt there because I knew that all the people there were so nice and I wouldn't see them again and that I just had to say goodbye and it was my choice wanting to come back and the feeling was a little bit different because I could go back to therapy but I couldn't go back to home so it was a little bit more positive knowing that I could come back but it was still very negative. (Cher)

Chloe also articulated that she recognised a similarity to other loss experiences but again that this was not within the same range as family losses:

No not really like there wasn't as an intense feeling 'cos I miss a lot of people like my sister and my Mum but the feelings that I've been missing feeling that I felt for Kate [therapist] wasn't quite as intense but it was still quite similar. (Chloe)

Although the young people described that ending therapy was not on a same level as other experiences in their lives, most significantly, the experience of coming into care, the feelings created by the end of therapy served to highlight the significant impact that the ending of the therapeutic relationship can have on a young person. The comparison to them leaving their parents and coming into care, for me, demonstrates the significance of the therapy relationship and how this is valued in their lives.

2. Means of coping

Overview

This theme aims to capture the ways in which the young people had adopted ways of coping with the experience of ending therapy. The young people adopted strategies, which seemed to protect them from feelings and experiences of both the actual ending event and also from the memories of the experience. For some this resulted in a disconnection and distraction from the experience and feelings. This was both on cognitive and emotional levels. Alongside this, the young people seemed to have developed an outlook on life of 'acceptance' which also seemed to help them manage with the ending experience. Coping overall appeared to be a personal learning experience for the young people, who each found diverse ways to manage feelings resulting from the ending of therapy.

2.1 Self protection and disconnection

During the build up to ending therapy, some young people seemed to develop strategies to protect themselves from the anticipation of ending. The account offered by Chloe captures a process of closing down or disconnecting from the therapist during this phase:

I didn't like interact with her as much maybe I'd go off and do my own thing but kind of individually for a little while, like close myself off a little bit (Chloe).

I felt this 'closing myself off' represented a difficulty Chloe felt in feeling let down by her therapist for leaving her and acted in some way for Chloe to regain

some control –she was rejecting her therapist before she herself was rejected. It may also relate to Chloe testing out how life might be without the therapist around and to being on her own again. Chloe then went on to describe that in the end she actually opened up to her therapist more so than usual:

I was very open that session [last session] more than often so I think I guess I thought well this was my last session and I want to get everything out while I can (Chloe)

The process of closing down and opening up was unique to Chloe and demonstrates strategies she used to help manage the ending event. Opening up again was seen as another form of self protection, in a way to get everything over to the therapist so she didn't have to continue holding it on her own post therapy. It may have also served as one last attempt to continue therapy, in a hope that the therapist would feel the need to extend the sessions.

The simplicity of the last session, as appreciated by Cher and Chris, was interpreted as a form of disconnection. This seemed to shield them from more complex emotions:

No I was just it really not like a big thing you know. Wasn't like I was feeling like extra depressed or like that I was just feeling you know normal. (Chris)

The disconnection from complexity enabled the young people to feel 'normal' and therefore experience the ending as manageable. Similarly, post therapy some young people gave the impression of attempting to disconnect from the emotions they experienced of ending therapy. Janet's words capture this when talking about remembering the ending:

Yeah, because if I think about it, I will just get upset and stuff (Janet)

Janet also attempted to disconnect from any further communication from the therapist, in a way to protect herself from the emotion that she experienced when thinking about therapy:

I just weren't happy that she actually sent me a letter, when she knew that I want nothing to do with her, I want nothing from her, nothing. (Janet).

Leila's account demonstrates the use of a cognitive technique of distraction as a strategy, which meant she didn't think about ending any further:

I was thinking about it [therapy] but then I think I got distracted so I didn't have time to like talk about it [therapy] (Leila).

Although on face value this does not seem a conscious effort of distraction, it served the purpose of disconnecting from the sadness she experienced at ending therapy. A form of distraction adopted by Cher was to focus on the positives:

Him talking about the future and about how I could improve, even though it was helpful it was quite sad knowing that he wouldn't be there for me in the future and that I would have to go about it myself, I think it could've been more based around talking to each other and how we have come a long way than talking about the future (Cher).

She described wanting to stay in the moment and concentrate on the positives. This seemed to serve a protective function from the difficulty of talking about more painful issues such as loss and being on her own. This coping style may relate to her life experiences, where it is a protective factor for her to think of the positives rather than the negatives. Also the concept of staying in the moment may have resulted from a life of uncertainty, where she has had to learn to focus on the here and now rather than be concerned about the uncertainty of the future.

2.2 Philosophy of acceptance

Five of the young people articulated a sense of acceptance to ending therapy. This seemed a positive and adaptive approach to managing, as it allowed the young people to move on and not resist or fight against the ending process.

Some of the young people seemed to make a link between the inevitability of ending therapy and the experience of life itself:

It's like life basically, you know when it's going to end but you don't really like to start moaning about it really do you (Chris)

Because life is life, it is gonna end sometime (Janet)

These accounts demonstrate the development of the concept of the universality of endings, which was then applied to the experience of therapy. This concept seemed to help the young people understand the process of therapy and that it must end:

Well obviously I liked the Brighton one and I was sad when that ended, it was quite sad, but I mean I knew that it had to end at some point (Jen).

For others the sense of acceptance seemed to be linked to some sense of helplessness, but that this made it possible to move on:

It's just something that I've done and I don't really like to try and figure it all out or anything like that, that's just you know I deal with it. What can you do you know. Cant there's no point like figuring it all out (Chris).

Chris' experience tells us that he prefers to adopt a strategy of 'dealing with it'; he sees little value in doing anything else. This approach was shared by others:

I knew that the choice was made and I couldn't turn back now. (Cher)

In contrast to the experience of other young people, there was an absence of 'acceptance' or 'inevitability' to ending in Leila's account. Throughout Leila's account she stated that she didn't think she needed therapy. Through both the analysis of her transcript and my experience of interviewing Leila, it was apparent that she presented as someone quite 'happy-go-lucky' and that this meant she held an alternative outlook on life which was perhaps different than 'acceptance' and 'inevitability'. Furthermore, because of the short-term nature of her therapy experience, she barely had time to think about what it was like to be in therapy and therefore had no opportunity or need to develop a strategy of acceptance:

I was more like overwhelmed having the therapy so I wasn't really thinking it was going to come to an end. (Leila)

Leila was one of the youngest people to take part in the research. It is considered that her concept of the inevitability of endings, as described by the other young people in this research, was not as well developed.

Meeting Leila, I got a sense of her independence. She did not elicit a need for nurture as I had experienced in interviews with other young people. On the surface level, it may be that Leila did not need support or therapy; however, it may be that this presentation is a defence against showing her dependency and vulnerability, which might confirm underlying negative ideas of fear of rejection.

3. Ambivalence

Overview

A prominent theme emerging from all interviews was the sense that ending therapy seemed to evoke a sense of confusion and ambivalence for the young people. Overall, there seemed to be an experience of both positive *and* negative emotions rather than an 'either/ or' experience. A further source of ambivalence arose from the sense of feeling unprepared for ending therapy, which caused some young people to feel shock, surprise and anger at ending. Feeling unprepared seemed to coincide with feeling out of control. The extent to which this was felt by the young people was varied.

3.1 Unprepared and out of control

Some young people experienced being unprepared for ending therapy, expecting it to continue much longer than it did:

I thought it'd be something I'd be doing for a while but it wasn't it was just a short kind of thing I think it was about umm [...] 2 years maybe I'm not quite that sure but I thought I'd be doing it 'till I was this age in a way but I wasn't. (Chloe)

In response to feeling unprepared, Chloe felt a sense of anger towards her therapist:

I don't know I guess maybe in a way I was upset and angry because in a way I believed I still needed it but it was fact that they made that decision for me you know I felt that I should have carried on a little bit longer but no they'd thought I was ready so ..(Chloe)

Together with feeling unprepared, Chloe's account tells us that she felt out of control or had little influence in the decision to end therapy. Similarly, others felt a sense of surprise at ending therapy:

I was not shocked 'cos I knew that I didn't need therapy but (pause) maybe a little bit surprised 'cos it didn't go on for that long. (Leila)

The emotion described here demonstrates a sense of not expecting therapy to come to an end so soon, implying that she had little involvement in the decision to end therapy. Although Leila herself wanted to end therapy, it seemed that the actual realisation of this happening was still a surprise for her.

In Jen's experience, she was denied the opportunity to prepare for the ending, due to forces out of her control:

Erm...well[...] I think they told me on the day that I was getting moved. (Jen)

Well it's all a bit of a blur, because it happened so quickly, like I just got, it was already jumbled and I was thinking 'oh my god where am I going?' (Jen)

Later in her account Jen demonstrates the value she places on feeling prepared for ending, advocating this as something of importance for therapists to consider when working with young people who are looked after.

I just know that they [looked after children] should be told in advance and then they have got time to think. (Jen)

For others, the sense of feeling unprepared led them to feel pressured to re-evaluate the work gained in therapy. In a way they felt they were unprepared for managing post therapy:

Getting to know him more and talking about how I could continue to control my anger in the future because time goes by very quickly and I had hardly any time to talk about that and take time to talk about the future and how I could help myself to control my anger (Cher)

Despite Cher precipitating the end of therapy, her account tells us of feeling rushed at the end and that she didn't have enough time to cover what she felt she needed to prepare her for ending therapy. Her emphasis on wanting to focus on how she could control her anger demonstrates a desire for her to feel competent.

In contrast, Chris and Janet, who also precipitated the end of therapy, did not describe feeling unprepared. In these instances, it seems the control over ending inhibited feeling unprepared:

At the end I was feeling calmer but I just didn't want to do it and didn't find it was interesting. (Chris)

This account demonstrates that Chris felt calm at ending therapy, with an absence of ambivalence or unpreparedness. Both Chris and Janet had experienced therapy as regressive and unhelpful, therefore I considered that the end, in some ways, was a welcome relief for them.

The sense of being unprepared for ending therapy seems to be juxtaposed to the previous theme of inevitability. This suggests a potential for feeling unprepared despite having a concept of inevitability to the end.

3.2 Positive AND negative

There was an apparent experience of strong emotions when faced with the prospect of ending therapy, with young people speaking of their confusion about their emotional experience. This subtheme captures the essence of young people's experience being both positive *and* negative. For the majority of young people, it was not a discrete emotion.

The following extracts from Cher and Chloe's accounts sum up this subtheme eloquently, demonstrating the potential of both positive and negative emotion:

It was positive a very positive thing but also it was also quite negative at the same time (Chloe)

Very emotional, like negative and positive but going away with helpful information made it easier because knowing that I can continue in future without him. (Cher)

Jen was unable to articulate the emotion she experienced at ending therapy, and instead emphasised the experience of mixed emotion:

I just remember feeling [...] just [...] mixed emotions really, because I had obviously a lot going on in my head at the time so you know it was just mixed. (Jen)

She did not seem to have a clear narrative or use of emotional language to describe her emotion of ending therapy. However, her account tells us that ‘mixed emotion’ is not just one feeling towards the end, but that it encompassed a range of complex thoughts and feelings. It seemed that her emotions and thoughts about ending continued to be confusing for her:

Feels like puzzle pieces but they are not all together. (Jen)

Unlike the other young people, Janet seemed unable to conceptualise this position of feeling mixed emotion or two opposing emotions at the same time. Her account seemed to capture polarised opinions and emotions, but that she was unable to hold a position that it was possible to be both:

I don't know, because I actually liked her and when she was being nice, and now that I am actually angry with her...I dunno. (Janet)

This account hints at Janet trying to make sense of her feelings towards her therapist, she seems ambivalent that she could like her and now feel angry with her. This ends with ‘I dunno’ reflecting her difficulty in holding this position.

4. Moving on from therapy

Overview

This theme aims to capture the sense that young people had a process of moving on from therapy that was enabling for their future and also impacted on future connections. For some this was more of a transition, such that they continued to maintain a psychological connection with their therapist and appreciated the ‘door being left open’. However, for one in particular, it was seen as final with no wish for re-connection. This theme incorporates the idea of ending therapy as enabling for future, that it allowed the young people to develop in their life and

independence and in future connections. Their individual meaning-giving processes also seemed to serve a function of enabling them to move on from ending therapy.

4.1 Stepping into independence

A prominent element in the young people's experiences was that ending therapy seemed to provide an impetus for their future development and independence.

Four of the young people experienced ending therapy as enabling for their future:

I was feeling happy you know I was doing something new 'cos I was going back to school and stuff like that and then obviously I was feeling sad you know like I might not see Philip again so I was just like you know, it was a nice day. (Chris)

Chris' experience of ending therapy was of starting something new and also letting go. He seems to have a sense that to move on, means also to let something go, but that this enabled him to develop. Similar to Chris, Chloe saw the end of therapy as enabling for her development, however, also as an achievement in managing on her own. In a sense she was closing one door and opening another where she was independent:

Yeah it was very helpful 'cos it not only meant that I was starting to catch up with my work but it also meant that again I could do something to make me feel good in a way instead of having to tell everybody my feelings so I was doing my own personal way, it was good. (Chloe)

Cher's account shows her reconnecting back to herself rather than the symptom of anger, indicating a personal development:

Just that it wasn't more talking about your anger, it was just more being yourself, and not having to show them how to control your anger, you could just talk about other things, apart from it. (Cher)

Through her positive therapeutic relationship, Cher experienced ending therapy as developing a different sense of self; one that would continue outside of therapy, as

if she had stepped into a different stage of independence. Cher experienced a sense of pressure about independence and growing up:

Because I'm only in this family for more number of years and then I have to get a job, live by myself and then my GCSEs will be more important. Because unless I haven't got the job then I cannot live my life properly (Cher)

Cher's choice to end therapy was based on her need to improve her grades, consequently not missing school to attend therapy. Ending therapy enabled Cher to prepare for her future; a more elaborate sense of developing independence.

Janet's experience of ending therapy as developing independence was slightly different:

She was just still treating me like a baby [...] when I wanted to carry on she was being really nice, that's why I decided to carry on, But then she started treating me like a baby so I decided not to. (Janet)

Janet's account tells us she experienced feeling disempowered during therapy and therefore took the decision to end therapy, thus moving to a position of independence and empowerment. The phrase 'treated like a baby' was repeated a number of times in her account and hints at feeling in a regressive relationship where she was unable to develop the sense of independence and autonomy she sought. Only through ending therapy was she able to overcome this conflict.

4.2 Ending as transition vs. finality of ending

The subtheme of 'stepping into independence' implies a sense of transition and for some this was explicitly linked to school transition:

Think it's probably like end of school like end of Primary School and going to High School, I think it's a bit like that like some people you might not see and some that you might see again. (Chris)

Young people's accounts tell us that they continued to hold a connection with their therapy and therapists indicating that the end is a transition maintained after the formal event of discharge:

Throughout the therapy that we had, she built this kind of little book of all the pictures of everything that we'd done um and that was quite helpful 'cos when I was missing her I could just pull that out and just have a look through just see what we'd done together so that was quite nice. (Chloe)

Chloe's account hints at the helpfulness of a transitional object to facilitate connection post therapy. For some, this connection was felt as a safety net, in that the door remained open and was never closed on them. Leila's view of ending captures this:

I thought it was helpful that Roxi said I could come back any time I wanted so it was like the door was kind of left open if I wanted to come back (Leila).

For Leila this provided her with a sense of safety post therapy. In the following account from Cher, the powerfulness of the connection post therapy seems to help to maintain her progress:

Remember feeling really happy inside knowing that I wouldn't ever forget everyone there. And knowing that I could improve remembering them and I could always call and talk to them if I really had to and made me feel more positive because technically we would still be in communication with them? (Cher)

The connection Cher continues to hold with her therapist was interpreted that she had formed an internalised representation of her therapist, which helped to sustain her. In contrast to the other young people, Janet's experience of ending came with a sense of finality:

Told her to fuck off and I walked out, didn't go back in, I didn't wanna see her ever again. That was the last session (Janet)

The finality of ending therapy seemed to parallel her experiences of coming into care and the stated reason for referral for therapy. Having experienced such finality of loss before, I interpreted her need for finality as a difficulty in her of connecting to a painful past of losses. Her use of the words 'didn't go back in' is in contrast to other young people's sense of the door left open. For Janet she

wanted to leave that space behind as if it was too painful to maintain the connection. Considering Janet finished therapy just three months prior to interview, it is possible that the dominance of anger overshadowed other emotions.

4.3 Therapy as blueprint for future connections

Several of the participants reflected on how their past experiences of therapy had impacted on their experience of their most recent therapy experience:

Didn't know he'd retired until like, just before I went in, not like, just before I went in the door but as I was just leaving, I was feeling like happy that you know oh I want to meet a new person, it's going to be really fun, fantastic but then the first three sessions were alright 'cos we were doing something new so that I hadn't done before and then I just got like bored yeah. (Chris)

Chris' experience had been of starting with a new therapist due to a situation out of his control. He was therefore required to form a new relationship on top of the loss of his previous therapist. He approached the new therapist with anticipation that it would be fun, much like his experience of his previous therapist; however after a short period of time he found his expectations were not met. In contrast, Jen found she was unable to start therapy again following the end of her previous therapy:

She was nice, she was a nice lady. I just knew like then, I was thinking about it for quite a while, I just knew that I didn't want therapy anymore, so...(Jen)

Jen's experience was to stop therapy before it began. Her account suggests she was unable to establish another connection, following the abrupt end of her previous therapy. Interestingly, both Jen and Chris had experienced unplanned endings which might account for the difficulty in forming new connections. Whilst they were not able to explain the link between past and future connections, Leila gives more of an indication that she would approach future connections with caution:

I might think that if I could get to really know somebody else this could happen again. Like I'd be happy with doing it but then I'd know it's gonna come to an end. (Leila)

Leila's account was generally positive experience of ending therapy; therefore it is interesting that she has now established a sense that endings happen and that this may impact on her future connections. In contrast to the other young people, Chloe had developed a positive representation of relationships:

It's positive because she was enabling me to go out and find somebody closer to me to express everything to and that she would leave me to handle my feelings for myself so I could get used to that for when I was older so that was quite nice. (Chloe)

I guess it built up trust for me like I can trust people more to tell my feelings to 'cos in the beginning I wouldn't tell anybody but after therapy I felt like I chose one person so that's lucky. So that I could feel now that she's the one person I can go up to and say to her I've got all these feelings and tell her everything and she'll just help me, so that's kinda nice. (Chloe)

For Chloe, the ending of her relationship with her therapist enabled her to adopt a positive representation of relationships, which supported her to consider developing future relationships. It seems she transitioned from her therapist holding her and her narrative, to her foster carer now adopting this position for her. Only through ending with her therapist was she able to then consider passing this role to someone else.

4.4 Understanding why

All of the young people had attributed certain meanings as to why therapy had come to an end. For some, they had made the choice to end, however, for others the decision was collaborative with their therapist. Conversely, some had the decision made for them. Despite varied reasons for why therapy ended, each young person had tried to understand why.

For some young people, they made sense out of ending because they felt other young people would need help more than them. This is most clearly captured in the following account from Chloe:

I knew I couldn't go back because there were other people who needed it more than me so yeah I understood why I couldn't have it. (Chloe).

The young people, seemed to identify that other people needed support more than them. This demonstrates an awareness that their therapist sees other children. The idea that other young people needed therapy seemed to justify the reason for their ending.

For some young people, there was a sense that therapy ended because they didn't need it anymore. Leila, clearly articulated this from the beginning of therapy:

I didn't think I needed therapy in the first place (Leila)

For others, there was a sense that they had improved enough not to need therapy:

... I stopped for a bit 'cos I was doing alright (Chris).

Janet and Jen both gave meaning to ending in relation to a lack of control. For Jen, the decision to end was a result of placement moves and therefore for her this is why she felt she ended therapy:

Obviously I was leaving the placement so I couldn't really be under that person anymore, because like when you move, your GP gets changed, you change schools. That's why. (Jen)

Janet made sense of ending therapy based on the simple fact for her that her therapist continued to treat her like a baby, as captured in theme of 'stepping into independence'.

DISCUSSION

The study's findings will now be considered in relation to the research questions, existing theory and literature. Key findings will be presented followed by a review of the clinical implications and suggestions for future research. Methodological considerations will be discussed. Finally, I will conclude with my closing reflections. IPA and other qualitative approaches often lead to new and unexpected themes emerging during the research process, thus some of the literature introduced below is new (Smith et al., 2009).

The following section discusses the main findings of this study in relation to the main research question, which was:

How do adolescents, who are looked after, experience the ending of psychological therapy?

In undertaking this project, I set out to develop an understanding of the experiences that are involved in the ending phase of psychological therapy for adolescents who are looked after. I hoped to explore the potential impact of ending therapy and also explore the coping strategies young people adopted to manage this phase of therapy. In trying to understand their experiences of endings and separation, it became clear that I needed to understand how they experienced connections within therapy. The findings are specific to the participants in this study but there is enough overlap and continuity in the themes to allow for some cautious generalisation.

This is the first study to provide an in-depth, qualitative account of the experience of ending therapy from the perspectives of adolescents who are looked after. Little is known about how this group of people experience this phase of therapy. Given the finding that a number of LAC receive mental health intervention, we can infer there will be a modest, yet significant proportion who enter therapy and consequently end therapy. Without knowledge about this complex process, therapists are reliant on personal experience and biases, personal social constructions and research perhaps inadequate to account for this targeted population. There is now high priority to improve mental health experiences for this group of people, incorporating the views of the service users themselves.

This study offers a detailed account of six adolescents who are looked after, however, it is not possible to conclude that the results of this study are necessarily unique to this population or group of people. It is possible that the results of this study may also be consistent with findings of all children and young people ending therapy. In trying to understand their experiences, it is therefore important to consider that the results may be relevant to all children, and not necessarily unique to the population of looked after young people.

Key Findings

Significance of the therapeutic relationship.

The end of therapy represented an important and memorable experience for all participants, which was inextricably linked to ending the therapeutic relationship. All of the participants felt the therapeutic relationship was a significant factor in the therapy experience and that ending therapy represented the end of the therapeutic relationship. This study lends strong support to the idea emerging across the literature which highlights the therapy relationship as significant, and our work should therefore “focus on therapist’s ‘being’ qualities rather than ‘doing’ skills” (Spinelli, 2005 p.173). This is consistent with literature suggesting therapeutic orientation might be secondary to other factors in distinguishing effective therapies (Stiles, Shapiro & Elliot, 1986).

Whilst this is likely to be important across therapeutic situations, it may be particularly relevant with a LAC population in light of their history of disrupted attachment relationships (Howe & Fearnley, 2003) and the importance of establishing a therapeutic relationship when working with LAC (Bowlby, 1988; Hughes, 2005). This finding is consistent with research presented by Davies and Wright (2008). In their review of the views pertinent to LAC regarding mental health services, they concluded that despite NICE guidelines focusing on intervention type, other aspects of staff interactions may be more important to LAC. The current study draws further attention to the value of focusing on the therapeutic relationship and highlights how this may impact on the ending experience.

The experience of the young people in this study has strong links with attachment theory (Bowlby, 1988) in that the participants' experience of the relationship with the therapist is of having a secure base. It seems that the therapists provided a sense of attachment and connection for the young people in this study. They valued therapist qualities of equality and respect, and felt contained with the knowledge of having someone 'always' there. The finding of this study is consistent with Rogers (1961) concept of 'unconditional positive regard' whereby the therapist offers unconditional acceptance and support of a person in order to facilitate healthy development. Furthermore, this lends support to research of Hughes, (2004, 2005) which demonstrates the significance of playfulness, acceptance, curiosity and empathy in working with LAC. This study points to the potential value of these qualities persisting until the very end of therapy.

The study's findings indicate that attunement is a significant factor affecting the experience of ending therapy for participants. Stern (1985) observed that infants learn to regulate their emotions through interaction with their caregiver, a process called 'attunement'. He argued that a lack of attunement results in children being unable to self-regulate and consequently unable to deal with overwhelming emotion. Although attunement was initially discussed in relation to parent-infant relationships, affective attunement is suggested to be a key factor highlighted in DDP and other treatment approaches (Hughes, 2005).

This study demonstrated that attunement during the ending phase of therapy seemed to enable the young people in this study to regulate their emotions to manage. In particular, this study demonstrated that some LAC appreciated attention and emotional salience to ending, whereas others preferred a more simplistic event. This finding may be particularly relevant as it demonstrates the potential challenge of adopting prescriptive treatment plans and offering the same approach for all LAC. The study's findings, together with existing literature, illuminate the importance of being responsive to the young people's needs and, in particular their needs regarding ending therapy. Thus, it seems that therapists, and importantly the therapists' attunement, is significant in the experience of therapy and how therapy is ended.

Also apparent in this study was the significance of the goodbye hug. The physical act of saying goodbye is seldom reported in the ending therapy literature; however, for the young people in this study, it seemed a powerful memory of the ending experience. The issue of touch, such as hugging clients, is a controversial issue in therapy, particularly in the psychodynamic tradition (Tune, 2001). Some therapists adopt principles in line with the view that any form of physical touch between therapist and client is unethical and inappropriate (Tune, 2001). However, Keith-Spiegel and Koocher, (1985) demonstrated that some therapists believed that touch may actually benefit clients in certain situations. For some young people in this study, it appears that the goodbye hug demonstrated the value of the relationship, and allowed for a sense of completion to the therapy experience. Doel and Shardlow (1998, p.87) argue that the “sense of completion is crucial for our moral well-being”.

Attachment and detachment

In this study the ending experience seemed to be dependent on the connection with the therapist. If they did not experience an attachment or connection with their therapist, then they were more likely to detach from therapy. This resulted in them feeling indifferent about ending therapy, consequently, remembering little of the experience. This is consistent with research which demonstrates clients are likely to drop out of therapy if they have experienced a rupture in therapy, or that they feel unheard or pressured by the therapists’ biases or agenda (Hill, Nutt-Williams, Heaton, Thompson & Rhodes, 1996). This finding may be particularly significant for LAC, as a lack of control or say in therapy may mirror their experience of being in the care system; an aspect of care often advocated by young people for change (Bradwell et al. 2008).

Furthermore, this finding supports the research of Knox et al. (2011) who observed that people who had a negative experience of therapy may find little hope of salvaging any sense of benefit from the therapy; in fact, the only sense of good may be that the therapy and its incumbent harm has finally ceased (Knox et al., 2011). This was evident in Janet’s account where it was observed that her independence was associated with ending a relationship that she experienced as

repressive. This study suggests that the presence, or absence, of therapeutic ruptures may hold substantial importance for the termination experience for LAC.

Conversely, for those participants who described a positive therapeutic relationship, the end of therapy was often described as both a positive and negative experience. The study therefore demonstrates the potential for both loss and gain to be experienced during the ending phase of therapy, a finding acknowledged by other researchers (Knox et al. 2011). Overall, this study again adds to the growing recognition of the significance of the therapeutic alliance and the impact of this on the clients' experiences of therapy and ending therapy. Furthermore, this gives support to research which has shown ending therapy as a two-person process with emphasis on mutuality (Quintana & Holahan, 1992).

'Daring to try again'

A key trend in the literature has been to describe young children who have experienced neglect and abuse, followed by abandonment, as having great difficulty in allowing anyone else to become close to them (Bartholomew & Horowitz, 1991). This view is consistent with attachment perspectives that suggest future connections are formed in relation to IWMs from early experience. However, other researchers question the legacy of early experiences (Clarke & Clarke, 2000). Demonstrating the complexity and contradictions within this area, young people in this study expressed mixed responses to forming connections. Some had difficulty forming new therapeutic relationships; some demonstrated the ability to 'dare to try again'. Although this was not the targeted focus for this research, some interesting findings emerged in relation to ending therapy. Furthermore, as already outlined, it became clear that to understand the experience of ending therapy, it seemed important to consider how they experienced connections within therapy.

Interestingly, for those that had difficulty forming new relationships, this seemed to be linked with a previous experience of therapy and in some instances when the ending was unplanned. It seemed that the therapy relationship served to form a blueprint for future relationships. For some participants they may have found it challenging to 'try again' and were therefore unable to continue in

therapy (Lanyado, 2003). For the young people in this study, it does not seem to be previous unrelated losses, such as moving into care, which impacts on the ability to form a therapeutic relationship, but the experience of loss of a similar figure in their lives. It is possible that the loss of moving into care was too abstract for the young people to connect with the loss of the end of the relationship.

Furthermore, it seems important to acknowledge that, for young people in the study, it seems nothing can quite compare to their early experiences of loss. This finding is consistent with Coltart's (1996) view that if therapy has been an authentic experience, the qualities of the new relationship, embodied in the therapeutic relationship, will mean that the end of therapy is a different kind of loss from past experiences. This further lends support to Many's (2009) view of offering an alternative sense of loss rather than adding to the traumatic string of losses already experienced in these young people's lives. Similarly, the potential for the end of the therapeutic relationship to inform a blueprint for relationships is an important finding from this study. This study therefore adds to the growing body of research demonstrating the importance of supporting young people through the transition of end of therapy. This lends further support to the development of targeted approaches for this population, as advocated by Tarren-Sweeney (2010).

Also apparent in this study was the potential for participants to form new therapeutic relationships, demonstrating strength and resilience in daring to try again. This finding is positive, and challenges beliefs that children who are deprived, often tragically, reject the help they so badly need, a phenomena which has been described as 'double deprivation' (Henry, 1974). The finding that the young people formed these relationships at all signifies the importance of the therapy relationship and quest for focusing on the impact of making and ending these connections.

Overall, these findings seem to represent young people's contradictory positions of forming and ending relationships. Factors of resilience may have played an important role in this study, distinguishing between those who were able to 'bounce back' from experiences of ending, and those who found this more

challenging. This research illustrates the complex nature of relationships for LAC and indicates further research as helpful to elucidate the processes.

Ending as loss and looking to a future without therapy.

The study's findings demonstrate that ending therapy represented a complex process of loss and gains for the participants in this study. Some young people experienced ending therapy as loss of relationship but also as enabling for their future.

Some of the difficulties associated with ending therapy relate to feelings associated with separation and loss. This finding is consistent in other studies of ending therapy (Many, 2009). The experience of loss is related closely to the experience of loss of the relationship. This lends support for the view that our work with LAC should be guided by a focus on loss, but perhaps specifically the loss of the therapy relationship (Lee & Whiting, 2007).

This study found that many of the young people maintained a connection with their therapist post therapy, which is consistent with the experience coined as a 'continuing bond' (Klass, Silverman & Nickman, 1996). The connection described by young people in this study, was in some ways a psychological connection, which seemed to be helpful for most of the participants. This challenges the need for 'letting go', which is seen in earlier literature as essential for overcoming grief (Klass et al., 1996). Furthermore, this finding is inconsistent with Bowlby's (1973) original three-stage model for separation and loss, which describes a stage of detachment as essential for healthy development. The trend for 'continuing bonds' is a recent trend in grief literature which purports that people maintain a link and continue the relationship over time (Klass et al., 1996). The maintenance of the connection with their therapist was experienced as comforting, upsetting and also facilitating for the young people in this study. Perhaps such a connection as experienced by these young people, could be viewed as continuing bonds, consistent with experience of loss.

This study suggests that, whilst there is the potential for young people to experience sense of loss following the end of therapy, there is opportunity for

positive gains to be made also. The finding that young people were able to process the experience of loss and attribute positive gains to ending therapy challenges dominant theories of loss and endings. Therefore, despite a consistent finding of the experience of loss, ending therapy also marked a beginning of starting something new for all those in the study. Young people's view of ending as transition was apparent across the interviews. This finding echoes Lanyado's (1999) perspective of ending therapy which is viewed much like other life transitions, in which beginnings and endings are intertwined. The present study supports these findings, indicating that ending therapy can be a transition rather than experienced as stark beginnings and endings.

In some instances, the participants in this study anticipated ending therapy with positive feelings, in looking forward to moving on to a new phase in their lives. Ending provided an impetus for the young people to develop independence and demonstrates an alternative trajectory to traditional models of loss. Therefore, the end of therapy for the participants is an opportunity for development and transformation, a view outlined in Quintana's model of loss (1993). In support of this model, the present research suggests that the component of 'termination as development' is evident in the participants' accounts. Whereas it has traditionally been the case that therapists must help clients focus on the emotionally painful aspects of this period, the study's findings suggest that it may be equally important to attend to clients' positive feelings. Having the privilege to share in the independence recognised at ending therapy along with the sadness and fear surrounding its ending, may play a significant role in this process.

Recent research has provided support for alternative trajectories of loss. Bonanno (2004) argues that our understanding of loss seems to be dominated with information from adults who have sought help to cope with the trauma of loss. Because of this, our knowledge base is limited and has neglected an alternative trajectory that focuses on the process of recovery and resilience in the face of loss or potential trauma. Bonanno (2004) argues that there are many and sometimes unexpected pathways following loss, with the most common related to a trajectory of resilience. The finding that the young people were able to consider how ending therapy enabled them for their future provides support for this position.

Furthermore, the finding that the young people were able to consider a positive outlook on ending therapy may have been a protective factor, and consequently enabled them to manage with this potentially distressing experience. This provides support for the 'positive psychology' movement for researchers such as Martin Seligman (2002) who have offered a counterpoint to the preoccupation with psychological and mental pain. A major finding from such research is that, given the same psychological stressor, those less affected find a way to believe that some good has come out of the experience, taking positive learning from it. Research has shown that those who are more resilient have a more hopeful, 'meaning-giving' outlook, even if they have no less distress than those who fared worse (Zautra, 2003). This was evident in the participants' accounts of giving meaning to ending because other young people may have needed it more than them. The complex interplay between resilience and LAC may have provided them with a unique experience of ending therapy as they may have been able to apply more 'meaning-giving' to their experience. This demonstrates the importance of keeping young people informed, in order to facilitate them justifying why therapy came to an end.

Managing with ambivalence.

Young people's ambivalence and confusion surrounding their ending therapy experience were prevalent in this study; many felt unprepared and both positive and negative emotions. This has also been acknowledged within other research studies (Bury et al, 2007). The mixture of emotions experienced by the young people in this study fits well with Lanyado's (2003, p.337) finding of a 'cocktail of emotion' experienced at the end of therapy. The prevalence of both positive and negative experiences, together with facilitation of independence, adds further weight to the argument against traditional models of endings, which view them as a traumatic struggle. In contrast, this research adds support for ending as eliciting mixed responses (Baum, 2005).

The theme of ambivalence about ending therapy can be understood within the context of LACs particular stage of development. The themes of loss and unpreparedness in moving towards the establishment of an independent identity

are central to their developmental stage. The young people are experiencing a need to separate and become independent and are therefore likely to experience particular difficulties and conflict in seeking help, and subsequently, to manage terminating help. Independence matches Western values about the importance of autonomy and is therefore supported in dominant discourses in society. Moving on can be seen as a transitional period when the young people attempt to adjust to a new situation without the structure and routine of therapy. This may form yet another change in the young people's lives. This highlights some of the possible dilemmas faced by LAC during adolescence and ending therapy. This transitional period coincides with the experience of ambivalence.

The finding in this study, that young people experience a sense of unpreparedness together with feeling out of control, is consistent with research which highlights the importance of using a collaborative approach to ending therapy in order to facilitate a positive experience (Baum, 2005). Young people in this study valued having some control and preparedness in ending therapy. The relationship between control and LAC is evident in the literature (Solomon, George & De Jong, 1995). Research has suggested that many LAC are likely to have experienced unpredictable and complicated early lives, resulting in them developing a controlling strategy as a desperate attempt to predict a volatile world (Solomon et al., 1995). Beneath a controlling presentation their minds can be filled with dangerous and frightening thoughts and impressions that the world is unsafe and unpredictable (Hodges, Steele, Hillman, Henderson & Kanick, 2003). The findings from this study, that the participants experienced ambivalence and uncertainty when ending therapy, could therefore be explained by their underlying cognitions of a need for a world which is controlled and predictable. A further indication of underlying presentation of control was the young people's attempts to take charge of the ending phase of therapy, as seen in the example of Chloe closing down during this period. This provides an important insight in to what young people may experience when ending therapy, which may be entering an unsafe world.

Developing ways of coping.

In relation to the research question of exploring strategies that were adopted by the young people, the study's findings demonstrate that they had developed strategies to manage with the ending experience; namely disconnection and distraction. A link between coping styles and early experiences has been acknowledged within the literature. Howe (2005) observed that children who have been abused tend to use cognitive disconnection as a strategy to deal with overwhelming emotion. This is seen as an attempt to deactivate attachment behaviours. Furthermore, the coping mechanism of 'acceptance' expressed by young people in this study, could be explained in a similar manner. Research has shown that neglected children can be passive, particularly under stress (Howe, 2005). These children have learnt that, no matter what they do, nothing makes a difference. Therefore, the end of therapy could have been experienced as activating schemas associated with neglect, resulting in strategies of disconnection and deactivation of attachment behaviours. The study's findings demonstrate a possible association with early experiences, ending therapy and coping strategies for participants in this study.

Although 'acceptance' can be viewed as a strategy associated with 'resignation' and 'giving in', the function of this strategy for some young people seemed positive and adaptive. Akin with concepts in acceptance and commitment therapy (Hayes & Smith, 2005), acceptance seemed to involve willingness on behalf of the young people to experience ending therapy, which facilitated them to move to the transition of independence. Hayes and Smith (2005) referred to 'acceptance' as an important process in order to move on in life, despite the experience of pain or psychological distress. This illustrates that for young people in this study, acceptance may be an important precursor to independence.

Several researchers suggest that types of coping strategies used by adolescents do change with age, and therefore the approaches adopted by the young people in this study may be related to developmental factors. Frydenberg and Lewis (1993) found that younger adolescents reported that they dealt with stress by working more and distracting themselves from the problem. This was evident in the current research, where Leila, the youngest participant in the study,

reported adopting the technique of distraction to manage with the experience of ending therapy. Frydenberg and Lewis (1993) also identified that older adolescents used tension reduction techniques more often than younger adolescents. This finding is consistent with Compas, Orosan, and Grant's (1993) conclusion that emotion-focused coping strategies increase in frequency through adolescence. Emotion-focused strategies manage or reduce distress and can involve problem avoidance through ignoring the issue, withdrawal, or expressing negative feelings. The common strategy of disconnection, as evident in this study, supports this as a strategy associated with developmental stage.

Gender differences in coping styles have also been described in the literature; however, there appears inconsistent support which purports significantly divergent coping strategies (Williams & McGillicuddy-De Lisi, 2000). Within the present study, only one male participated, therefore it is not possible to conclude whether this study confirms or disconfirms previous research. This would need to be explored more fully as it is recognised that this was not within the remit of this study. Coping strategies have seldom been reported in the current knowledge base for ending therapy, therefore this study provides an insight in to how young people not only experience ending therapy but also how they may cope with this experience.

The finding of inevitability to ending and the link to the experience of life itself was an unanticipated finding from the study. By interviewing adolescents who are looked after about their experiences of ending therapy, this unique outcome emerged. This is something that I had not come across in the literature review. A key finding from this research was that the young people seemed to approach therapy and subsequently ending therapy, based on a discourse of 'inevitability to end'. Although evidence for some discourses as proposed by Fredman and Dalal (1998) was evident in this study, namely 'ending as loss' and 'ending as transition', it is proposed that a discourse for LAC in this study may be one of 'ending as inevitable'. This discourse impacted on how they approached the ending experience, for some with acceptance. Given this finding, it could be important to consider this as a discourse specific to LAC and as something which could be recognised within the therapeutic process.

Ethical reflections.

There are ethical and professional imperatives for psychologists and other staff to ensure that the services that they provide for users are, in fact, meeting user needs and being delivered in the most effective and appropriate manner. Researchers have drawn attention to the potential harm caused by psychotherapeutic intervention for people with attachment difficulties, such as LAC. Although the current study is not able to generalise on the whole population of LAC, it seems that ending therapy is an important aspect of therapy process, which has the potential to arouse complex emotions, and processes for participants. This research demonstrates that the ending phase of therapy should therefore be considered with the same responsibility as phases of assessment and intervention.

Clinical implications

Some important considerations for clinical practice emerged from this study. It supports proposals of developing approaches specific for this population and that therapy cases should be formulated within appropriate conceptual frameworks (Tarren-Sweeney, 2010). This research highlights a valuable role for Clinical Psychology in providing and informing interventions and in the formation of practice guidelines in working with this population.

This study highlighted the potential need for careful and on-going consideration of the ending phase of therapy with this population, both prior to ending and to enabling young people for a future without therapy. This study raised the importance of therapists being aware of the difficulties and conflicts that LAC may experience during the ending phase of therapy. This study identified that the young people were variable in the extent to which they felt prepared to end therapy and in how the ending was marked by the therapists. The therapist's attunement to the young people's needs at this time appeared of particular importance, with careful consideration given to how the end is managed. The therapists in this study were all experienced clinicians working specifically with the looked after population. It is therefore considered important for all therapists, especially the less experienced, who work in generic services

with LAC, to be aware of the possible experiences of their clients. Given the finding, that the relationship seems central to the experience of ending therapy, it appears to be critical to consider these factors when starting therapy.

This study highlights the importance of collaborative approach to ending therapy. When the young people felt out of control, this coincided with a sense of feeling unprepared. In future, clinicians may focus on developing a sense of collaborative approach to ending therapy and to ensure the young people are involved in the decision making process. This may aid their ability to develop a positive 'meaning-giving' account to their experience. Even when ending is precipitated by the young people themselves ending can still evoke a sense of unpreparedness therefore an emphasis on collaborative approach should not be underestimated.

Further to the above two points, the findings of this study raise concerns about the current climate of short-term work. The participants in this study described the difficulty in making and breaking connections and their need for more time and certainty around this process. This demonstrates the potential critical factor of allowing time, resource and commitment to this phase of therapy for LAC. Without this, we may expect more young people to experience feeling unprepared and out of control. Although this may be evident in other clinical populations, it is considered particularly relevant for LAC given their early years experiences.

The finding that, for some participants, ending was not the traumatic struggle as originally suggested in the literature, may be a particularly salient finding from this research. It is recognised in clinical practice, that some therapists do not address the ending phase in concern of the clients regression or re-experience of painful traumatic emotions (Martin & Schurtman, 1985). Given the finding that this is not the case for the young people in this study should provide therapists with confidence to address this phase in therapy. This may go some way to help young people feel prepared for and have greater control at ending therapy.

Finally, the value of this research is that it demonstrates that qualitative research can be employed with this population, a finding consistent with previous

research (Davies et al., 2009). Despite some challenges in terms of recruitment and ethical procedures, this research demonstrates that research within this field is viable and provides the reader with a rich detailed account of young people's experiences. The young people in this study described that they were keen on their views of this research being used to help inform clinical practice. This supports Gilligan's (2000) suggestion that involving young people in research can help give them a sense of involvement and power to have their views taken seriously.

Methodological considerations

A strength of this study was the use of qualitative methodology which allowed adolescents to voice their experiences, something which has previously been neglected in the research. The methodology chosen for this study fitted with the aims of the research, resulting in a rich, complex and rigorous account of LAC's experiences of ending therapy.

Based on the understanding that actual lived experience can never be fully grasped and that IPA is an idiographic approach that does not seek to find definite answers, it is not possible to make claims about the generalisability of the results for the wider population of LAC in therapy. Furthermore, by exploring the experiences of six adolescents who ended psychological therapy, this study offers one possible construction of the research question particular to this study. Therefore, although others may have had similar experiences, it is important to consider the transferability and generalisability of these findings within this context. Nevertheless, the results of this study contribute to a gradually growing knowledge base and help to shed light on the broader context. Furthermore, the findings can indicate areas of likely significance that might warrant further investigation.

Therapists in this study were from several theoretical and professional backgrounds. Ending processes were also varied for all of the young people. Thus, although this could be considered a limitation, given that the sample was not homogenous in the context of ending, I think this sample captured the wide range of ways contemporary therapy is delivered and ended. I feel this captures the experiences of young people in looked after children's services, that there is no 'majority' or 'normal' way in which endings are processed for young people or

that LAC receiving mental health intervention all receive the same theoretical approach or model. This diversity therefore reflects more of the lived experience of young people.

Although every attempt was made to be rigorous and transparent, it must be acknowledged that the results generated from this study are based on my interpretations and other researchers may have found other factors more salient. To enable the reader to gain access to this process, an audit trail for one interview is included (Appendix 12). It is important that researchers consider these factors in the interpretation of findings.

The aim of IPA is to produce an in-depth account of a small number of participants' experiences and this is what I set out to achieve. The sample in this study is in keeping with the sizes recommended for IPA (Smith et al., 1999). A small group can never be a representative sample but IPA recommends a relatively homogenous group, which allows for commonalities to emerge, as well as some differences. One of the strengths of IPA is derived from its foundation in the principle in idiography. The accounts of the individual adolescents can be traced throughout the analysis that I have produced and in conducting the analysis, I focused on working outwards from individual cases to the whole group.

During the design of the interview schedule and interview process, I was challenged as to how to gain rich and detailed accounts from a population who are traditionally considered less articulate. McDonagh and Bateman (2011) suggest that questions be direct, using more prompts in contrast to interviews with adults. I was also aware of the importance of making the young people feel at ease during the interview. IPA interviews with adults are generally more free flowing than the interviews completed for this study. Despite this difference, I feel this adaptation was essential to enable the young people to describe their experiences.

I was also aware of the potential influence of power within the research study. LAC are often in a position of a lack of control and influence over their care and circumstances. Talking with a Trainee Psychologist may have left the young people feeling disempowered as they may have felt that I was biased in my position or agenda for the research. Furthermore, it is possible that the young people may have felt anxious about seeming ungrateful, if they were to describe

more negative aspects of their experience. Conversely, some adolescents may have hoped that their negative accounts would have been fed back to the therapist for them to feel their pain and connect with their experience. Despite these potential factors, I feel the young people described an open and honest account of their experiences. They were able to share both positive and negative experiences. Furthermore, when asked at the end of the interviews whether they felt they had expressed all they would like, they often reported that they enjoyed talking about their experience and found it helpful, suggesting that they gave an accurate reflection of their experience.

A further factor to consider is the potential of selection bias of those choosing to take part and those identified to participate. Young people were identified as having potential to participate in the study by the clinicians who worked with them. They may have therefore been selective about those where they considered the therapy and ending phase went well, in order to defend against the potential of the responses reflecting them in a bad light. Some adolescents themselves also chose not to take part. The majority of young people referred to this project were female. It is therefore considered that there may have been a bias in clinicians' perspectives of those they put forward for research, perhaps expecting that girls would be more suitable for qualitative research than boys. Therefore the experiences of those choosing not to take part may have been quite different from those taking part.

It is generally acknowledged that the criteria relating to validity in quantitative research are not appropriate for the evaluation of qualitative studies. As outlined in the methodology section, this project was designed and conducted in accordance with criteria outlined by Yardley (2000) and Elliot et al. (1999). Quality checks were conducted during each stage of analysis with peers also conducting IPA research projects. This was further supported by research supervisors familiar with IPA methodology.

A final methodological issue concerns the use of member validation. There are conflicting views in the literature regarding its usefulness as a method establishing credibility from the findings. Although this can be a helpful check to ensure that the participants' views are not misrepresented, it relies on the

assumption that there is a fixed truth to which the accounts can be measured (Angen, 2000). Furthermore, Yardley (2008) argues that member validation checks can be inappropriate as they can lead to participants becoming confused, and unable to relate to the analysis. It was therefore decided not to complete member validation checks but to ensure other measures of validity were adhered to, such as credibility checks of transcripts and analyses.

Suggestions for future research

This study offers a detailed account of how LAC experience an important aspect of therapy using qualitative methodology. The literature in the field, specifically focusing on the experiences and views of the young people themselves is a neglected area of research. As demonstrated in this study, qualitative methodology offers a unique opportunity to capture the lived experience of young people from their perspective rather than based on pre-determined measures. This has helped to enhance our understanding of this aspect of therapy process and highlights areas for improving our clinical practice. Further research would be beneficial to build on the findings from this study.

It would be interesting to conduct research which distinguished between clients ending therapy and ending therapy as a collaborative/ planned process. In this study, there seemed to be some areas of difference that may be related to the actual event of ending. Wilson and Sperlinger (2004) demonstrated that, for those individuals who dropped out of therapy, there was a sense that they were shopping around for therapy in order to explore a particular approach and the extent to which they can tolerate or benefit from it. The value of this research indicates it is not possible to group those who stay in therapy or drop out as successes or failures, but rather that there is a complex process attributed to this. Further research may help to enhance understanding about the processes involved in these different contexts.

Further research could focus on expanding the age range of people recruited, for example, recruiting younger children and adults to consider how developmental stages may impact on the lived experience of ending therapy. Following this, it would be interesting to conduct further research which could

highlight the interaction of gender and the influence on ending therapy. This study recruited five females and one male and, although consideration was given to conceptualising differences from a gender narrative, further work may help to enhance understanding in this area.

Furthermore, little is known about the impact of culture on ending therapy. It is acknowledged that the processes of ending may elucidate subtle differences due to other factors such as experiences and cultural narratives. Given that the population from which the participants were recruited were ethnically diverse, the sample recruited for this study was a fairly homogenous group. Culture not only influences the motivation to seek help but also impacts on how mental illness is experienced. For example, a recent study by Jim and Nistrang (2007) demonstrates that culture can impact on the therapeutic relationship. The results of their study highlight that, although participants with a Chinese background reported perceptions of therapy which showed similarities to those reported by clients of European-American descent, culture entered into the therapeutic relationship in complex and diverse ways. Differences in values and belief systems of Eastern and Western cultures are frequently cited as one reason that Chinese clients may terminate therapy prematurely (Jim & Nistrang, 2007). Their study presents findings of just one example of how culture impacts on the therapy process. Such values are likely to impact on people's experiences of ending therapy. Further research could explore the experiences of ending therapy from the perspective of young people from different cultural backgrounds. It is important to remain mindful that people will vary in the degree to which they adhere to cultural norms. It is recognised that culture is multi-dimensional and complex.

It would also be interesting to consider the experience of ending therapy from the therapist's perspective. Research tends to focus on the clinicians' understanding of the client's experience. However, little is known about how the therapists themselves negotiate this phase of therapy with LAC. Research has demonstrated that therapists' countertransference and negative feelings can have a profound impact on the experience of their clients as well the course of therapy and its termination process (Mohr, 1995; Todd, Dean, & Bragdon, 2003). It could therefore be argued that the therapists themselves bring important factors to the

experience and are also affected by the experience. Within this study, Chris felt that the task of the therapist ending therapy with a number of young people would lead them to feel depressed:

Maybe he is like really depressed 'cos like one kid [ending] feeling sad, like two kids and three kids like feeling like depressed. (Chris)

This gives recognition to the sometimes, and yet inevitable challenge of providing therapy. Fredman and Dalal (1998) suggest that it is not only the client discourse which impacts on the ending experience, but also the discourse of the therapist. This is in line with systemic principles of therapy, which view the therapist as very much involved in the therapy process, a process termed second order-cybernetics (Dallos & Draper, 2005). This would help enhance understanding of the challenges of working with LAC and how supervision and training may be facilitated to consider these factors.

Final reflections

Throughout this project, I have been committed to understanding how my position may influence this research project and vice versa. The process of thinking about my own position in relation to the interviews and literature involved inviting some outside reflection on them, including discussions with my research supervisors, peers and professionals within the field.

Whilst writing my discussion, I became aware of a song which had played repeatedly on the radio in the background. This song became my anthem for this thesis. In the very last week of writing I learnt that this song was called 'Never let me go', (Florence and the Machine). Personally, I feel this song represents a dominant discourse in Western society of a desire to be held in the mind of another and for relationships to be permanent. For me, this song represents the challenge of letting go, when perhaps it feels natural to hold on. This highlighted how such concepts and discourses may underlie the experiences of the young people in this study.

Throughout this research project, I was invited to think about what my relationship was to my research. This research has probably been one of my most

challenging experiences to date. I was provided with an insight into the inevitable challenges of conducting research in this area. At times I felt restrained from continuing, particularly when recruiting participants and completing the ethics process. My enthusiasm for this project was sustained by my continued review of the literature followed by the insightful experience of interviewing the young people. I felt privileged to meet the young people and admired their ability to talk about their experiences. Upon analysing the data I found myself immersed in the data of the young people and feel a sense of achievement that I have been able to produce an account of their experiences based on their data.

I recognise that during this research, I was also undertaking my own ending experience of coming to the end of my clinical training programme. Furthermore, I was also ending with a number of clients at the end of my clinical placement. Personally, I also faced a transition of ending. I recognised that during these times I found myself thinking about the literature and how it may help explain the processes associated with these events. Furthermore, I noticed that I often found myself thinking about the young people in this study and how they described moments of strength and resilience. I reflect that this fuelled my own strength at difficult times.

Although I recognise that it is only possible to know part of the story, at times I felt connected to the lives of the young people who agreed to take part. I was at times shocked by the experiences of participants and felt a sense of responsibility that I was from the profession that had led to some negative experiences for young people. At times I also felt overwhelmed by their strength and resilience. Their experiences and understandings seemed beyond their years and I felt these young people had impressive philosophies to manage with the challenge of life. I feel indebted to the young people who took part in this study: some said that they hoped that this research would help other young people who are in therapy.

Clinically, I have learnt a great deal from conducting this research. Notably, this has emphasised the importance of treating our work with considerable caution and rather than accept cases because this becomes 'run of the mill' and because we become pressured by targets, I have learnt to question

accepting each new case and how I will be taking a step, if invited, in to the lives of those referred. I hope this finding is disseminated and shared by other therapists. This has also highlighted the importance of the ‘small things’ and to be ‘human’ over and above any therapeutic technique or tool.

A key aspect of completing an IPA project that struck me was the requirement to be a ‘flexible researcher’. The hermeneutic cycle element of this research encompassed each stage of the research. I found myself constantly reworking, re-structuring and re-evaluating my interpretations and themes. As new information emerged within the data I found I was reviewing older interpretations and so forth. Throughout I was aware of keeping immersed within the data and not become focused on one approach or theory. For me this experience demonstrated the importance of ‘bracketing off’ and remaining within the context of the data. Finally, this research has demonstrated how the researcher cannot be independent from the researched: that the whole process is influenced by personal background, stance and interpretations.

CONCLUSION

The aim of this study was to explore how young people experience ending psychological therapy. In summary, this study has provided an original in-depth account of six looked after adolescents’ experiences of ending psychological therapy using an IPA methodology. Using IPA has allowed for the development of a rich account of the experience of ending therapy for the looked after adolescents interviewed.

To summarise, while this study tells us how complex the process of ending therapy is, it also highlighted the resilience of looked after adolescents and their ability to not only form connections, but manage the transition of ending with strength and resource. Most notably, the ending of therapy facilitated a new phase of development and independence for participants, challenging older perspectives that clients regress or experience this phase of therapy with negativity. Finally, this study gives further support to the significance of the therapeutic relationship.

In order to generalise the findings of the results to wider population of LAC, further research needs to be conducted.

I consider the following quote offered by Marx and Gelso (1987, p.7) powerfully reflects my understanding of the experience of LAC in this study and highlights that ending therapy is not a simple reflection of things gone by, but also captures the sense that ending involves looking to the future:

Termination appears to consist of the following three themes: looking back, looking ahead, and saying good-bye

(Marx & Gelso, 1987, p.7)

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APPENDICES

Appendix 1: literature review search strategy

Stage 1: Initial Exploratory Search

An initial search began with a review of relevant books within the Learning Resource Centre at the University of Hertfordshire and database searches using Web of Science and Google Scholar. The search terms used at this stage were:

'Ending Therapy' OR 'Therapy termination' AND

'Looked after children'; 'looked after adolescents'; 'adopted and fostered children'

'Psychological therapy'

'Adolescence'

Stage 2: Following up references

From relevant articles, key references were identified and followed up. At this time, key authors were also identified and relevant papers obtained.

Stage 3: Contacting Researchers in the Field

I joined the CP-LAAC (the National Network of Clinical Psychologists working with Looked After and Adopted Children) and liaised with Clinical Psychologists working with looked after children who were able to advise me regarding the nature of my research, the specific research question, and further references.

Stage 4: Detailed Review of the Literature over 18 months

Informed by my previous searches, I went on to conduct a detailed review of the literature according to the criteria outlined below:

Inclusion Criteria:

- Studies of young people with who had ended psychological therapy
- Papers published in English (or where translations were available)
- Peer reviewed Journals
- Papers which provided an insight into the experiences of young people who were looked after and had ended psychological therapy.

Exclusion Criteria:

- Studies of adults ending therapy

Dates of Search: 1985-2012

Search Terms

Using Boolean operators and truncation options to ensure all relevant papers were retrieved, the following search terms were employed:

- Looked after children – looked after adolescents, LAC, children looked after
- Adolescence – young people, teenagers, children, childhood, growing up, adolescent
- Experience – lived experience, personal experience,
- Ending therapy – termination therapy, discharge therapy,
- Therapeutic relationship – client / therapist qualities,
- Qualitative Methodology – IPA, phenomenology, qualitative methods, reviews, case study, case report, descriptive, meaning making, grounded theory, thematic analysis, discourse analysis, social constructionism

Search Engines

Citation alerts were set up associated with key papers identified through the search. The following search engines were used:

- Web of Science
- Google Scholar
- Scopus
- Psyc Info
- Pubmed
- The Pro quest Theses & Theses database

General Web Searches

More generic sources were needed to inform certain aspects of the study. These were obtained through World Wide Web searches to locate the following:

- NICE guidance
- Department of Health guidance
- National Research Ethics Service

Appendix 2: Ethical approval documents


National Research Ethics Service
NRES Committee East of England - Cambridge South
Victoria House
Capital Park
Fulbourn
Cambridge
CB21 5XB

Telephone: 01223 597656
Facsimile: 01223 597645

16 September 2011

Ms Hannah Baron
Trainee Clinical Psychologist
Cambridgeshire and Peterborough NHS Mental Health Trust
Doctorate in Clinical Psychology
University of Hertfordshire
Hatfield, Hertfordshire
AL10 9AB

Dear Ms Baron,

Study title: Experiences of Ending Psychological Therapy;
Adolescents Who are Looked After Perspective
REC reference: 11/EE/0307

Thank you for your letter of 09 September 2011 responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

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

Ethical review of research sites

NHS Sites

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

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

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

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

This Research Ethics Committee is an advisory committee to the East of England Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within
the National Patient Safety Agency and Research Ethics Committees in England

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

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

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

Approved documents

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

Document	Version	Date
Covering Letter from Hannah Baron		05 August 2011
Evidence of insurance or indemnity - Zurich Municipal (01.08.2011 to 31.07.2012)		02 August 2011
GP/Consultant Information Sheets (Appendix J)	Version 1	July 2011
GP/Consultant Information Sheets Appendix J GP information pack		September 2011
Interview Schedules/Topic Guides (Appendix A)	Version 1	July 2011
Investigator CV - Hannah Baron		
Letter from Sponsor Professor J M Senior, Pro Vice-Chancellor (Research) at the University of Hertfordshire		21 July 2011
Other: CV - Clare Norris (Academic Supervisor)		July 2011
Other: CV - Dr Emma Greatbatch (Key Investigator)		
Other: Additional Information Form (Appendix B)	Version 1	July 2011
Other: Home Visiting Guidelines (Appendix C)	Version 1	July 2011
Other: checklist		22 July 2011
Participant Consent Form: Social Worker	Version 1	July 2011
Participant Consent Form: Birth Parent	Version 1	July 2011
Participant Consent Form: for Adolescents (Age 16-18)	Version 1	July 2011
Participant Consent Form: Assent Form for Adolescents (Age 13-15)	Version 1	July 2011
Participant Consent Form: Assent form for adolescents age 13-15	version 2	September 2011
Participant Information Sheet: CAMHS brief information sheet (Appendix D)	Version 1	July 2011
Participant Information Sheet: CAMHS detailed information sheet (Appendix E)	Version 1	July 2011
Participant Information Sheet: Social Worker Information Sheet (Appendix F)	Version 1	July 2011
Participant Information Sheet: Young Person Information Sheet (Appendix G)	Version 1	July 2011
Participant Information Sheet: Birth Parent Information Sheet (Appendix I)	Version 1	July 2011
Participant Information Sheet: Birth parent information sheet and consent form	version 2	September 2011
Participant Information Sheet: Appendix E CAMHS detailed information sheet	version 2	September 2011
Participant Information Sheet: Appendix F social worker	version 2	September 2011

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the National Patient Safety Agency and Research Ethics Committees in England

information pack and consent form		
Participant Information Sheet: Appendix G young person information form	version 2	September 2011
Protocol	Version 1	July 2011
REC application Submission code: 74972/234194/1/408		22 July 2011
Referees or other scientific critique report - peer review		July 2011
Response to Request for Further Information from Ms Hannah Baron		09 September 2011
Summary/Synopsis	Version 1	July 2011
Summary/Synopsis	version 2	September 2011

Statement of compliance

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

After ethical review

Reporting requirements

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

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

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

Feedback

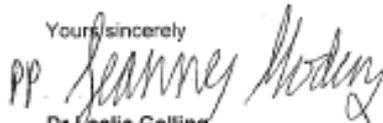
You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

11/EE/0307	Please quote this number on all correspondence
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With the Committee's best wishes for the success of this project

Yours sincerely

PP. 

Dr Leslie Gelling
Chair
Email: leanne.moden@eoe.nhs.uk

This Research Ethics Committee is an advisory committee to East of England Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within
the National Patient Safety Agency and Research Ethics Committees in England

Ms Hannah Baron
Trainee Clinical Psychologist
Cambridgeshire and Peterborough NHS Foundation Trust
University of Hertfordshire
Hatfield
Hertfordshire
AL10 9AB

**Research Management and
Governance Department**
Undergraduate Centre
Whittington Hospital
Magdala Avenue
London
N19 5NF

Tel: 020 7288 3405

Senga.Steel@whittington.nhs.uk

26th October 2011

Dear Ms Baron,

**Study title: Experiences of Ending Therapy: Adolescents Who- Are Looked
After perspective**

REC Ref No: 11/EE/0307

RM&G Ref No: 2011/22 (Please quote in all correspondence)

I am pleased to note that NRES Committee East of England- Cambridge South reviewed this study and concluded that there is no ethical objection to this research being conducted at this site.

The RM&G Department has also reviewed this study and is satisfied that it meets the necessary research governance standards. The RM&G Department is pleased to give the approval of the Whittington Hospital NHS Trust for this research to proceed according to the study protocol and the approved documentation listed below:

- NHS SSI Form, v3.1 signed on 26 August 2011
- NHS REC Form , v3.1 signed on 5 August 2011
- Research protocol, v.1 dated 1 July 2011
- GP/Consultant Information Sheets (Appendix J) v2 dated Sept 2011
- Interview Schedules/Topic Guides (Appendix A) v1 dated July 2011
- Additional Information Form (Appendix B) v1 dated July 2011
- Participant Consent Form: for Adolescents (Age 16-18) v2 dated Sept 2011
- Participant Consent Form: Assent for adolescents age 13-15, v2 dated Sept 2011
- Participant Information Sheet: Birth parent information sheet and consent form, v2 dated Sept 2011
- Participant Information Sheet: CAMHS brief information sheet (Appendix D) v1 dated July 2011
- Participant Information Sheet: CAMHS detailed information sheet (Appendix E) v2 dated Sept 2011

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- Participant Information Sheet: Social worker information pack and consent form (Appendix F) v2 dated Sept 2011
- Participant Information Sheet: Young person information form (Appendix G) v2 dated Sept 2011
- Evidence of insurance or indemnity – Zurich Municipal (01.08.2011 to 31.07.2012) dated 02 Aug 2011
- Letter from Sponsor Professor JM Senior, Pro Vice Chancellor (Research) at the University of Hertfordshire dated Sept 2011
- Ethical approval letter dated 16 September 2011
- Principal Investigator CV - Ms Hannah Baron
- Key Investigator/Supervisor CV - Dr Clare Norris
- Academic supervisor CV - Dr Emma Greatbatch

This approval is only valid concurrently with the appropriate ethical consideration for this study and is therefore subject to the conditions set out by NRIES Committee East of England- Cambridge South and the conditions set out in this letter. Should you fail to adhere to these conditions, the Trust would consider your approval to undertake research to be invalid.

The study has been registered with the finance department who will contact you directly regarding any queries over the financial aspects of this study.

You will be aware that as Principal Investigator you have various responsibilities under the Department of Health's *Research Governance Framework for Health and Social Care*. Please be reminded of your responsibilities as outlined in Appendix A to this letter.

All researchers undertaking research within the Trust are reminded of their duties and responsibilities under the Health and Safety at Work Act 1974, contained in Appendix B and the Data Protection Act 1988 contained in Appendix C to this letter.

Conditions of approval:

- This approval is subject to your consent for information about your project to be included in NHS project registration/management databases and, where appropriate, the NIHR study portfolio
- Except in the case of commercially funded research projects, the following acknowledgement must appear in all publications arising from your work.
-

"This work was undertaken by [investigators name] with the support of the Whittington Hospital NHS Trust, who received ["funding" or a "proportion of funding"]*from the NHS Executive; the views expressed in this publication are those of the authors and not necessarily those of the NHS Executive".



* "a proportion of funding" where the research is also supported by an

.... caring for you



external funding body;

* "funding" where no external funding has been obtained

- The RM&G Office and appropriate REC must be informed of any amendments to the protocol, including changes in study personnel.
- The RM&G Office and appropriate REC must be informed of any adverse events occurring at the Whittington study site or unexpected results that may affect the safety of the research. All adverse events must be reported following the Trust's Adverse Incident Reporting Policy.
- A Progress Report Form must be submitted to the RM&G office and REC one-year from the start of the study and thereafter on an annual basis. This form should also be used to notify the RM&G Office and REC when your research is completed and should be sent within 3 months of completion.
- The Trust will be carrying out audits of informed consent and checking compliance with other ethical and governance requirements. You are strongly advised to use an investigator file to store all the study documentation and to keep copies of all consent forms in this file to help facilitate the research audit process. You will be notified in writing if your study is selected for audit.

Yours sincerely,



Anna Jones
Research Network Co-ordinator

Cc: Clare.Norris@hertspartsft.nhs.uk
Emma.Greatbatch@islingtonpct.nhs.uk

Providing Partnership Services in Bedfordshire, Essex and Luton



28th July 2011

Ms Hannah Baron,
35 Rossway,
Slipend,
Bedfordshire,
LU1 4DD

Research Governance for Bedfordshire and Luton
South Essex Partnership Trust
Disability Resource Centre
Poynters House
Poynters Road
Dunstable, LU5 4TP

Chair: Lorraine Cabel
Chief Executive: Dr Patrick Geoghegan OBE

Dear Ms Baron,

Re: Experiences of Ending Psychological Therapy; Adolescents Who are Looked After and Therapists Perspective. RGG ref: RGG-2011-03/06

Thank you for submitting your research application to South Essex Partnership University NHS Foundation Trust (SEPT). The application was reviewed at the Research Governance Group meeting on the 21st July 2011. Overall, the group thought that the research was well designed and would provide interesting and worthwhile outcomes. The group felt that for your own safety, a condition of approval is for interviews to be carried out on Trust premises or in social work offices. Based on this condition being met, I am pleased to inform you that your research application was successful and has been approved.

In receiving this letter you are accepting that your study must be conducted in accordance with the research governance framework and in line with the Trust's policy on research conduct processes (CLPG19), health and safety and data protection guidelines. If you are unsure about your obligations in relation to these three areas, please contact me immediately. Throughout the course of your research you will be sent monitoring forms and audits. It is important that you fill these in and return them. A failure to do so may result in your approval being withdrawn.

Additionally, brief details of your project (title, aim and project lead), may be posted on our internal website to give other staff a flavour of the research currently taking place in the organisation. Details of research funded by pharmaceutical companies will not be added but all others may be used, unless you notify me of your objection.

If it should be necessary for any researchers to access SEPT, who are not current employees of SEPT, for the purposes of this research project, they will be required to have a Letter of Access issued beforehand. Please advise this office of any external researchers who may need a Letter of Access at your earliest convenience.

www.SEPT.nhs.uk



South Essex Partnership University 
NHS Foundation Trust

At the end of your study, please forward a copy of the final report to me, together with presentations or publications relating to the project so that I can keep an accurate record of the outcomes of research in our area.

We wish you every success for your study. Please do not hesitate to contact me if you require any further assistance during the project.

Best wishes,



Nicole Stokoe
Research Management and Governance Officer
South Essex Partnership University NHS Foundation Trust

On behalf of the Research Governance Group

Cc
Dr Clare Norris, Academic Supervisor

Appendix 3: Information sheets for Social Workers

Version 2 Created September 2011

Reference Number 11/EE/0307

Social Worker information sheet

You are invited to consider a research study exploring the experiences of adolescents who are looked after about ending psychological therapy.

Title of Research Study: Experiences of Ending Therapy; Perspective from Adolescents who are Looked After.

Why would it be helpful to take part in the study?

The study will involve adolescents who are looked after taking part in an interview which will explore their experiences of ending psychological therapy. It is hoped that taking part in this research might be particularly helpful for children in care who experience difficulties in ending relationships, specifically with people they have come close to. It is therefore hoped that by exploring how adolescents who are looked after experience the ending of psychological therapy, it might also help therapists to be aware of issues which may arise.

There is currently a great deal of support for the inclusion of children and young people in the development of mental health services. A gap in the literature exists as to how adolescents who are looked after experience this important phase of therapy.

This research may give greater understanding as to how adolescents experience this process, giving a voice to the lived experience of adolescents who are looked after. Having more understanding of the real life experiences of these individuals in how they understand and experience the ending of psychological therapy, may lead to better psychological therapy and service provision. This may in turn reduce psychological distress and improve quality of life. This could also be used to enhance psychological therapy within CAMHS, with a potential impact that they may return if other issues arise.

How will participants be recruited to take part in the research study?

I am interested in exploring the experiences of adolescents (13 – 18years old) who are looked after who have recently ended psychological therapy from a CAMHS service (in the last 3 – 18 months).

Inclusion Criteria:

1. Childs age range to be between 13 – 18 years
2. Those children who are Looked After by the local authority under a voluntary care order or under a full Care Order and have been looked-after for at least one year, so as to ensure that separation from their birth parents is not a new and raw experience
3. Young people who have ceased therapy from child and adolescent mental health service for at least 3 months and for no longer than 18 months.
4. Participants of any ethnicity, religion, gender, sexual orientation or cultural background are eligible to participate in the study

Exclusion Criteria:

1. Participants will need to have a good understanding of the English language in order to participate and therefore non-English speakers will not be eligible to take part in the study.
2. Children currently involved in court proceedings relating to their care/abuse.
3. Children who have clear suicidal ideation/risk identified by CAMHS clinician involved in the case

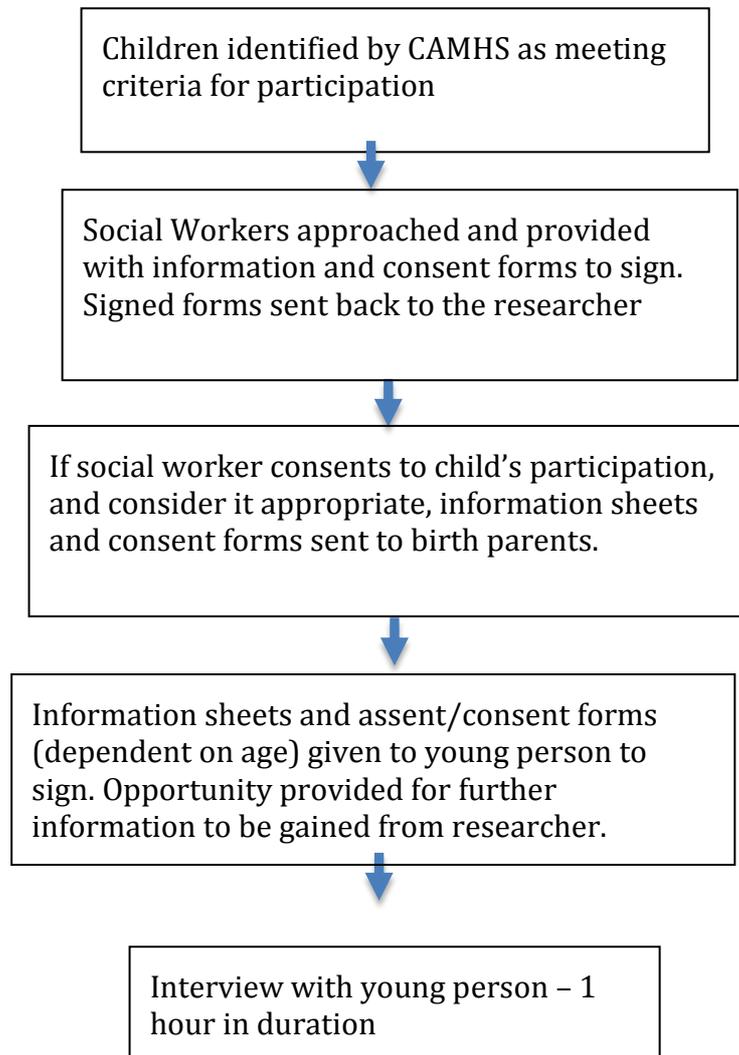
In total, there will be between 6 – 8 young people taking part in the study.

What would the study entail?

Interviews will be carried out with young people identified as meeting eligibility criteria relating to their experience of ending psychological therapy. The interview will be audio taped and will last approximately 1 hour. The interviews will take place at a location convenient to the participants, either at the NHS base or Social Work office.

An additional brief information questionnaire will also be used which will ask for information such as length of CAMHS treatment. This will be completed by the CAMHS clinician.

The proposed procedure is mapped out in the following diagram below:



A pilot of this procedure will be carried out on a Child Looked After to check that the procedure is feasible for young people of this age range.

What would happen if I gave consent for the young person to take part?

To be able to take part in the study, it is necessary to gain the child's allocated Social Worker's informed consent that it would be appropriate for them to participate prior to them being approached individually. In addition, the young person will need to agree to take part in the study.

Any information about the young person will be kept anonymous and confidential. For example, their names will not be written on the questionnaire or interview response sheets. Each person completing the study will be given a code number, so that names will not need to be written down. Following completion of the study there is a possibility that

participant's direct quotations from their interviews might be used when the findings of this research are written up. A summary of the main research findings might also be published in a research paper. Although every effort will be made to anonymise this information, the use of direct quotations may mean that there is a slight possibility of identification.

Does the young person have to take part?

No. It is up to you and the young person to decide. We will ask your consent and the assent of the young person that they are happy to take part.

Will taking part be confidential?

Yes. If the young person takes part in the study, their personal information will be stored safely and will only be accessible by the researchers. The transcripts of recordings will be anonymised and stored on password protected computers, in a separate location from your personal information. This information will be kept for up to five years after the research is submitted for examination (until approximately June 2017) and will be stored securely according to the University of Hertfordshire's 'Good Practice in Research' guidelines.

The only circumstances under which confidentiality could be broken are if the young person discloses information that raises concerns regarding their safety or that of others. In this instance, it is likely that these concerns would be initially discussed with their Social Worker in order to establish an appropriate course of action.

Young people will not be approached until consent has been gained from their Social Worker. The researcher will therefore not have access to the young persons personal details except for those which the Social Worker has given consent.

The young person's GP will be informed of their participation in the research study.

Further information

As the study will involve talking about potentially upsetting issues surrounding ending therapy there will be the opportunity after the interviews for young people to talk about some of the issues which might have been raised during this time. If necessary, a plan to address these concerns will also be considered.

Who has reviewed this study?

This study was reviewed by NHS Research Ethics Committee and was given ethical approval. The study has also been approved by the Trust's Research and Development Team.

What do I do now?

Feel free to read and discuss all the information provided with your team. The CAMHS clinician has identified a potential young person who meets the criteria for this study. As the child's allocated Social Worker, the project requires that you consent to their participation. If you would like to discuss this project further with the researcher, please feel free to make contact (details below). I will then be able to answer any questions you may have regarding the research. Alternatively, please feel free to discuss this with the CAMHS clinician who has approached you regarding this study.

If after you have considered their participation and feel happy for them to participate in this research project please read and sign the attached consent form. Once complete please send this back to the researcher who will then make contact to discuss sending the young person information sheets.

Contact Details of the researcher:

Researcher name: Hannah Baron

Email address: h.baron@herts.ac.uk

Telephone number: xxx

Postal address:

Doctorate in Clinical Psychology Programme

Health Research Building

University of Hertfordshire

College Lane

Hatfield, Herts

AL10 9AB

Social Worker Consent Form

Reference number: 11/EE/0307 Version 1 Created July 2011

Participant identification number:

CONSENT FORM

**Project Title: Experience of ending psychological therapy:
Perspective from adolescents who are looked after**

Name of researcher: Hannah Baron, Trainee Clinical Psychologist

To be completed by allocated social worker (Please initial each box):

<p>1. I confirm that I have read and understand the information sheet dated September (Version: 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.</p>	
<p>2. I understand that the young person is free to decline entry into the study and they are able to leave the study at any time without giving a reason.</p>	
<p>3. I consent to the tape recording of the young persons interview</p>	
<p>4. I understand that relevant sections of the data collected by this research will be looked at by authorised persons from the University of Hertfordshire (Sponsoring organisation). Anonymised sections of the data collected may also be looked at by representatives from academic and professional assessment bodies in order to assess the quality of this doctoral research project. All will have a duty of confidentiality to the young person as a research participant.</p>	
<p>5. I understand that a professional transcription service may be used to transcribe the interview. In this instance, the young persons recording will be given an identified code (e.g. Interview A) to maintain their anonymity. Furthermore, the</p>	

service will have signed a confidentiality agreement.	
6. I consent for the young person to be contacted for their comments on the findings of the study. I am aware they can decline their involvement at any time.	
7. I consent that anonymised quotes from the young persons interview may be used in any publications. I understand that although efforts will be made to maintain anonymity, the use of direct quotations and the individual nature of the analysis means there is a possibility that those close to them might be able to identify the young person.	
8. I understand that the young person's GP will be informed of their participation in this study.	
9. I understand that the transcriptions of the recordings and personal details will be kept securely for 5 years after the research is submitted for examination (until approximately June 2017), after which time it will be destroyed by the researcher.	
10. I consent for the young person named below to take part in the above study.	

Name of Social Worker: **Signature:**

On behalf of

Name of young person

Date

Name of the Researcher

taking the consent **Signature:**

Date

Appendix 4: information sheets for young people

Version 2 Created September 2011

Reference number: 11/EE/0307

Young Person Information Sheet – Part 1

Experiences of Ending Therapy: Perspective of Adolescents who are Looked After

We are asking if you would join in a research project to explore your experiences of ending therapy. Before you decide if you want to join in, it's important to understand why the research is being done and what it will involve for you. So please consider this leaflet carefully. Talk to your family, friends, doctors, social worker or nurse if you want to.

Why are we doing this research?

There is currently a great deal of support for the inclusion of children and young people in the development of mental health services. The end of therapy is important, but we don't know about what this feels like for young people in care. This research may give greater understanding as to how young people experience this process and might also help therapists to be aware of these experiences to better support young people.

Why have I been invited to take part?

You have been invited to join our study because you are a young person who is currently looked after and has recently ended psychological therapy. We hope that seven other young people will join in our study.

Do I have to take part?

No. It is up to you. We will ask you for your assent/ consent (dependent on your age) and then ask if you would sign a form. We will give you a copy of this information sheet and your signed form to keep. You are free to stop taking part at any time during the research without giving a reason. If you decide to stop, this will not affect the care you receive.

What will happen to me if I take part?

You will be invited to attend an interview with a researcher who is also a Trainee Clinical Psychologist. The interview will last approximately 1 hour and will be held at a place and time convenient to you. This could be at social work offices or in the CAMHS building.

What will I be asked to do?

The researcher will ask you questions about your experiences of ending psychological therapy. They will audio record the interview. Following the

interview you will be invited to talk with the researcher about the interview. This will take approximately 15 minutes.

Is there anything else to be worried about if I take part?

Any information collected will be kept anonymous and confidential. For example, your name will not be written on response sheets. You will be given a code number, so that names will not need to be written down.

Following the study, there is a possibility that your direct quotations from the interview might be used when the findings of the research are written up. A summary of the main research findings may also be published in a research paper. Every effort will be made to anonymise this, so no identifiable information will be reported. This means that no one should be able to identify that it was you who participated in the study. However, there may be slight possibility of identification.

The only time that confidentiality could be broken is if you disclose information which raises concerns regarding yours or others safety. If this happens, concerns will most likely be discussed initially with your allocated Social Worker.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get might help treat young people who are looked after with better endings in psychological therapy.

Thank you for reading so far – if you are still interested, please go to part 2:

Contact Details

Researcher / Trainee Clinical Psychologist: Hannah Baron

Telephone number: xxx

Email: h.baron@herts.ac.uk

Version 2, Created September 2011

Reference number: 11\EE\0307

Young Person Information Sheet – Part 2

Experiences of Ending Therapy: Perspective of Adolescents who are Looked After

Information you need to know if you want to take part

What happens when the research project stops?

Once you have completed your interview you will no longer be involved in the research project. If once you have finished the research project, you have any questions or concerns you are free to contact the researcher or discuss your concerns with your social worker.

What if there is a problem or something goes wrong?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this via the NHS Patient Advice and Liaison Service. Details can be obtained by visiting www.pals.nhs.uk where contact details are available.

Will anyone else know I'm doing this?

Your allocated Social Worker has given consent for you to take part in this research project and they will therefore know you are taking part. Your GP will be informed of your participation in the research study. Your CAMHS clinician will also know that you have been invited to take part in this study.

We will keep your information in confidence. This means we will only tell those who have a need or right to know. Wherever possible, we will only send out information that has your name and address removed.

Who is organising and funding the research?

This research project is organised and sponsored by the University of Hertfordshire.

Who has reviewed the study?

Before any research goes ahead it has to be checked by the Research Ethics Committee. They make sure that the research is fair. Your project has been checked by the Cambridgeshire South Research Ethics Committee.

Thank you for reading this- please ask any questions if you need to.

Appendix 5: Information sheets for birth parent(s)

Version 2 Created September 2011 Reference 11/EE/0307

Parent information sheet

The Social Worker responsible for looking after your child has suggested that he/she would be a suitable person to assist in a research study. You are invited to consider a research study exploring the experiences of adolescents who are looked after about ending psychological therapy.

Title of Research Study: Experiences of Ending Therapy; Perspective from Adolescents who are Looked After.

Why would it be helpful to take part in the study?

The study will involve adolescents who are looked after taking part in an interview which will explore their experiences of ending psychological therapy. It is hoped that taking part in this research might be particularly helpful for children in care who experience difficulties in ending relationships, specifically with people they have come close to. It is therefore hoped that by exploring how adolescents who are looked after experience the ending of psychological therapy, it might also help therapists to be aware of issues which may arise.

There is currently a great deal of support for the inclusion of children and young people in the development of mental health services. Evidence indicates that children who are looked after show marked ambivalence towards mental health services, which is not evident in studies of other children. The ending of therapy is highlighted as an important phase of therapy process which is often neglected in clinical practice, research and training. Much of the current literature is theoretical based on therapist's speculations about adult's experiences from a psychoanalytic perspective. A gap in the literature exists as to how adolescents who are looked after experience this important phase of therapy. This research may give greater understanding as to how adolescents experience this process, giving a voice to the lived experience of adolescents who are looked after.

Adolescents who are looked-after often have exposure to broken attachments and ending of relationships such as numerous placements and social workers. Having more understanding of the real life experiences of these individuals in how they understand and experience the ending of psychological therapy, may lead to better psychological therapy and service provision. This may in turn reduce psychological distress and improve quality of life. This could be achieved by addressing issues of ending therapy in order to reduce emotional distress. This could also be used to enhance psychological therapy within CAMHS, with a potential impact that they may return if other issues arise.

How will participants be recruited to take part in the research study?

I am interested in exploring the experiences of adolescents (13 – 18years old) who are looked after who have recently ended psychological therapy from a CAMHS service (in the last 3 – 18 months).

Inclusion Criteria:

- Childs age range to be between 13 – 18 years
- Those children who are Looked After by the local authority under a voluntary care order or under a full Care Order and have been looked-after for at least one year, so as to ensure that separation from their birth parents is not a new and raw experience
- Young people who have ceased therapy from child and adolescent mental health service for at least 3 months and for no longer than 18 months.
- Participants of any ethnicity, religion, gender, sexual orientation or cultural background are eligible to participate in the study

Exclusion Criteria:

- Participants will need to have a good understanding of the English language in order to participate and therefore non-English speakers will not be eligible to take part in the study.
- Children currently involved in court proceedings relating to their care/abuse.
- Children who have clear suicidal ideation/risk identified by CAMHS clinician involved in the case

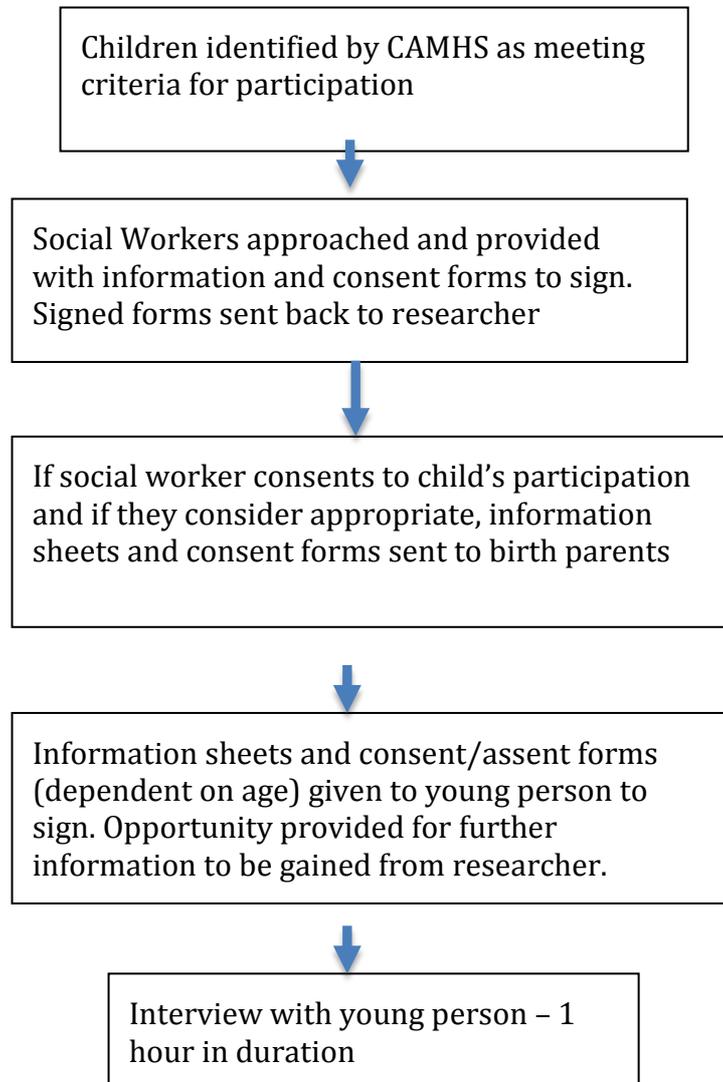
In total, there will be between 6 – 8 young people taking part in the study.

What would the study entail?

Interviews will be carried out with young people identified as meeting eligibility criteria relating to their experience of ending psychological therapy. The interview will be audio taped and will last approximately 1 hour. The interviews will take place at a location convenient to the participants either at the NHS base or Social Work Office.

An additional brief information questionnaire will also be used which will ask for information such as length of CAMHS treatment. This will be completed by the CAMHS clinician.

The proposed procedure is mapped out in the following diagram below:



A pilot of this procedure will be carried out on a Child Looked After to check that the procedure is feasible for young people of this age range.

What would happen if I gave consent for my child to take part?

To be able to take part in the study, it is necessary to gain the birth parents and child's allocated Social Worker's informed consent that it would be appropriate for them to participate prior to them being approached individually. In addition, your child will need to agree to take part in the study.

Any information about your child will be kept anonymous and confidential. For example, their names will not be written on the questionnaire or

interview response sheets. Each person completing the study will be given a code number, so that names will not need to be written down. Following completion of the study there is a possibility that participant's direct quotations from their interviews might be used when the findings of this research are written up. A summary of the main research findings might also be published in a research paper. Although every effort will be made to anonymise this information, the use of direct quotations may mean that there is a slight possibility of identification.

Does the young person have to take part?

No. It is up to you and the young person to decide. We will ask your consent and the assent of your child that they are happy to take part.

Will taking part be confidential?

Yes. If your child takes part in the study, their personal information will be stored safely and will only be accessible by the researchers. The transcripts of recordings will be anonymised and stored on password protected computers, in a separate location from your personal information. This information will be kept for up to five years after the research is submitted for examination (until approximately June 2017) and will be stored securely according to the University of Hertfordshire's 'Good Practice in Research' guidelines.

The only circumstances under which confidentiality could be broken are if your child discloses information that raises concerns regarding their safety or that of others. In this instance, it is likely that these concerns would be initially discussed with their Social Worker in order to establish an appropriate course of action.

Your child will not be approached until consent has been gained from you and their Social Worker. The researcher will therefore not have access to your child's personal details other than which have been volunteered after consent has been gained for their participation.

Your child's GP will be informed of their participation in this study.

Further information

As the study will involve talking about potentially upsetting issues surrounding ending therapy there will be the opportunity after the interviews for young people to talk about some of the issues which might have been raised during this time. If necessary, a plan to address these concerns will also be considered.

Who has reviewed this study?

This study was reviewed by NHS Research Ethics Committee and was given ethical approval. The study has also been approved by the Trust's Research and Development Team.

What do I do now?

Feel free to read and discuss all the information provided with your child and allocated social worker. If you would like to discuss this project further with the researcher, please feel free to make contact (details below). I will then be able to answer any questions you may have regarding the research. Alternatively, please feel free to discuss this with your child's allocated Social Worker.

If after you have considered their participation and feel happy for them to participate in this research project please read and sign the attached consent form. Once complete please send this back to the researcher. The researcher will then make contact with your child to see if they would like to take part in the research study.

Contact Details of the researcher:

Researcher name: Hannah Baron

Email address: h.baron@herts.ac.uk

Telephone number: xxx

Postal address:

Doctorate in Clinical Psychology Programme

Health Research Building

University of Hertfordshire

College Lane

Hatfield, Herts

AL10 9AB

Birth parent Consent Form Version 2 created September 2011

Reference 11/EE/0307

CONSENT FORM

**Project Title: Experience of ending psychological therapy:
Perspective from adolescents who are looked after**

Name of researcher: Hannah Baron, Trainee Clinical Psychologist

To be completed by birth parents(Please initial each box):

<p>1. I confirm that I have read and understand the information sheet dated September 2012 (Version: 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.</p>	
<p>2. I understand that my child is free to decline entry into the study and they are able to leave the study at any time without giving a reason.</p>	
<p>3. I consent to the tape recording of my child's interview</p>	
<p>4. I understand that relevant sections of the data collected by this research will be looked at by authorised persons from the University of Hertfordshire (Sponsoring organisation). Anonymised sections of the data collected may also be looked at by representatives from academic and professional assessment bodies in order to assess the quality of this doctoral research project. All will have a duty of confidentiality to my child as a research participant.</p>	
<p>5. I understand that a professional transcription service may be used to transcribe the interview. In this instance, my child's recording will be given an identified code (e.g. Interview A) to maintain their anonymity. Furthermore, the service will have</p>	

signed a confidentiality agreement.	
6. I consent for my child to be contacted for their comments on the findings of the study. I am aware they can decline their involvement at any time.	
7. I consent that anonymised quotes from my child's interview may be used in any publications. I understand that although efforts will be made to maintain anonymity, the use of direct quotations and the individual nature of the analysis means there is a possibility that those close might be able to identify my child.	
8. I agree to my child's GP being informed of their participation in this study.	
9. I understand that the transcriptions of the recordings and personal details will be kept securely for 5 years after the research is submitted for examination (until approximately June 2017), after which time it will be destroyed by the researcher.	
10. I consent for my child to take part in the above study.	

Name of parent(s):

.....

Signature(s):

.....

On behalf of (young person)

Date

Name of the Researcher taking the consent Hannah Baron

Signature:Date:

Appendix 6: Assent / consent Forms for participants

Version 2 Created September 2011 Reference number 11/EE/0307

Assent Form for Adolescents

Age 13 - 15

**Experiences of Ending Therapy: Perspective of Adolescents who are
Looked After**

Name of researcher: Hannah Baron, Trainee Clinical Psychologist

Has somebody else explained this project to you? Yes/No

Do you understand what this project is about? Yes/No

Have you asked all the questions you want? Yes/No

Have you had all your questions answered in a way you understand?
Yes/No

Do you understand it's OK to stop taking part at any time? Yes/No

I agree to my GP being informed of my participation in this study. Yes/No

I agree to my interview being transcribed and that anonymised quotes may
be used in any publications
Yes/No

I agree to a professional transcription service being used to transcribe my
interview
Yes/ No

Are you happy to take part?

Yes/No

If any answers are 'no' or you do not want to take part, don't sign your name!

If you do want to take part, you can write your name below

Your Name _____

Date _____

The person who explained this project to you needs to sign too:

Print name _____

Sign _____

Date _____

Thank you for your help

Consent form for Adolescents 16 – 18

Version 2 Created September 2011 Reference number 11/EE/0307

Consent Form for Adolescents

Age 16 - 18

**Experiences of Ending Therapy: Perspective of Adolescents who are
Looked After**

Name of researcher: Hannah Baron, Trainee Clinical Psychologist

Has somebody else explained this project to you? Yes/No

Do you understand what this project is about? Yes/No

Have you asked all the questions you want? Yes/No

Have you had all your questions answered in a way you understand?
Yes/No

Do you understand it's OK to stop taking part at any time? Yes/No

I agree to my GP being informed of my participation in this study Yes/No

I agree to my interview being transcribed and that anonymised quotes may
be used in any publications
Yes/No

I agree to a professional transcription service being used to transcribe my
interview
Yes/ No

Are you happy to take part?

Yes/No

If any answers are 'no' or you do not want to take part, don't sign your name!

If you do want to take part, you can write your name below

Your Name _____

Date _____

The person who explained this project to you needs to sign too:

Print name _____

Sign _____

Date _____

Thank you for your help

Appendix 7: Interview Schedule

Topics for interview schedule with young people

1). Relationship to sessions/ therapy

- What was it like for you going to therapy? Prompt: any change over time?
- What did you like about your sessions?
- Was there anything you didn't like about the sessions?

2). Relationship with the therapist

- What was it like for you seeing (therapist name) for help?

Prompt – positive/ negative

- What did you especially like about your therapist?
- Was there anything you didn't like?

3). Ending therapy / saying goodbye to your therapist

- Why did therapy come to an end?
- How did you know you were ending therapy? – who explained this? Did you talk with therapist about ending? Talk with anyone else?
- What do you remember about your last therapy session?

Day of week/ time

Feelings

Thoughts

Did you feel it anywhere in your body?

What else do you remember at that time?

- What was different about your last therapy session to other sessions?
- What happened when you left your last therapy session?

Prompt: support/ feelings? Did you say goodbye to each other?

- Was ending similar or different to what you expected?

3). The impact of ending

- Was there anything you found particularly helpful about ending phase of therapy? (ways of coping)

- Was there anything you found particularly unhelpful about ending phase of therapy?
- Is there anything you would have liked to have been different about ending therapy? What would make it easier?
- How do you think your therapist felt about ending therapy?
- Did ending therapy feel similar to other previous experiences?

4). After the ending

- What happened after you finished therapy?
- If you were to give one piece of advice to therapists working with people with similar experiences to yourself, what would it be?
- Looking back now, how do you make sense of how you felt about ending therapy?

5) Closing the interview

- Do you have any questions you want to ask?
- How has it been for you talking with me today? – any questions or concerns?

Appendix 8: Information sheets for clinicians

Version 1

Created July 2011

Reference Number 11/EE/0307

Have you recently ended psychological therapy with a young person who is looked after aged between 13 and 18 years old?

If so, you might be able to help me in my study. I am interested in how adolescents who are looked after experience the ending of psychological therapy. Research has shown that ending therapy can elicit mixed responses for clients. More specifically, adolescents have described feelings of ambivalence together with issues of separation and loss surrounding the process of ending therapy. The experience of ending therapy is likely to be more challenging for individuals who have a history of loss and disruption. It is hoped that by exploring adolescent's experience of this important phase of therapy, might help therapists and others around the young person provide a more containing experience.

I aim to recruit 6 – 8 adolescents who are looked after and recently (between 3- 18 months) ended psychological therapy to take part in the study.

Inclusion Criteria:

- Childs age range to be between 13 – 18 years old
- Those children who are Looked After by the local authority under a voluntary care order or under a full Care Order and have been looked-after for at least one year, so as to ensure that separation from their birth parents is not a new and raw experience
- Young people who have ceased therapy from child and adolescent mental health service for at least 3 months and for no longer than 18 months.
- Participants of any ethnicity, religion, gender, sexual orientation or cultural background are eligible to participate in the study

Exclusion Criteria:

- Participants will need to have a good understanding of the English language in order to participate and therefore non-English speakers will not be eligible to take part in the study.
- Children currently involved in court proceedings relating to their care/abuse.
- Children who have clear suicidal ideation/risk identified by CAMHS clinician involved in the case

If you are working with a young person and due to finish psychological therapy shortly or have ended therapy with a young person in the last 18months whom you think meets eligibility for this study, please contact me. I will then be able to answer any questions you may have regarding the research. Please also see information sheet for full details.

I would be greatly appreciate it if you would also discuss this with the young person's Allocated Social Worker in order to gain consent for the young person to be directly approached to take part in the study. Social Worker information packs are currently held with Hannah Baron, please contact me directly.

Please feel free to contact me to discuss this further

Researcher Name: Hannah Baron (Trainee Clinical Psychologist)

Email Address: h.baron@herts.ac.uk

Telephone number xxx

Thank you for your time.

Your help is greatly appreciated.

CAMHS detailed information sheet

Version 2 Created September 2011

Reference Number 11/EE/0307

CAMHS information sheet

You are invited to consider a research study exploring the experiences of adolescents who are looked after about ending psychological therapy.

Title of Research Study: Experiences of Ending Therapy; Perspective from Adolescents who are Looked After.

Why would it be helpful to take part in the study?

The study will involve adolescents who are looked after taking part in an interview which will explore their experiences of ending psychological therapy. It is hoped that taking part in this research might be particularly helpful for children in care who experience difficulties in ending relationships, specifically with people they have come close to. It is therefore hoped that by exploring how adolescents who are looked after experience the ending of psychological therapy, it might also help therapists to be aware of issues which may arise.

There is currently a great deal of support for the inclusion of children and young people in the development of mental health services. Evidence indicates that children who are looked after show marked ambivalence towards mental health services, which is not evident in studies of other children. The ending of therapy is highlighted as an important phase of therapy process which is often neglected in clinical practice, research and training. Much of the current literature is theoretical based on therapist's speculations about adult's experiences from a psychoanalytic perspective. A gap in the literature exists as to how adolescents who are looked after experience this important phase of therapy. This research may give greater understanding as to how adolescents experience this process, giving a voice to the lived experience of adolescents who are looked after.

Adolescents who are looked-after often have exposure to broken attachments and ending of relationships such as numerous placements and social workers. Having more understanding of the real life experiences of these individuals in how they understand and experience the ending of psychological therapy, may lead to better psychological therapy and service provision. This may in turn reduce psychological distress and improve quality of life. This could be achieved by addressing issues of ending therapy in order to reduce emotional distress. This could also be used to enhance psychological therapy within CAMHS, with a potential impact that they may return if other issues arise.

How will participants be recruited to take part in the research study?

I am interested in exploring the experiences of adolescents (13 – 18 years old) who are looked after who have recently ended psychological therapy from a CAMHS service (in the last 3 – 18 months).

Inclusion Criteria:

- Childs age range to be between 13 – 18 years
- Those children who are Looked After by the local authority under a voluntary care order or under a full Care Order and have been looked-after for at least one year, so as to ensure that separation from their birth parents is not a new and raw experience
- Young people who have ceased therapy from child and adolescent mental health service for at least 3 months and for no longer than 18 months.
- Participants of any ethnicity, religion, gender, sexual orientation or cultural background are eligible to participate in the study

Exclusion Criteria:

- Participants will need to have a good understanding of the English language in order to participate and therefore non-English speakers will not be eligible to take part in the study.
- Children currently involved in court proceedings relating to their care/abuse.
- Children who have clear suicidal ideation/risk identified by CAMHS clinician involved in the case

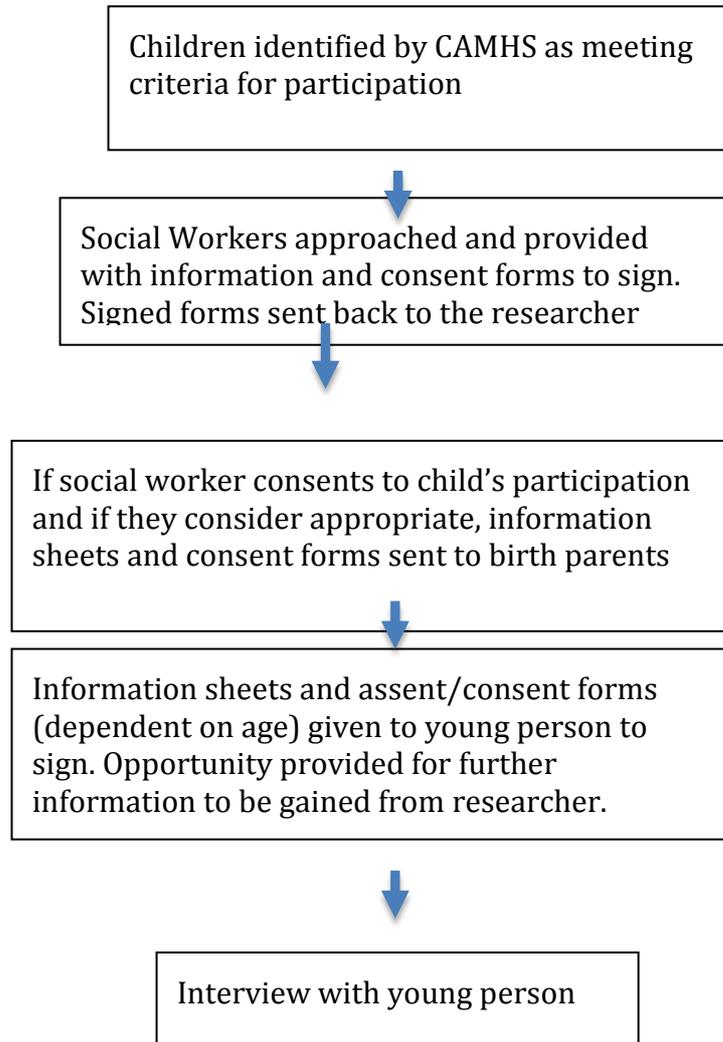
In total, there will be between 6 – 8 young people taking part in the study.

What would the study entail?

Interviews will be carried out with young people identified as meeting eligibility criteria relating to their experience of ending psychological therapy. The interview will be audio taped and will last approximately 1 hour. The interviews will take place at a location convenient to the participants, either at the NHS office or social work office.

An additional brief information questionnaire will also be used which will ask for information such as length of CAMHS treatment. This will be completed by the CAMHS clinician.

The proposed procedure is mapped out in the following diagram below:



A pilot of this procedure will be carried out on a Child Looked After to check that the procedure is feasible for young people of this age range.

What would happen if I identified a young person to take part in the study?

To be able to take part in the study, it is necessary to gain the child's allocated Social Worker's informed consent that it would be appropriate for them to participate prior to them being approached individually. Please feel free to discuss this with you team manager, if necessary or alternatively the Social Worker directly. In addition, the young person will need to agree to take part in the study. The Social Worker will also be asked to provide advice as to whether the child's birth parent(s) should be approached to also provide informed consent on behalf of their child.

Any information about the young person will be kept anonymous and confidential. For example, their names will not be written on the questionnaire or interview response sheets. Each person completing the study will be given a code number, so that names will not need to be written down. Following completion of the study there is a possibility that participant's direct quotations from their interviews might be used when the findings of this research are written up. A summary of the main research findings might also be published in a research paper. Although every effort will be made to anonymise this information, the use of direct quotations may mean that there is a slight possibility of identification.

Will taking part be confidential?

Yes. If the young person takes part in the study, their personal information will be stored safely and will only be accessible by the researchers. The transcripts of recordings will be anonymised and stored on password protected computers, in a separate location from your personal information. This information will be kept for up to five years after the research is submitted for examination (until approximately June 2017) and will be stored securely according to the University of Hertfordshire's 'Good Practice in Research' guidelines.

The only circumstances under which confidentiality could be broken are if the young person discloses information that raises concerns regarding their safety or that of others. In this instance, it is likely that these concerns would be initially discussed with their Social Worker in order to establish an appropriate course of action.

Young people will not be approached until consent has been gained from their Social Worker. The researcher will therefore not have access to the young persons personal details except those for which the social worker has given consent.

The young person's GP will be informed of their participation in the research study.

Further information

As the study will involve talking about potentially upsetting issues surrounding ending therapy there will be the opportunity after the interviews for young people to talk about some of the issues which might have been raised during this time. If necessary, a plan to address these concerns will also be considered.

Who has reviewed this study?

This study was reviewed by NHS Research Ethics Committee and was given ethical approval. The study has also been approved by the Trust's Research and Development Team.

What do I do now?

Feel free to read and discuss all the information provided with your team. If you have identified a young person whom you think might be eligible to take part in the study, then please contact me using the details below. I will then be able to answer any questions you may have regarding the research. Alternatively, please feel free to discuss this with the young person's allocated Social Worker. Social Worker information packs and consent forms have been provided to your team.

Contact Details of the researcher:

Researcher name: Hannah Baron

Email address: h.baron@herts.ac.uk

Postal address:

Doctorate in Clinical Psychology Programme

Health Research Building

University of Hertfordshire

College Lane

Hatfield, Herts

AL10 9AB

Telephone number: xxx

Appendix 9: Information sheets for GP

Version 2 Created September 2011 Reference number 11/EE/0307

Hannah Baron
Trainee Clinical Psychologist
University of Hertfordshire
Hatfield
AL10 9AB

Dear Dr

Re: <<insert name and details of young person participating in study>>

I am writing to inform you that <<insert young persons name>> has agreed to participate in a research project exploring their experiences of ending psychological therapy. Informed consent has been obtained from their Allocated Social Worker and the young person has provided their assent/consent (dependent on age) to participate. The study has been approved by the local Research and Development department as well as being approved by the National NHS research ethics committee. Please find enclosed further information regarding the study.

If you have any questions or concerns regarding this study please do not hesitate to contact me.

Yours Sincerely

Hannah Baron

Trainee Clinical Psychologist

Title of Research Study: Experiences of Ending Therapy; Perspective from Adolescents who are Looked After.

Why would it be helpful to take part in the study?

The study will involve adolescents who are looked after taking part in an interview which will explore their experiences of ending psychological therapy. It is hoped that taking part in this research might be particularly helpful for children in care who experience difficulties in ending relationships, specifically with people they have come close to. It is therefore hoped that by exploring how adolescents who are looked after experience the ending of psychological therapy, it might also help therapists to be aware of issues which may arise.

There is currently a great deal of support for the inclusion of children and young people in the development of mental health services. Evidence indicates that children who are looked after show marked ambivalence towards mental health services, which is not evident in studies of other children. The ending of therapy is highlighted as an important phase of therapy process which is often neglected in clinical practice, research and training. Much of the current literature is theoretical based on therapist's speculations about adult's experiences from a psychoanalytic perspective. A gap in the literature exists as to how adolescents who are looked after experience this important phase of therapy. This research may give greater understanding as to how adolescents experience this process, giving a voice to the lived experience of adolescents who are looked after.

Adolescents who are looked-after often have exposure to broken attachments and ending of relationships such as numerous placements and social workers. Having more understanding of the real life experiences of these individuals in how they understand and experience the ending of psychological therapy, may lead to better psychological therapy and service provision. This may in turn reduce psychological distress and improve quality of life. This could be achieved by addressing issues of ending therapy in order to reduce emotional distress. This could also be used to enhance psychological therapy within CAMHS, with a potential impact that they may return if other issues arise.

How will participants be recruited to take part in the research study?

I am interested in exploring the experiences of adolescents (13 – 18years old) who are looked after who have recently ended psychological therapy from a CAMHS service (in the last 3 – 18 months).

Inclusion Criteria:

- Childs age range to be between 13 – 18 years
- Those children who are Looked After by the local authority under a voluntary care order or under a full Care Order and have been looked-after for at least one year, so as to ensure that separation from their birth parents is not a new and raw experience
- Young people who have ceased therapy from child and adolescent mental health service for at least 3 months and for no longer than 18 months.
- Participants of any ethnicity, religion, gender, sexual orientation or cultural background are eligible to participate in the study

Exclusion Criteria:

- Participants will need to have a good understanding of the English language in order to participate and therefore non-English speakers will not be eligible to take part in the study.
- Children currently involved in court proceedings relating to their care/abuse.
- Children who have clear suicidal ideation/risk identified by CAMHS clinician involved in the case

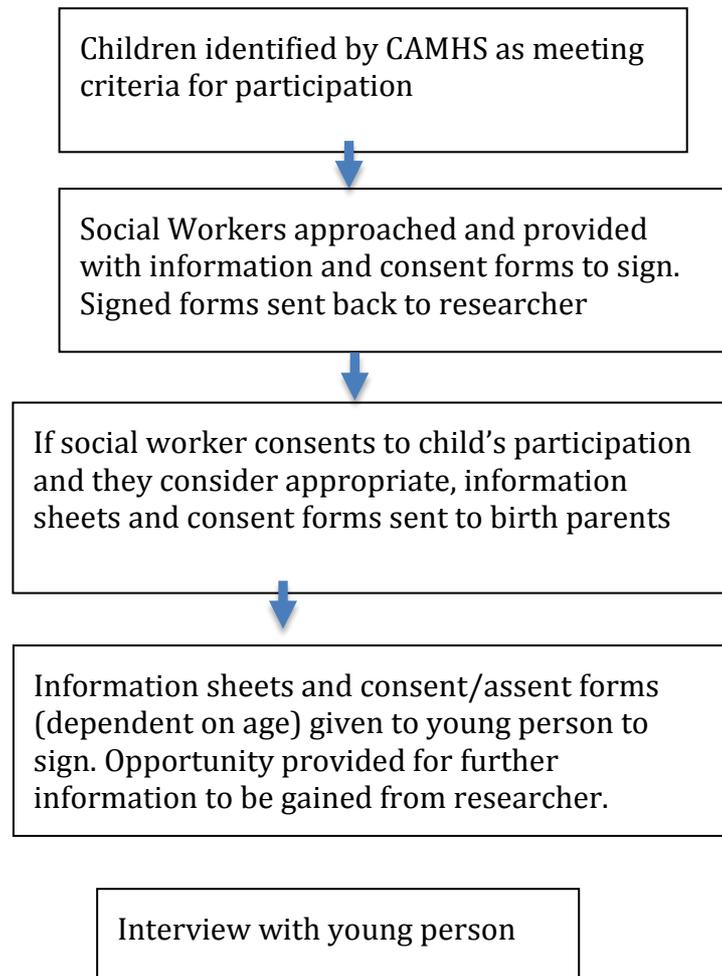
In total, there will be between 6 – 8 young people taking part in the study.

What would the study entail?

Interviews will be carried out with young people identified as meeting eligibility criteria relating to their experience of ending psychological therapy. The interview will be audio taped and will last approximately 1 hour. The interviews will take place at a location convenient to the participants, either at the NHS base or Social Work office.

An additional brief information questionnaire will also be used which will ask for information such as length of CAMHS treatment. This will be completed by the CAMHS clinician.

The proposed procedure is mapped out in the following diagram below:



A pilot of this procedure will be carried out on a Child Looked After to check that the procedure is feasible for young people of this age range.

What would happen if I identified a young person to take part in the study?

To be able to take part in the study, it is necessary to gain the child's allocated Social Worker's informed consent that it would be appropriate for them to participate prior to them being approached individually. Please feel free to discuss this with you team manager, if necessary or alternatively the Social Worker directly. In addition, the young person will need to agree to take part in the study. The Social Worker will also be asked to provide advice as to whether the child's birth parent(s) should be approached to also provide informed consent on behalf of their child.

Any information about the young person will be kept anonymous and confidential. For example, their names will not be written on the

questionnaire or interview response sheets. Each person completing the study will be given a code number, so that names will not need to be written down. Following completion of the study there is a possibility that participant's direct quotations from their interviews might be used when the findings of this research are written up. A summary of the main research findings might also be published in a research paper. Although every effort will be made to anonymise this information, the use of direct quotations may mean that there is a slight possibility of identification.

Will taking part be confidential?

Yes. If the young person takes part in the study, their personal information will be stored safely and will only be accessible by the researchers. The transcripts of recordings will be anonymised and stored on password protected computers, in a separate location from your personal information. This information will be kept for up to five years after the research is submitted for examination (until approximately June 2017) and will be stored securely according to the University of Hertfordshire's 'Good Practice in Research' guidelines.

The only circumstances under which confidentiality could be broken are if the young person discloses information that raises concerns regarding their safety or that of others. In this instance, it is likely that these concerns would be initially discussed with their Social Worker in order to establish an appropriate course of action.

Young people will not be approached until consent has been gained from their Social Worker. The researcher will therefore not have access to the young persons personal details other than which have been volunteered after consent has been gained for their participation.

Further information

As the study will involve talking about potentially upsetting issues surrounding ending therapy there will be the opportunity after the interviews for young people to talk about some of the issues which might have been raised during this time. If necessary, a plan to address these concerns will also be considered.

Who has reviewed this study?

This study was reviewed by NHS Research Ethics Committee and was given ethical approval. The study has also been approved by the Trust's Research and Development Team

Appendix 10: brief information questionnaire

Version 1 Created July 2011 Reference Number: 11/EE/0307

**Experiences of Ending Psychological Therapy: Adolescents who are
Looked After**

Dear CAMHS colleague,

<<insert name of young person>> has agreed to take part in the above research project. Could you please complete the questionnaire below and return to Hannah Baron as soon as convenient. This information will help provide contextual details which may aid part of the analysis. If you have any questions please do not hesitate to contact me.

1. On what date did you end psychological therapy with << insert name>>
2. How many sessions did you have with <<insert name>>?
3. How long was <<insert name>> in psychological therapy?
4. Please describe briefly the reason for referral?
5. Please describe briefly the reason for ending therapy?
6. Please describe briefly the main approach(s) used in sessions? (e.g. CBT, narrative).
7. Please provide any other comments which you feel may be relevant for this research?

Thank you for your time in completing this questionnaire. Please post to Hannah Baron in a confidential envelope.

Appendix 11: interview Response sheet

Participant ref:

Date of interview:

Content:

What were the main points of the discussion?

Any notable areas of conflicts experienced?

Any notable themes identified during the interview?

Process:

Interpersonal factors (e.g. rapport):

Participant engagement (e.g. talkative, anxious):

Factors which may have influenced the process of interview?

Use of open/ closed questions?

Researchers comments on self:

Appendix 12: Transcript confidentiality agreement

Doctorate in Clinical Psychology
University of Hertfordshire

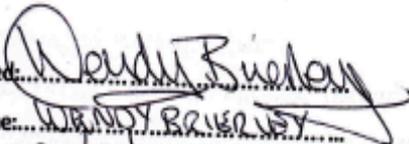
Transcription confidentiality/ non-disclosure agreement

This non-disclosure agreement is in reference to the following parties:
Hannah Baron
And
Wendy Brierley WMBT Secretarial services ('the recipient')

The recipient agrees to not divulge any information to a third party with regards to the transcription of audio recordings, as recorded by the discloser. The information shared will therefore remain confidential.

The recipient also agrees to destroy the transcripts as soon as they have been provided to the discloser.

The recipient agrees to return and or destroy any copies of the recordings they were able to access provided by the discloser.

Signed: 
Name: WENDY BRIERLEY
Date: 21/2/12

Appendix 13: Audit trail Interview 4

Full transcript removed for publication to retain participant confidentiality

Audit Trail: Initial themes from interview 4

Uncertainty	Sense of agency
Forming relationship	Limited time
Positive experience therapy	Sense of togetherness
Contained space	Holding on and letting go
Cut off difficult emotion	Resonance with family experience
Struggle to feel understood as an adolescent	Maintaining a connection
Making a connection	Unpreparedness
Therapist qualities important	Valuing connection and relationship
Learning how to relate with another	Centrality of relationship
Feeling torn	Safety net of therapy
Making decision of best interests	Wish for more time
Protection of self	Wish for simplicity
Feeling torn	Struggle with letting go and independence
Therapy as learning experience	Anticipated loss
Disconnection from emotion	Staying in the here and now
Being yourself	Therapist as role model
Role reversal	Experience of being looked after
Mixed emotion	Adaptive strategy
Anticipated loneliness/ isolation	Managing difficult emotions
Stepping into independence	Continued sense of hope
Being in the mind of another	Connecting before saying goodbye
Therapist as Parental figure	Ending as special
Ending relationship	Ending enabled future
Finality of ending	Like a friend
Acceptance	
Wanting a re-connection/ yearning loss	
Reality of isolation	

Audit trail: Table of themes interview 4

Superordinate theme	Subordinate theme	Emergent themes	Page/line	Key words
Special nature of ending confirms special relationship with therapist	Ending signifies value and respect	Ending as special	11/289	'Well him bringing food and stuff'
		Therapist qualities important	10/266	'And then it was like really hard to say goodbye but then I said goodbye and he watched me go off in my car'
	Relationship is special	Centrality of relationship	3/59	'I could talk to about any problems I've had during the week'
		Contained space	6/169	'Yeah, I felt glad that we got to know each other and we'd been through lots together'
		Therapist as parental figure	18/496	'Because he was like a friend to me'
		Sense togetherness		
Ending as Stepping into independence	Connecting back to self than 'symptom'	Being yourself	5/127	'It was just more being yourself'
	Ending as enabling for future	Enabling future	16/452	'knowing that I can continue in the future without him'
		Stepping into independence	16/458	'Knowing that I could be the person that I wanted to be'
			17/475	'Knowing that now I am starting to get my GCSE'
	Therapy as learning experience to manage in future	Therapy as learning experience	6/171	'knowing that if I tried really hard I could come a long way'
			2/41	'I found it helpful to find ways to behave'
Journey from connection to	Making a connection with	Being in the mind of another	1/24	'I got along with Mike and I found it really comfortable to be around him'

isolation back to connection	someone	Making a connection Therapist as parental figure Containing space Valuing connection Like a friend	3/59 6/169	'It was quite useful knowing that someone was there' yeah, I felt glad that we got to know each other and we'd been through lots together.
	Ending as joint venture	Togetherness to the end	10/264 14/393 14/399	'we had got on really well and what we felt during the sessions ' 'We have to think of all the positives of the session and support each other as' we did really well and that we can continue to get to know each other'
	From connection to isolation	Anticipated isolation Reality of isolation Ending relationship Loss	8/228 13/347 7/108 10/271	'I couldn't communicate to anyone' 'It was quite sad knowing that I probably wouldn't see him again' 'I felt kind of like, like really upset that I wouldn't see him again' 'I wont see you again and that I have got to move on'
	Re-connecting before disconnecting	Connecting before saying goodbye	11/306 16/440	'I wanted to talk about and getting to know him more in my last session' 'More talking about each other'
	Maintaining a psychological connection	Maintaining connection	12/321 15/420	'And knowing that I could improve remembering them' 'think that he helped me a lot in that maybe I need to keep trying to control my anger'
Ambivalence of ending	Feeling torn	Feeling torn Yearning Holding on and letting go Struggle with letting go and independence	4/90 4/96 5/134	'yeah I made the decision but it did make my behavior, the anger, go all the way back up to really cross again'. 'no I just knew that I had to, I wanted to carry on' 'so I just had to, it was a hard choice for me to make'

	Resonance with family experience signifies importance	Resonance family experience	10/278	'I could go back to therapy but I couldn't go back to home'
	Unpreparedness	Limited time Wish more time	12/341	'I had hardly any time to talk about that'
	Mixed emotion	Mixed emotion	6/161	'Well I felt quite relievedbut I also felt quite upset'
Resilience and coping to manage ending	Self protection	Making best interests decision	3/83	'I had to be more in school, unfortunately I just had to make a decision just to end it.'
		Protecting future of self Cut off from difficult emotion	5/117	'I think the 1st one was talking about how I could control my anger.'
		Difficulty being in the looked after role	9/239	'I'm only in this family for more number of years and then I have to get a job live by myself'
			6/148	'I didn't want to hurt his feelings or anything'
			14/393	'I don't know maybe talking to him about how he shouldn't be upset'
	Managing in the moment	Staying in the here and now	13/356	'could've been more based around talking to each other...talking about the future'
	Acceptance	Acceptance	8/208	'But I knew that the choice was made and I couldn't turn back now'
	Keeping a safety net for future	Safety net	11/313	'If I really wanted to come back that I could at any time'

Audit trail: Superordinate themes from all interviews

Interview 1:

1. Therapy as gain
2. Nothing gained nothing lost
3. Ending as transition
4. Challenge of letting go
5. Relationship as blueprint inhibiting future connections
6. Acceptance

Interview 2:

1. Ambivalence and conflict
2. Centrality of therapy relationship
3. Avoidance painful feeling
4. Inevitability to ending
5. From disempowered to taking control
6. Finality of ending

Interview 3:

1. Opening up vs. closing down
2. Strategies to manage
3. Ending as loss
4. Closing one door and opening another
5. Ambivalence about ending
6. Centrality of relationship to therapy experience
7. Ending event itself signifies relationship

Interview 4:

1. Ending as stepping into independence
2. Special nature of ending confirms special relationship with therapist
3. Journey from connection to isolation back to connection (safety net)
4. Ambivalence of ending
5. Resilience and coping to manage

Interview 5:

1. Out of control and powerless vs. wish for certainty
2. Undesirable feelings about ending
3. Helpfulness as indicator of engagement/ disengagement with therapy
4. Disconnection as strategy to manage
5. Past impacting on future
6. Attachment impacts on end

Interview 6:

1. No gains therefore no need to continue
2. Therapy as connection
3. Distraction as ways to cope
4. Ending as loss
5. Confusion and uncertainty
6. Door left open
7. Ending informs blueprint future relationships

Audit Trail: Master table of themes for all participants

Master theme	Superordinate	Supporting quotes
Means of coping	Self protection and disconnection	Cher: could've been more based around talking to each other (21/384) Chloe: I didn't like interact with her as much (7/147) Chris: No I was just it really not like a big thing you know. (15/445) Jen: erm..a little bit. Erm.. not really though. But a little bit (22/295) Leila: I got distracted so I didn't have time to like talk about it. (17/498) Janet: yeah, because if I think about it, I will just get upset and stuff (8/134)
	Philosophy of acceptance	Jen: but I mean I knew that it had to end at somepoint (25/345) Cher: But I knew that the choice was made and I couldn't turn back now (12/248) Chris: you know when it's going to end (15/575) Janet: because life Is life, it is gonna end sometime (15/269)
Master Theme	Superordinate theme	Supporting quotes
Inextricable link between therapy and therapy relationship	Ending highlights the special nature of the relationship	Jen: yeah, I said goodbye and gave her hug. (11/152) Chloe: gave me a hug and yeah said goodbye which was nice. (9/179) Leila: we just talked and then said goodbye and that was it. (15/432) Chris: he wasn't like say extra like you're going now (16/466) Cher: and I was allowed to be who I wanted to be (11/192)
	Detachment from vs. attachment with therapist	Chris: it was always he was in a good mood and he was always like happy to like talk (5/124) I just kind of said there is nothing else to do. Let's just stop. (12/354) Jen: But I wasn't very close to that one, so I wasn't really very sad or anything (14/188) Chloe: sessions were a lot better because the trust was there (1/11) Leila: Because I didn't think I needed therapy (14/402) Janet: treat us in how we are supposed to be treated. (11/197) Cher: because he was like a friend to me (29/351)
	Ending means loss of relationship	Jen: I just felt a bit sad because it was coming to an end (10/139) Chris: Well I was feeling sad oh you know, Philip was like a friend (18/510) Leila: I was just thinking I wouldn't see her again (9/248) Cher: it was quite sad knowing that I probably wouldn't see him again (20/370) Chloe: constant ache in a way (11/224) Janet: I'm just angry with her...not the sessions, just her (13/239)

Master Theme	Superordinate theme	Supporting quotes
Ambivalence	Unprepared and out of control	Cher: I had hardly any time to talk about that (20363) Chloe: I thought it'd be something I'd be doing for a while but it wasn't (13/280) Jen: I just know that they should be told in advance (24/326) Leila: maybe a little bit surprised 'cos it didn't go on for that long, so yeah. (13/364)
	Positive and negative	Leila: just that I felt happy (9/247) Jen: just...mixed emotions really (13/170) Chris: It was OK it wasn't like that amazing, or that dreadful it was just (3/75) Chloe: It was positive a very positive thing but also it was also quite negative at the same time (18/388) Cher: very emotional like negative and positive (26/484)
Master Theme	Superordinate theme	Supporting quotes
'Moving on' from therapy	Stepping into independence	Chris: feeling happy you know I was doing something new (15/433) Cher: it was just more being yourself, (7/127) Chloe: so I was doing my own personal way it was good. (12/251) Janet: But then she started treating me like a baby so I decided not to (6/113)
	Ending as transition vs finality of ending	Chris: I think it's probably like you know like end of school (15/433) Chloe: look through just see what we'd done together so that was quite nice (14/301) Cher: knowing that I could improve remembering them (19/339) Leila: I thought it was helpful that Roxi said I could come back any time (13/387) Janet: told her to fuck off and I walked out (2/28)
	Therapy as blueprint for future connections	Chris: I want to meet a new person, it's going to be really fun Chloe: it's positive because she was enabling me to go out and find somebody closer (18/389) Jen: I just knew that I didn't want therapy anymore, so...(6/71) Leila: this could happen again. (20/588)
	Understanding why	Chloe: I knew I couldn't go back (11/221) Leila: I didn't need therapy in first place (7/190) Chris: I stopped for a bit 'cos I was doing alright (2/56) Jen: I was leaving placement (17/225) Janet: But then she started treating me like a baby so I decided not to (6/113) Cher: I knew I was going to be doing GCC's very shortly that I had to be more in school (5/83)

Audit Trail: Recurrence of themes

Super-ordinate theme	Subordinate theme	Chris	Cher	Chloe	Jen	Janet	Leila
INEXTRICABLE LINK BETWEEN THERAPY AND THERAPY RELATIONSHIP	Ending means loss relationship	✓	✓	✓	✓	✓	✓
	Ending highlights the special nature of relationship	✓	✓	✓	✓		✓
	Detachment from vs. attachment to therapist	✓	✓	✓	✓	✓	✓
AMBIVALENCE	Unprepared and out of control		✓	✓	✓		✓
	Positive AND negative	✓	✓	✓	✓		✓
MEANS OF COPING	Philosophy of acceptance	✓	✓	✓	✓	✓	
	Self protection and disconnection	✓	✓	✓	✓	✓	✓
MOVING ON FROM THERAPY	Stepping into independence	✓	✓	✓		✓	
	Ending as transition vs. finality of ending	✓	✓	✓		✓	✓
	Therapy as blueprint for future connections	✓		✓	✓		✓
	Understanding why	✓	✓	✓	✓	✓	✓