Holding - the Contentious Balance

A Grounded Theory Study of how Child and Adolescent Psychiatrists and Psychologists, Consider Child Trauma in Disorder Diagnosis, with Children and Young People, in Ireland.

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Declaration

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Doctor of Psychotherapy is entirely my own work, and that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

Signed:  (Candidate) ID No.: 20212739 Date: 1 August 2024

Dedication

Dedicated to my dear mum, who went to her final dwelling place, amidst this Doctorate.

I hear your voice behind me saying, "*Go on……*

In Your name we go forward".

Acknowledgements

I would like to acknowledge my supervisors Dr Gemma Kiernan and Dr Mark Philbin who guided me through this Doctorate research study.

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To my husband David, thank you for your deep companionship and partnership in life. I couldn't continue to do this work without the safety you bring.

To my bedrock and steadfast God, who makes all things new, whose internal promise spurs me on "*to bind up the broken hearted and set the captives free"* Isaiah 61.

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Abstract

Joy Winterbotham

Holding - the Contentious Balance: A Grounded Theory Study of how Child and Adolescent Psychiatrists and Psychologists Consider Child Trauma in Disorder Diagnosis, with Children and Young People, in Ireland.

This study explores how child trauma is considered in disorder diagnosis with children and young people in Ireland. This grounded theory study conducted 1-1 semi structured interviews with 12 child and adolescent psychologists and psychiatrists, working in mental healthcare, in Ireland. The participants interviews, conducted in person, and online, via zoom, represent a diverse demographic, of age, (28-68 years approx.) gender (7 female, 5 male) and work contexts (perinatal hospital, training university, child and adolescent mental health services, and private practice).

A constructivist grounded theory methodology (Charmaz, 2006) was used to analyse the transcribed interview data with an iterative process of coding, categorising, of observing and elevating emerging patterns, facilitating the emergence of the substantive theory of *Holding - the Contentious Balance.* Reflective memos were instrumental throughout the conduct of this study, demonstrating personal learning challenges and informing operational processes that directed analysis towards the emerging theory.

The findings contribute a rich insight into this understudied phenomenon, presenting the *Contentious Balance* as the main concern. This *Contentious Balance* represents the practice challenges and dilemmas, of how this sample, balance the '*subjective*, *movable*' nature of child trauma, within the '*fixed rigid'* diagnostic frameworks that this cohort, are '*under systemic pressure*' to employ. The findings identify that this tense engagement between child trauma and disorder diagnosis, is undergirded by an intersecting category; '*tolerating uncertainty'* that influences this samples, actions, and interactions to child trauma in diagnostic practice. In the light of the findings and current national and international diagnostic literature, the study identifies the practice challenges and the underlying difficulties of balancing the complexity of child trauma, when intersecting with disorder diagnosis, in practice. The study explores the properties underlying these findings and the influences and implications on professionals working with child trauma in mental health care. Whilst acknowledging the challenges and dilemmas experienced by this sample, represented in the core category of the *Contentious Balance*, this study proposes an alternate theoretical framework to resolve this main concern, urging a 'Holding' position that is focused on a recovery approach, to a child impacted by trauma. The study identifies the implications of '*Holding - the Contentious Balance*' on psychotherapy, and the wider field, as child trauma is considered in disorder diagnosis.

Chapter 1: Contextualizing the Research Study

Introduction

This research study is grounded in practice, constructed through more than 30 years working with children, young people and their families in the education, community, and therapeutic sectors. My formative training and experience, informs, guides, at times directs this research, from initial exploration to this documented thesis. Thus, acknowledging that "what we bring to it and do with it, is a fundamental part of constructing grounded theory" (Charmaz, 2021, p. 156).

This chapter presents a context to this study's phenomenon, that led to the development of the aim and objectives of this study. A conceptual understanding of child trauma is presented, outlining the impact of early life trauma on children and young people. The chapter concludes with an overview of the thesis, identifying the interaction between each of the chapters.

The Research Phenomenon

Child trauma is considered a "silent epidemic" (Kaffman, 2009, p. 624) with a concerning reference to young children impacted by trauma as a "neglected population" (De Young et al., 2011, p. 231) in our society. With an increased percentage of children and young people presenting to services with complex needs (Copeland et al., 2007, Fitzgerald et al., 2020) and diagnosed disorders, this research seeks to explore the role of child trauma in this 'diagnosis creep phenomenon' (D'Andrea et al., 2012, p. 195).

Although the complex impact of trauma on children and young people has been identified by many comprehensive studies, in diverse contexts (Briggs-Gowan et al., 2010; DeBellis et al., 2005; Perry, 2009; Shonkoff et al., 2012) child trauma is still considered to be a young field of study (Alisic et al., 2011) with international literature suggesting that an increased understanding of children's trauma responses is needed (Rutter, 2011; Taylor, 2011). International concern also arises questioning the correlation between childhood trauma and disorder diagnosis, with findings identifying that 40% of children with any trauma history have at least one other mood, anxiety, or disruptive behaviour diagnosis (Copeland et al., 2007). It is also widely debated that this percentage is indeed higher.

It is this increase in children and young people who present to therapy with a trauma history, accompanied by diagnosed disorders, that provoked curiosity towards this phenomenon. In my work as a family therapist in marginalised community-based projects, children and young people increasingly present with a range of diagnosed disorders. These frequently include, Emotional Unstable Personality Disorder (EUPD) Obsessive Defiant Disorder (ODD), Emotional Intensity Disorder (EID), Pathological Demanding Avoidance (PDA) and Attention Deficit Hyperactivity Disorder (ADHD). Many of these children and young people presenting in family therapy, have a complex trauma history, live in marginalised communities impacted by drugs, violence and gangland crime. Many of the families have been engaged in these community projects for years, displaying an intergenerational cycle of addiction and mental health difficulties. Yet, I am increasingly concerned that limited reference is made to the lived history of trauma, in the diagnostic reports that accompany these children, to my therapeutic practice.

My curiosity towards this research question is strongly influenced by my 'multiple selves' (Berks & Mills, 2023, p. 34) of experience and roles in the education, community, and psychotherapeutic fields. This positioning to this phenomenon is important, as it contextualises the emergence of this study's research question and objectives. Spending 10 years' as a teacher in a primary school classroom, provided deep insight into a child's world. I observed that a child's capacity to function socially, emotionally and psychologically, was frequently dependent on "what was going on" for them in their life worlds. Questioning this interconnectedness, this systemic integration of a child's story and their presenting behaviour, caused me to move from teaching, to pursue family therapy training. This was intersected with 5 years working face -face in a marginalised communities co-ordinating back to education, lads and dads programmes for disengaged fathers, and facilitating parenting groups. This direct engagement with marginalised community life was foundational in giving me a lived context to the intergenerational and cyclical nature of community trauma. Yet, it also provided insight into the immense capacity of children to recover, to repair from complex trauma experiences, and their resilience, when in safe trusting relationships.

My present work as a family therapist, mainly with families affected by drug misuse, in marginalised communities for over 20 years, guides and directs the formation of this research study. I have observed a limited questioning by mental health professionals of the possible correlation between a child's presentation, their symptomology, their lived

experiences and the diagnosis that accompanies them. Also, my work as a cross professional supervisor, supervising social workers, project workers, those in social care, managers of community and voluntary agencies, as well as therapists, alerts me to the increasing challenges for these workers, working with children and young people, with mental health difficulties. Observing an increased pursuit of diagnosis for children and young people within these sectors, has evoked a curiosity as to how, or if, a child's trauma experience influenced, or was considered in the diagnostic process.

This study aims to explore this phenomenon within a mental health system in Ireland, that has seen an increase of 526% in mental health presentations to an Irish paediatric emergency department over a 10-year period, from 2006 to 2016, (Fitzgerald et al., 2020) and where "enormous gaps exist [in provision for] children and adolescents with complex clinical issues who do not fit neatly into one specific diagnostic criterion but have multiple needs" (Finnerty, 2023, p. 129). In the light of this "growing epidemic" (Fitzgerald et al., 2020, p. 20) and of the neglected gap where "studies and research of trauma in paediatric patients are in their infancy and severely understudied" (Debellis & Zisk, 2014, p. 185) the development of the following research question emerged. As a practitioner engaged on a weekly basis with children impacted by trauma, I considered it essential to begin to understand the perspective and practice of mental health professionals who form diagnosis with children and young people. The presenting aim and objectives were formed in an attempt to gain this understanding into where, or if, and how, child trauma 'fits' in diagnostic practice.

The Research Question

How is child trauma considered in disorder diagnosis with children and young people? A grounded theory study of the perspectives of mental healthcare professionals, in Ireland.

Study Aim: To explore how child trauma is considered in disorder diagnosis with children and young people in Ireland.

Objectives:

- To examine the meanings of childhood trauma, from the perspectives of psychologists and psychiatrists.
- To explore how mental healthcare professionals' respond to a child/young person's trauma in the assessment process.

- To inquire into how, and whether, mental healthcare professionals regard childhood trauma as significant, when making a disorder diagnosis.
  To analyse the role childhood trauma takes in disorder diagnosis with children and young people.
- To identify challenges faced by mental health professionals in considering child trauma experiences, in the diagnostic process.

Trauma and Children

Charmaz (2017) emphasises the importance of "historical periods, diverse cultures, specific institutions, local worlds, and interactional moments, in contextualizing and generalizing our research" (p. 299). Therefore, in adopting this constructivist grounded theory philosophy this introduction identifies and contextualises the concept of child trauma. The increased acknowledgement of the impact of trauma on early life is welcomed across the psychology, psychiatry, and psychotherapy fields, with "the concept creep of trauma" (Haslam & McGrath, 2020, p. 509) gaining much traction in media, and wider society. Yet, the concept of trauma is not new, for the etymology history of trauma originates from the Greek word for 'wound' and was first used around 1693 and its use has developed considerably within social and cultural contexts. From the early understandings of trauma as hysteria, to neurosis, to the confined criteria of Post Traumatic Stress Disorder (PTSD) to acknowledging symptomology as an enactment of the trauma itself (Herman, 1997). Yet, recent concern arises regarding the appropriate use of the word 'trauma'. The trauma debate has begun to question a potential mislabelling of trauma where, "on the one hand we might use the word a bit loosely, where it really matters, it doesn't even exist" (Mate, 2022, para. 17). In the light of contextualising the use of the term child trauma as identified in this study, the following section gives an understanding of child trauma, and its impact on the child and young person.

Defining Child Trauma

A fundamental definition of trauma is encapsulated through the collaborative work of the Substance Abuse and Mental Health Administration (SAMSHA, 2014) and identifies individual trauma as resulting from "an event, series of events, or set of circumstances that is experienced by an individual, as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (p. 7). Mate (2022) further

emphasises that trauma is beyond the event or incident, but is determined by the individual's response, contending that, "trauma is not what happened to us. It is what happens inside of us" (p. 20) as a result of what happened. This perspective on trauma is significant, in the light of this study, which questions and explores the interaction between child trauma and disorder diagnosis in this participant cohort.

In the context of this study, trauma can perhaps best be understood as a psychological wound, that can, under safe trusting environments move towards healing and recovery. This study supports a conceptual understanding of trauma, where trauma is not the event that inflicted the wound (Mate, 2022) but is an internal response that is influenced by a child's age, natural pathology, and availability of a nurturing care giver (Levine & Kline, 2008). This understanding of trauma acknowledges the impact of single events, caused by accidents, violence, natural disasters, as well as the complex trauma that can be experienced as a result of multiple exposure to abuse and neglect. Yet it is essential to clarify that "trauma theory posits that individuals experience psychological trauma when they encounter events that are overwhelming, threatening life or safety and create feelings of helplessness (Pena, 2023, para. 4). Therefore, it is how the individual child or young person experiences the event and their subjective responses to the experience, that determines whether the term trauma, is used. Levine and Kline (2008) continue to clarify that the "vulnerability to trauma differs from child to child" (p. 7). With a child's subjective response to trauma, predominately presenting as a behaviour, displaying a "somatic reactivation" (Goodyear Browne, 2019, p. 200) to a lived memory. This variance in trauma responses, and the impact or absence of their care giving structure, further accentuates the complexity, not only in defining trauma beyond the event, but also formulating a cohesive understanding that can inform diagnosis.

The literature chapter in this study further illustrates an understanding of child trauma, exploring what 'it' is called and how child trauma is documented nationally and internationally. The findings chapter of this study contributes participants understanding of child trauma, with the theoretical framework of this study. This is informed by the complexities that arise, as the participants engage this subjective movable meaning of trauma, within their diagnostic practice.

The Impact of Trauma on Children and Young People

The extensive advances in neuroscience highlight the significant neurobiological impact of early child trauma on the developing child (Cimeša et al., 2023; Perry et al., 1995). This brings an increased understanding of the connections between early trauma and the physical, emotional, and behavioural presentations in children, where traumatic memories are remembered primarily as bodily states which play out in behaviours, rather than recalled as narratives (Siegel, 1999). Early life trauma has diverse and profound impact, disrupting the developmental processes and neural pathways for children, socially disrupting their capacity for attachment, and for forming trusting relationships (Perry, 2009). A hypervigilance, a cortisol arousal 'that is always on' interrupts a child's cognitive processes, that presents as distracted and inattentive behaviour. This connection between the inability to manage normal life activities and a child's trauma may not be recognised (SAMHSA, 2014) but present very real dilemmas for children in their life worlds and their primary care givers. The impact of trauma often increases 'after the threat is over', with symptomology not appearing in the immediate 'now'. This unrecognised impact of early life stress can consequentially mean that, 'too often this early trauma is ignored or minimised and treatment delayed until a child is older' (Ryan et al., 2017, p. 121) until an increase in dysregulation and challenging behaviours are displayed. This positioning, that acknowledges the emotional social and psychological impact of child trauma "requires understanding behaviours not as 'challenging or difficult' but adaptive coping mechanisms that have developed in the face of trauma" (Dermody, et al., 2020, p.18). Acknowledging this interconnection between a child trauma and the presenting biopsychosocial impact in their lives, forms a foundational understanding on which this study was explored, and on which the theoretical framework Holding - the Contentious Balance was constructed. The following chapters demonstrate the interplay of implementing a Constructivist Grounded Theory (CGT) approach to this study's data analysis, and construction that informed and developed this substantive theory. A brief chapter outline is presented below.

Layout of Thesis

This thesis provides an account of the complex balance that the 12-participant child and adolescent psychiatrists and psychologists attempt to navigate, as they consider child trauma in their diagnostic practice. This is documented through 6 interconnecting chapters.

This introduction chapter has given a context to this study's phenomenon. It has outlined the aim and objectives of this exploration, demonstrating the foundational impact of early life stress on children and young people as they present in clinical practice. The following chapter 2 situates the concept of child trauma in the existing adult focused diagnostic structures, as documented in national and international literature and studies. It presents the theoretical framework to child trauma and diagnosis, giving insight into the context within which the participants practice. This illuminates the literary tension, that undergirds the dilemmas and challenges to the inclusion of child trauma, on the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD) criteria that is used by psychiatrists and psychologists to determine a disorder. This chapter also identifies gaps in existing literature that pertains to this phenomenon.

Chapter 3 documents how the research study was implemented, from recruitment stage to data gathering and analysis, through to construction of theory, utilising CGT principals. It presents the ontological and epistemic underpinnings of constructivist grounded theory methodology, as determined by Kathy Charmaz (2000) giving attention to my positionality as co-construct in this study. This chapter focuses on how the systematic format and rigorous process, were followed, to implement the discerning principles of CGT. It demonstrates the iterative process between data and analysis, identifying how the tools of coding and constant data comparison, formed tentative categories giving hierarchy and relevance to categories, as the theory emerged. Chapter 4 presents the study's findings, documenting how the participant data informed the analytical coding, that developed the tentative categories, that in turn elevated the core category of *The Contentious Balance*. Chapter 5 discusses the findings in the light of existing literature and draws on the recovery approach to support the workability and relevance of the substantive theory of *Holding - the Contentious Balance* in practice. The final Chapter 6, outlines the strengths and limitations of the study, presenting recommendations for potential future research and practice implications. This chapter presents the utility of the theoretical framework with potential for interdisciplinary collaboration and development, towards trauma recovery practice, for the psychotherapy field and beyond.

Reflective memos provide a reflexive human thread throughout the work, presenting rationale, dilemmas, and challenges to the research process and in developing the substantive theory.

Child Trauma Terms

Child psychologist Karyn Purvis (1944-2016) is widely recognised in the field of child and family trauma therapy as coining the term ‘children from hard places’ giving a contextualised understanding to child trauma. Similarly, as a family therapist working in marginalised communities, I consider my role in trauma therapy recovery is to hold the hard stories (Goodyear Browne, 2019) of children, young people, and their families. Yet, for the purpose of presenting this research study, I use terms of reference throughout this thesis; ‘children impacted by trauma’, ‘child trauma’, and ‘children with a trauma history’, to refer to the diversity that describes the adverse experiences of children. It is also important to note that when reference is made to ‘child’ or ‘children’ or ‘young person’ in the writing, this refers to a person under 18 years.

Chapter 2: Reviewing the Literature

Introduction

This chapter presents an understanding of child trauma, as documented in national and international literature, highlighting the diverse perspectives, that undergird this study. This review demonstrates the clinical diagnostic context in which child trauma is situated, and the complex diagnostic dilemmas, that this presents for clinicians working in the field of child and adolescent mental health. The initial section describes the literature search process and draws attention to how the review of literature, is situated in the philosophy of grounded theory methodology. Particular reference is given to literature reviewed in the Irish research context, highlighting the absence of research work documenting this phenomenon. This chapter demonstrates how the literature documents the impact of trauma on children, and the complexity this evokes within the existing diagnostic frameworks, illuminating the challenges and tension in the field. The final section explores the ongoing pursuit of alternative diagnostic frameworks for child trauma that emerge in the literature.

Literature Review Search Process

This review is conducted by a Data Base search of SAGE, EBSCO, PsycINFO, PsycARTICLES, Pub MED, using; 'child* trauma AND mental health'. Considerable refining of the search was needed to elicit relevant material. Defining the search using, Trauma and Disorder Diagnosis IN Children, presented 151,191 findings. SAGE presented 29,809 results for 'Child Trauma and Disorder Diagnosis'. This was further defined using 'Trauma and Mental Health Disorder Diagnosis IN Children.

Further searches to identify Irish contexts used, 'Child Trauma and Disorder Diagnosis IN Ireland'. With expansive findings of studies based in the northern Ireland setting of socio-political contexts, drawing much research attention to *Children in Care, Vicarious Trauma, Adult Survivors Sexual Abuse, Institutional Abuse, Irish Famine, Irish Asylum System, Physical /Child Accidents, CAMHS.* These findings highlighted the need to refine searches to, 'Child Trauma IN Ireland NOT Northern Ireland'.

References cited in relevant articles from the original data search, provided further material applicable to this review. Key international mental health websites were also searched, with contributions made to the conversation through media and social media coverage, also informing this review.

Reviewing the Literature in Grounded Theory Methodology

The concept of prior knowledge and the influential role of literature on the integrity of theory formation is well debated in Grounded Theory studies. The timing of conducting the literature review, is frequently disputed in the grounded theory community (Glaser, 1998; Glaser & Strauss, 1967) with differing emphasis placed by the founding grounded theorists on the appropriacy of pre reading literature before developing the substantive theory. Charmaz & Thornberg (2021) clarifies the concern, outlining that, "immersion in the research and theoretical literatures before conducting research would sway researchers and subsequently, preconceive their studies" (p. 310) yet acknowledges that researchers already come with passion and curiosity to their research area. Holding this tension, Glaser and Strauss (1967) also recognise that the researcher 'does not approach reality as a tabula rasa' (p. 3) therefore acknowledging the reality that I already hold theoretical information. Glaser (1998) advocates that if theory development is at a stage where literature will not inhibit the "rich first-hand data" (Charmaz & Thornberg, 2021, p. 310) informing the theory, then literature can be reviewed. Thus, highlighting a principle where, 'the literature is discovered as the theory is' (Glaser, 1998, p. 69).

Differences in opinion are presented (Charmaz, 2014; Strauss & Corbin, 1990) with "it is more typical now that grounded theory researchers become familiar with the literature surrounding their topics because it can also sensitise them to aspects of an experience and pressing related issues" (Levitt, 202, p. 34).This engagement with the literature "provides the researcher with knowledge of the substantive area in sufficient depth to understand the parameters of the discourse and to enter into the theoretical conversation" (Lempert, 2007, p. 261). More flexible approaches are adopted by contemporary grounded theorists (Bryant, 2017; Charmaz, 2006, 2014; Corbin & Strauss, 2015; Thornberg & Charmaz, 2014) with Byrant & Charmaz, (2007) advocating that the literature review provides "a level of understanding to provide orientation" (p. 20). Therefore I adopted this philosophical approach to conducting the literature review, identifying with the Charmazian GT philosophy of acknowledging multiple realities, seeking diverse perspectives, and engaging in critical analysis throughout the research process (Charmaz & Thornberg, 2021, p. 311).

In addition, as the theoretical concepts developed, the philosophical and theoretical concepts of, reductionism in medical thinking, emerged in the data with the recovery

approach to trauma informing the substantive theory that was constructed in, and from, the findings. An exploration of the literature, to situate these theoretical concepts in the light of this study's findings, are documented later in the discussion chapter. Before exploring these issues in the international literature, it is considered important to contextualise the concept of child trauma that undergirds this study.

Child Trauma - Locating a Conceptual Understanding in Literature

The following section presents a conceptual understanding of trauma, grounded in, and from, the existing literature. Its purpose is to clarify and evaluate how the literature gives reference to children impacted by trauma. The literature presents significant diversity in the conceptualisation of child trauma, suggesting a positionality towards this phenomenon. The section below identifies child trauma terms and locates their perspectives.

The seminal work of van der Kolk (2014) identifies child trauma as, "not the story of something that happened 'back then'. It's the current imprint of that pain and horror living inside people *now*" (p. 21). This perspective that emphasises the 'aliveness' of child trauma, sits alongside alternative approaches that appear frequently throughout the research literature. The work of Williamson et al., (2019) refers to 'childhood trauma' retrospectively, documenting adults who have experienced trauma as children. With Ireland & Huxley (2018) exploring the vicarious trauma experienced by professionals as they work with 'traumatised children', suggesting a studied position that is removed from the child. Similar patterns are referenced in the work conducted by the Portman Clinic in London, under Music (2014) referring to 'overtly abused children'. This use of 'overtly' to describe child abuse, curiously draws my attention. Trauma is widely experienced by children in covert, hidden contexts and internalised by children therefore the absence of reference to the significant 'covert' nature of trauma experienced by children is questionable. This externalising of child trauma is also reflected in the work of Kiser et al. (2019) using the term 'trauma exposed' to describe her work in developing a conceptual model of complex trauma in families. With a retrospective perspective emerging again in a university student survey on childhood adverse experiences and their attachments, by Corcoran & McNulty (2018) referring to, 'childhood adversity'. Spinazzola & van der Kolk (2012) expands this adversity concept as 'traumatic interpersonal adversity' or 'childhood interpersonal trauma'. This interrelated aspect to child trauma concurs with the

influential work of Finkelhor (1985) who developed a Precondition Model which has been built upon to understand the contexts of child sexual abuse. Importantly, he depicts the interactive relational foundations of trauma as "harm that comes to individuals because other human beings have behaved in ways that violate social norms" (p. 23). This portrayal of trauma not only emphasizes the systemic nature of trauma, beyond the child, but illustrates the naming of the "psychological reality" (Herman, 2015, p. 116) of trauma.

Herman (2015) has made a critical contribution to the field of trauma, documenting the physical reality and systemic nature of community trauma, that is experienced by many children living in marginalized communities. The impact of community violence, gangland crime and the intersection of poverty and limited resources on family and community life have a significant impact on the developing mind, body and spirit of children and young people. Frequently in these communities, "the collective reality of safety" (Levine and Kline, 2008, p. 204) and of predictability, is under threat. Children and young people learn to form "adaptative responses, requiring states of hyperarousal and collapse" (Goodyear Browne, 2019, p. 55) where their nervous system enables them to stay alert, to be prepared and be on guard, as they attempt to function in their communities. The literature draws attention to the symptoms of community trauma that permeates "the social-cultural environment, the physical/ built environment and the economic environment" (Pinderhughes et al. 2015, p. 4) of community life. This also contributes to the intergenerational nature of trauma (Yehuda & Lehrner, 2018) where families living in the same social/cultural environment of violence, crime and poverty for many years, are frequently exposed to potential traumatic incidents. This intergenerational nature of trauma documented in the literature where "communities have deteriorated over time, generation after generation" (Pinderhughes et al. 2015, p. 27) brings a further complexity and wider dimension, to understanding a child's exposure to trauma.

The systemic perspective to child trauma is also represented in the widely referenced ACE criteria (Adverse Childhood Experiences). The ACE criteria originated through the work of Kaiser (1995) and later developed by Felitti et al. (1998) provides a conceptual trauma framework that is frequently referenced in literature and used in practice (documented below). This framework is used internationally by the World Health Organisation (WHO) and UNICEF as a model to identify child trauma. The ACE criteria is also used in the influential trauma work of child psychiatrist, Perry (2008) and referenced

in an Irish study by Hickey et al., (2020) to identify the cumulative exposure of a child, to 10 distinct areas. An ACE score (0-10) indicates a child's experience of 5 criteria, relating to the child themselves, physical, emotional, and sexual abuse, as well as physical and emotional neglect. The other 5 explicate the child's household, identifying the impact of a child's significant other, regarding mental illness, addiction, incarceration, loss, or living with domestic violence. The exposure to these adverse childhood experiences has been widely acknowledged as impacting on mental health across the life span (Ryan et al. 2017) suggesting a direct relationship between a child's trauma history and their mental health presentations. The ACE criteria appear to present a very practical application of a trauma criteria. An interesting Irish study emerged (Dermody et al. 2020) highlighting the use of the ACE criteria, where an exploration of the prevalence of the ACEs among young people engaged in Garda Youth Diversion Programmes was used to inform practice. Yet, complexity increases with a child's presentation of multiple, repeated ACE's, which Findelkor et al. (2007) terms poly-victimization. Although the ACE criteria may present as a useful lens through which to identify exposure to trauma, it is how the child or young person experiences these, that determines a trauma response. Levine & Kline (2019) bring insight, explaining that "trauma resides not in the external event, but in how the child's nervous system processes the event" (p. xiii).

Although the ACE criteria is used extensively throughout the literature it is how a child responds to these trauma experiences, that present as trauma symptoms, that undergird the crucial intersection between trauma and diagnosis that is explored in this research study. The subjective individuality of these trauma experiences is illustrated by Perry (2008) in his work on attachment and developmental trauma. Perry (2008) best depicts the understanding of trauma that undergirds this research study, explaining succinctly,

> There is no one label for child trauma. Rather there are very individualized patterns of exposure to trauma (all with unique timing, nature, and patterns), so we don't call 'it' anything. We describe it and try to 'illustrate' each child's trajectory separately. (p. 245)

It is how this individualised nature of children's trauma experiences, intersects and relates to the existing diagnostic frameworks, that provokes an evident tension that emerges in the international literature. Contextualising how child trauma is documented in the Irish research literature is explored below.

Child Trauma Literature in the Irish Context

Trauma literature in the Irish context highlights a distinct perspective and presents significant gaps in documented trauma research relating to this study's phenomenon. Extensive research and documented reports demonstrate our countries distinct history of trauma. A large body of work documents northern Ireland studies, highlighting community trauma and civil violence, focused on the socio-political struggle (Bolton, 2017; Fargas - Malet, et al., 2016; Stewart & Thomson, 2005). Many findings in the southern Irish context, refer to physical trauma studies, in hospital settings (O'Reilly et al., 2019) with limited references to the psychological impact of child trauma.

The reviewed literature found research focused predominantly on a retrospective approach to trauma, focused on adult survivors of child sexual abuse and adult responses to childhood trauma (Burns & Lynch, 2008). These were focused mainly on adult survivors of institutional child abuse with an indication of Ireland's child abuse inquiries influencing the systemic restructuring of "what was, and what some say still is, an underdeveloped child protection and welfare system" ((Reilly & Dolan, 2016, p. 2). The crisis in mental health services for children is well documented where CAMHS, the national mental health service for children and adolescents is over stretched, with approximately 4,400 currently awaiting first time CAMHS appointments (Jan 2024).

This acknowledgment of underdeveloped provision within an undocumented field of child studies, is also identified by a study (Carr, 2018). This outlines the difficulties of transition from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS). Yet again this is an adult focused study presenting adult professional perspectives of this transition without references to the children's mental health. Although the Maskey report (2022) identifies the mental health services for children as " a profoundly serious issue" and requires a "fundamental review right across the services" the retrospective nature of research studies has prevailed in the literature. With Corcoran & Mc Nulty (2018) documenting a survey of university student experiences of childhood adverse experiences and their attachments, and a longitudinal study by Healy & Fitzgerald (2000) evaluating long-term outcomes (16 years) of 50 children who had been inpatients in a child psychiatry unit in Dublin (1978-1980).

Kate Duggan, CEO of Tusla, Child and Family Agency in Ireland, recently drew attention to the concerning 14% increase in referrals, highlighting "that is 46,661 children

where somebody is concerned that they are suffering from neglect, where there is a concern about ability to thrive, where there is a concern that that child is being harmed" (Kelleher, 2023, para. 3). The PRIMERA research programme, Promoting Research and Innovation in Mental hEalth seRvices for fAmilies and children (Furlong et al., 2022) identifies Ireland as having the 3rd highest incident of adult mental health across 36 counties in Europe and points to a crisis in adult mental health. The impact on the children in the care of these adults is concerning. With Tusla documenting the increase demand for services from "Children whose parents are for whatever reason unable to care for them. 3,800 children in homeless services, 4,800 children in Direct Provision …..we have seen a 500 percent increase in the number of separated children seeking international protection" (Kelleher, 2023, para.13).

Yet, despite these concerning statistics relating to the needs of children impacted by trauma in the Irish context, there appears to be limited published studies of psychological disorders in children (Martin, 2006) with an absence of studies that are focused on children's psychological trauma experiences. The Maskey report (2022) alerts attention to the serious consequences of "micromanaging patients with medication, rather than looking at psychosocial interventions" within CAMHS in Ireland. Yet, further searches to source studies of child and adolescent professionals perspectives of working with children impacted by trauma in Ireland presented limited findings with a study by Mc Nicolas et al., (2020) focused on burnout of consultants in the CAMHS system. Yet, the Irish Governmental Child and Family Agency (Tusla) recognizes the need in the field, advocating for evidence-based research practice to "build on our research strategy to develop policy and enable evidence based decision-making and high-quality service delivery" (Waterstone & Brattman, 2015, p. 6).

An Irish governmental report, "Trauma Strategy - A Trauma System for Ireland" (2018) also adds weight to the need for "strategic vision for the development of trauma services in Ireland, informed by international best practice (The Health Management Institute of Ireland, 2023). Yet, 'major trauma' in this visionary context in implementing an Irish national trauma system within major trauma centres, is identified from a physical injury perspective. With the estimated long-term effects of Adverse Childhood Experiences (ACES) such as harmful substance use, mental health problems and physical health issues costing 2% of Irelands GDP (Prevention and Early Intervention Network, PEIN, 2022), it is surprising that further emphasis is not placed on meeting the

foundational impact of child trauma. In the light of the recent Maskey report (2022) and and the crisis in mental health, challenging questions arise to the Irish governmental interventions and developments for a wider perspective to compass all contributing factors to psychological trauma, beyond and including, this emphasis on physical trauma.

Sharing the Vision Implementation Plan, 2022 – 2024, (HSE, 2022) contributes a welcomed focus on an individualised response to mental health care in Ireland. Its systemic philosophy in recognising the "complex interplay of intergovernmental departments" (p .8) demonstrates a shift in perspective towards integrated practice across mental health. It is encouraging to source movement toward the consideration of the impact and consequences of traumatic experiences in the increase in Trauma Informed Care (TIC) awareness and training being integrated into health, community and education services (Lambert & Gill-Emerson, 2017; O'Toole, 2022) across the country. A trauma informed model of care equips a program, organization, or system to realize the "widespread impact of trauma and understands potential paths for healing; recognizes the signs and symptoms of trauma in staff, clients, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings" (SAMHSA, 2012, p. 4). This movement has contributed much to incorporating understanding and sensitivity of the significant impact of child trauma across a wide sector working with children and young people in Ireland. A recent study by Hyland et al. (2021) documents the first Irish assessment of the prevalence of trauma exposure, and Post Traumatic Stress Disorder (PTSD) and Complex PTSD (CPTSD). Although this assessment was conducted with adults, rather than children and young people, it demonstrates a welcomed Irish contribution to the limited trauma literature. Yet, it is perhaps Maguire et al., (2020) who after an extensive analysis report 'Children Seen & Heard', over a period of 10 years (2008-2018) best demonstrates the Irish literary landscape on this phenomenon, concluding that "a review of the literature demonstrates that relatively little is known about acute psychiatric presentations of children 0-12 years" (p. 8). This clearly indicates that further studies and opportunities for literary exploration are needed in the field of child trauma, beyond a retrospective, adult focused, and physical injury perspective to childhood trauma.

Dr Niall Muldoon, ombudsman for children in Ireland, recently advocated for the urgent need to address the mental health crisis for children in Ireland expressing his frustration, "I feel compelled, to express my frustration and disappointment at the lack of

progress on a number of issues affecting children" advocating "a radical and brave reimagining of our mental health services for children"(Dunphy, 2024).

This current research study hopes to contribute to this absence and is grounded in the concern of the significant impact of trauma on children and its relationship with increased disorder diagnosis. Kessler et al. (2010) outlines that "childhood adversities have strong associations with all classes of disorders at all life course stages and account for 29.8% of all disorders across all WMH (World Mental Health) countries (p. 378). Although concerning as this association between disorder and child trauma is, exploring this interaction between a child's trauma history and how it is considered in disorder diagnosis with mental health professionals, does not appear as a studied phenomenon in any of the reviewed literature searches. In an independent review of existing child and adolescent services, diagnostic assessment frameworks for children in Ireland, appear to be at the clinical preferences and discretion of the clinician, as highlighted in the independent review of the mental health services for children and adolescents (Finnerty, 2023).

Although there is a recent increase in studies documenting the prevalence of mental health issues with young people in Ireland with McDonnell et al., (2021) determining changes in mental health attendance and Mc Nicolas et al., (2021) documenting the patterns of referral during the Covid - 19 pandemic, there appears to be an absence in exploring the context of these changes. Although rates of specific disorders were indicated by an earlier study (Martin, 2006) the conclusion outlined that "cases and controls had distinctive personal and family profiles" (p. 44) with no further exploration or account of a child's family or environmental context. Recent Irish governmental surveys, My World (2012- 2019) a national study of youth mental health, GUI (Growing up in Ireland), a Covid -19 Survey, and BOBF, (Brighter Options Brighter Future, 2019) have contributed much towards acknowledging young people's mental health. Yet these studies appear to be limited in exploring and researching the underlying factors of this "growing epidemic" (Fitzgerald, et al., 2020, p. 20).

Questions arise as to why this is an understudied and underdeveloped field of research in Ireland. Kessler et al., (2010) in their WHO mental health survey on childhood adversities and psychopathology, suggest a rationale for this absence that "although children are often reluctant to admit these childhood adversities, health professionals are often reluctant to ask" (p. 383). This study intersects this position, asking the question, and

exploring, how a child's trauma is considered by mental health professionals in their diagnostic practice. This intersection between child trauma and diagnosis is explored extensively below in the light of the international literature, giving an insight into the wider clinical context within which this study's participants practice.

Child Trauma and Diagnostic Frameworks - Dilemmas in the Field

As the diverse attempts to clarify child trauma expand in the literature, it is accompanied by what McNally (2003) terms a "conceptual bracket creep" (p. 232) articulating attempts to define a diagnostic framework for child trauma. This engagement with a diagnostic "measurement of psychological trauma generates considerable controversy" (Weathers & Keane, 2007, p. 107) in the field of child trauma and diagnosis. The existing diagnostic structures and the accompanying controversary are identified below contextualising the clinical landscape within which these research participants practice. Gaebel et al. (2020) brings clarity to the existing the categorial measurement to diagnosis, documenting its process,

> Current classification systems of mental disorders are based on a polythetic categorical approach. In these classification systems, a list of characteristic symptoms is provided for each diagnosis. The presence of a usually predefined, number of symptoms from this list is sufficient to assign the respective categorical diagnosis. (p. 15)

The literature focuses mainly on two classification systems for diagnosing mental health disorders, the ICD-11, International Classification of Diseases, (initiated in Paris in 1900) and used in WHO member states, and the DSM-5, Diagnostic and Statistical Manual of Mental Health Disorders, American Psychiatric Association (APA, 2013). The emergence of the recognition of trauma in these diagnostic frameworks began in the 1970's with the contentious history of Post Traumatic Stress Disorder (PTSD) in the DSM for adults, due to post war veteran presentations with flash backs and nightmares. This shift in the diagnostic practice acknowledged trauma as PTSD, under the addition in the DSM-3, in 1980. PTSD for adults has been under regular review, represented by changes in the more recent DSM-5 (2013) where PTSD was relocated from anxiety disorders to a new diagnostic category under Trauma and Stressor - Related Disorders. Changes also occurred in the ICD-*10* to *ICD-11* (implemented in January 2022) with alterations to include the adaptations, to CPTSD (Complex Post-Traumatic Stress Disorder) and the inclusion of the Mental, Behavioural and Neurodevelopmental Disorders (MBND) chapter representing a

move towards a diagnostic focus on "a developmental continuity across the lifespan" (Gaebel et al., 2020, p. 8). Attempts continue to converge these two (DSM-5, ICD) diagnostic frameworks (Tyrer, 2014) yet, difficulties arise regarding existing diagnostic structures, that are appropriate for children. The reviewed literature identifies the historical and present dilemmas that point to "the chasm we have created between child and adult psychiatry" (Kaffman, 2009, p. 625). Criteria for diagnosing trauma in adults is widely documented, yet with no specific diagnostic criteria beyond PTSD used in psychiatry, to define the symptom presentations in children, impacted by trauma. The pressing need to define trauma for children within the existing diagnostic frameworks, appears to dominate the debates in the literature, (which is given further exploration later in this chapter).

In addition, a growing debate permeates the more recent literature (Astle & Fletcher-Watson, 2020; Constantino, 2018; Klin et al., 2020) presenting the limitations of disorder diagnosis linked to a single diagnostic system (Dalgleish et al., 2020; Hogg et al., 2023). The substantive theory underlying this research study conjoins with this debate, where a single diagnostic process does not account for the complexity of child trauma symptomology, but trauma responses are best understood as a spectrum of conditions rather than as a single disorder (Herman, 2015, p. 119). Edder & Angold (2006) argues this reductive single diagnostic practice towards trauma displays a weaknesses in specification with limited identification and comparison of symptoms. This concern is supported by Kolk et al., (2012) below, highlighting the difficulties have arisen for trauma diagnosis for children, where:

> No single current psychiatric diagnosis accounts for the cluster of symptoms that research is shown frequently to occur in children exposed to interpersonal trauma. Despite the breath of post traumatic dysfunction, only one diagnosis in the DSM specifically identifies trauma as posttraumatic stress disorder (PTSD). However, PTSD may not fully capture the spectrum of post traumatic symptoms, particularly among children. (p. 188)

Shapiro (2010) concurs with this perspective highlighting that there is more to trauma than PTSD, recognising the complexity to trauma "represented by a constellation of complex and interacting cognitive, emotional, and behavioural symptoms beyond that of PTSD alone" (Cruz et al., 2022, p. 8). This presenting challenge to capturing the relationship between trauma and psychiatric illness is perplexing (Teichor & Samson, 2016). How the literature contends with this challenge, to develop diagnostic frameworks that take account

of the significant impact and distinctive differences in child presentations of trauma, is reviewed below.

Diagnosing Trauma Symptomology - The Impact of Child Trauma

De Young et al. (2011) contends that the existing DSM and ICD diagnostic frameworks lacks "developmental sensitivity" to children with their "unique developmental differences in the rate and manifestation of trauma symptomatology" (p. 231). Towards this endeavour, illuminating the differences in children and adults is fundamental, where "children affected by interpersonal trauma often experience more global and profound changes than adults who conceivably have more developed adaptations to stress and more cognitive resources to mitigate risks and promote resiliency" (Cruz et al., 2021, p.1). The evidential impact of trauma is a well-documented field of research (Trickett, et al., 2011; O'Connor et al., 2011), with Levine (2010) contending that there is a strong connection between trauma and mental health, conjecturing that "unresolved trauma is responsible for a majority of the illnesses of modern mankind" (p. 184). It is this impact of trauma experiences that present in clinical practices, demonstrating traumas "lasting negative effect upon self and psyche" (Shapiro, 2017, p. 39) that causes concern. Documenting this formative impact of child trauma is essential, as it highlights the transdiagnostic factors that underlie disorder diagnosis (Dalgleish et al., 2020) further contextualising this study research question, as to the how trauma is considered in disorder diagnosis. Ford (2005) concurs with this debate arguing for the need for clinical acknowledgment of trauma amidst the comorbid complexity in diagnosis. Ford emphasizes that "diagnosis based upon exposure to developmentally adverse interpersonal trauma, victimization, and neglect during childhood, has the potential to alert clinicians to the influential role of childhood trauma psychopathology" (p. 168). Exploring this influential impact of trauma and its role in, and relationship with, mental health clinicians' diagnostic practice, undergirds this research study.

The clinical documentation, reported mainly through qualitative research and case studies of child trauma, demonstrate the impact of trauma in diverse contexts. The 'toxic stress and complex trauma' defined by Humphreys & Zeanah (2015) describes "the cumulative and pernicious effect of multiple, chronic environmental adversities, (that) is believed to disrupt developing brain circuitry and other organ systems, with long-term implications for physical and mental health" (p. 154). This disruption to brain circuits has

significant implications on child psychopathology, with developmental interruptions presenting diverse symptoms across a child's biopsychosocial development. Music (2014) extends this perspective integrating Freud's thinking, and contemporary neuroscience, contributing a distinct voice to existing child trauma literature, through a psychoanalytical lens, emphasising the inability for the child's ego to develop, due to the impact of trauma. The significant impact of child trauma on young children has been identified by many studies, documenting the adverse effects on a child's "biological, social, cognitive, emotional, and spiritual/existential development" (Cruz et al., 2022, p. 7). This immense impact on all aspects of a child's life is well documented, frequency displayed through a child's behaviour and their capacity for learning and social interaction (Putnam 2006; Luby, et al., 2022; Richardson et al., 2015). In addition concerning trauma study findings, conscribe for a significant increase in violence (Maxfield, 2001) contributing to attempted suicide and self-harm (Ermagan-Caglar et al., 2020) with psychopathologies associated with child trauma from an early age (Downey & Crummy, 2022).

Documenting the extensive impact of child trauma is foundational in contextualising this study where "early, repeated interpersonal traumas interrupt the development of secure attachment and precipitate the emergence of chronic and severe traumatic adaptations" (Cruz et al., 2022, p. 1). It is these adaptations to trauma that present to this study's participants 'awaiting' a clinical response. How clinicians consider children's complex responses to neglect and potential danger which often disrupt personality functioning (Crittenden & Landini, 2011) is fundamental to clinicians engagement with diagnosis. Children impacted by trauma frequently present easily distracted, with limited focused attentiveness due to a constant state of hyperarousal. How this is interpreted and given account for determines the diagnostic outcome. This extends to the physical impact of trauma experiences where ongoing vulnerability to trauma is also considered to impact the immune system (Robles, 2021) leading to physical symptomology, and illness in children and young people (D'Andrea et al., 2012). These physical symptomology also beg for notice in this complex intersection of trauma responses.

Yet, trauma symptomology is not a linear criteria. Just as defining trauma is individual, subjective, and identified as 'movable' in this study's findings. So too trauma symptomology for the child, is subjective and movable, determined by influencing

factors. A richly documented field (Briggs-Gowan et al., 2010; DeBellis &Van Dillen, 2005; Perry, 2009; Shonkoff et al. 2012) outlines several factors that determine the individual impact of trauma on each child. These influencing factors are outlined as (i) the severity of the trauma, (ii) the type and duration of the trauma, (iii) the developmental age of the child (Scheeringa, 2019) and (iv) the presence and effectiveness of response of the caregiver (Ford et al., 2021) and (v) the natural pathology of the child significantly influences the impact of trauma (Perry, 2008). The significant role of the psychopathology of the caregiver is also given attention in the work of Muller et al., (2013). The literature continues to document the significant impact of early life trauma causing "significant alterations to children's cognitive, emotional, physiological, and relational capacities, and widespread disruptions to their academic, social, and occupational functioning" (Cruz et al., 2022, p. 5).

Despite the literature presenting "highly suggestive evidence of an association between any type of trauma in childhood and any mental disorder" (Hogg et al., 2023, p. 403) there appears to be a gap in the diagnosis debate or "the role played by personality development and our adaptations to the trials of surviving" (Wilkinson, 2022, p. 505). Ryan et al., (2017) in their study of preschool children contends that child trauma is frequently ignored and advocates towards early intervention for children impacted by trauma. With the dept of current knowledge that child trauma "can affect the early development of the brain, producing impairments in the neuro-regulatory system, generating neuro-behavioural changes and limiting cognitive and social abilities" (Dermody, et al., 2020, p.12) it is concerning that the impact of child trauma, with its presenting symptomology, and its relationship with disorder diagnosis has not demanded more literary research in the child and adolescent mental health field.

Although Teicher & Samson (2016) advocates that adverse child experiences are the "most important preventable cause of psychopathology accounting for about 45% of the population attributable risk for childhood onset psychiatric disorders" (p. 241) the disconnection between a well-documented field of the impact of trauma and its role in informing diagnostic practice, remains under documented. This research study positions itself within this gap and explores the underlying dilemmas that mental health professionals face as they too balance the practice implications, amidst the clinical diagnostic structure, within which they work. Within the limitations of clear guidance or direction beyond the existing classification frameworks, the literature presents a field that

is searching and exploring alternative frameworks. These explorations to identify child trauma that function within the existing medical model of mental health in the literature are documented below.

Considering Alternatives to a Fixed Diagnostic Approach

The challenge to consider the complex impact of a child's underlying trauma amidst a child's presenting behaviour symptomology is difficult. Interventions, frequently focus on behaviour modification. These are helpful toolsso that children can function within their social engagement system. Yet, if the understanding that has been informed from my practice, that a child's behaviour is trying to communicate something of their internal world, it is questionable if attempts to adapt children's behaviour alone, is truly child centred. Many contributing factors add to the complexity of alternative perspectives to understanding diagnosis approaches for children impacted by trauma. The literature draws attention to the contributing factors of a child's temperament (DeLisi et al., 2018) of attachment and neglect (Clarkin, 2006) that accompany the child's environment and family support systems (Brock & Kochanska, 2016; Sumari et al., 2021) impacting a child's capacity in overcoming the wounds of trauma. Levine & Kline (2008) emphasizes the vital role of resilience, influenced by a child's "states, traits, events and processes" (Wilkinson, 2022, p. 505) in determining a child's capacity to manage their early life stress. Yet, despite these considerations influencing intervention, the underlying continuum to pursue an appropriate diagnosis for child trauma, persists in the literature. The following section presents the exploration to structure alternative frameworks that arise in the reviewed literature.

The potential for alternative diagnosis frameworks for children impacted by trauma has been in the field of child and adolescent mental health for some time (Cloitre et al., 2019; DePierro et al., 2019, Hyland et al., 2017). Ford (2005) contributes to the diagnostic debate contending that "the sequelae of children impacted by trauma, may constitute the basis for a distinct new psychiatric diagnosis" (p. 167). Herman's advocation back in 1992 for the consideration of DESNOS (Disorders of Extreme Stress, Not Otherwise Specified) to indicate a cluster of symptoms in response to trauma diagnosis, still appears to hold weight in the literature, acknowledging the complexity of child trauma symptomology. This concept of DESNOS where that element of uncertainty, of the unknown, symptomology that can't be specifically diagnostically classified is important. This

perspective in regard to the complex impact of trauma experiences and definitive diagnostic criteria, aligns with the underlying categories of the substantive theory of this research study which are depicted later in the findings. The literature draws attention to two areas that informs the debate in how this is best navigated in practice. Existing documentation in the literature suggests that increased understanding of trauma responses is needed, alongside a recommendation for new diagnostic categories to define child trauma (Rutter, 2011; Taylor, 2011).

The complexity to this phenomenon expands as, this "persistent puzzle in psychopathology research" (Krueger & Markon, 2006, p. 133) of comorbidity is considered. Comorbidity, which was first introduced in medicine by Feinstein (1970) "denoting those cases in which a 'distinct additional clinical entity' occurred during the clinical course of not only those cases in which a patient receives both a psychiatric and a general medical diagnosis, but also those cases in which a patient receives two or more psychiatric diagnoses" (Maj, 2005, p.182). Owen (2020) identifies this comorbidity as "clear overlaps" (p. 83) in the diagnostic criteria between disorders, suggesting the application of comorbid diagnosis with traumatized children as normative practice (Taylor, 2011; Ford, 2021). Yet, despite acknowledging comorbidity, the caution arises in the current trauma diagnostic framework that "this runs the danger of relegating trauma treatment to only one disorder; (PTSD) that is experienced by only a small fraction of traumatized children who are in psychiatric treatment" (Taylor, 2011, p. 131). This leads to movement in the literature to "support advancements and alterations in the construct of diagnosis to move beyond the global categories provided by ICD or DSM" (Wilkinson, 2022, p. 505) to address the concern that children who are impacted by repeated trauma experiences (Ford, 2017) is underreported. The alterations would aim to facilitate a broader diagnostic framework, that would consider the "high comorbidities between trauma and other disorders which are underestimated by PTSD diagnostic criteria" (Cruz et al., 2022, p. 2).

Herman (2015) expresses a concern that the connection between the "present symptoms and the traumatic experience is frequently lost" (p. 118) when attempts are made to adjust presentations to fit existing diagnostic frameworks. Taylor (2011) addressing this concern advocating a need for the development of alternative constructs for trauma and suggests 'Developmental Posttraumatic Adaptation' as a diagnostic term to identify the symptoms experienced by children who are traumatized. This developmental

perspective is in paradox to the defined diagnosis of PTSD where clear delineation of symptoms determines the criteria. These considerations add to the complexity, diversity and shifting constructs that are required to facilitate clinical diagnostic practice with this child cohort impacted by trauma. Spinazzola & van der Kolk (2012) present an invitation to the field of psychotherapy and child and adolescent mental health services, to consider a biopsychosocial perspective to child trauma diagnosis, outlining the benefits where,

> A new diagnosis could enhance treatment selection and outcomes for this difficult to treat cohort and could reduce diagnostic confusion and enhance the outcomes by promoting a targeted treatment approach focused on post traumatic biopsychosocial dysregulation. (p. 194)

Yet, Rutter (2011) identifies the need to separate research and clinical classifications and advocates for the development of primary care classification for causes of referral, to both medical and non-medical primary care. These problems in classification are also identified by Rohde (2011) advocating for a dimensional rather than a categorial system that observes and takes into account the individual child's symptoms but also the source of that information. This systemic consideration that suggests movement and flexibility from the existing categorial classification of child trauma to a dimensional framework is essential in widening the framework of identifying and clarifying the considerable impact of trauma on children and young people.

As demonstrated, the review of the literature identifies the complexity in the existing diagnostic frameworks for children. Yet, Owen (2020) critiques this practice phenomenon more explicitly than had been reviewed in the literature to date, bringing light to the underlying difficulties of pursuing alternative constructs. Owens depicts the mental health field, with "two competing schools of thought". With "one posture's nosology focuses on the post-traumatic stress responses; the other focuses on the deviant behaviours that ensue from pathogenic care in early childhood" (Owen, 2020, p. 83). The literature appears to increasingly acknowledge the significant impact of early life trauma. With Cruz et al., (2022) identifying the "multi-faceted and longstanding consequences (that) underscores critical periods of development, complex stress-mediated adaptations, and multilevel, trans-theoretical influences" (p. 1). Yet despite the well documented impact of trauma, there appears to be an absence in how this acknowledgement influences clinical diagnostic practice. Owen (2020) in their review of 73 articles addressing childhood trauma, continues to contribute an interesting perspective to the debate, potentially drawing some light on the rationale for this absence of attention to "interacting components"

(Johnson et al., 2021, p. 61). Owens (2020) draws attention to the contrasting approaches taken to child trauma and disorder diagnosis where "the prognosis and course of treatment vary significantly between the two etiologies—apparently at least in part due to possible clinician bias in conceptualizations of the two populations" (p. 83). It is perhaps this acknowledgment of clinicians two schools of conceptualization that gives insight into the challenges faced by psychologists and psychiatrists as they consider child trauma in their diagnostic practice. Adopting these conceptual frameworks that align with a single categorical or a wider dimensional approach to child trauma has significant implications on how child trauma is considered and given attention in the diagnostic assessment process. Exploring and critiquing why and how clinicians adopt certain schools or approaches to trauma conceptualisation within the existing diagnostic frameworks, is central to this study's exploration. Yet in the light of the documented literature on this phenomenon it is within the constraints of the existing diagnostic DCM and ICD frameworks for child trauma, that the literature focuses predominately on pursuing alternative diagnostic constructs and approaches.

This current research study situates itself within a field, that appears to pursue a continuous exploration towards alternative constructs, that deem fitting to the immense impact of trauma. The rigorous pursuit of an alternative framework for defining trauma in the literature, demonstrates a discomfort and what I have termed a 'dis-ease', with the existing categorial structures that informs diagnosis. Below outlines positions and approaches to disorder diagnosis presented in the literature, and particularly the consideration of early life trauma in diagnosis, that attempt to reframe how child trauma is considered in diagnosis.

In the light of a "move beyond an implicit single core deficit framework" (Johnson et al., 2021, p. 611) research practitioners present alternative frameworks for disorder diagnosis, documenting a more developmentally appropriate trauma diagnosis for children (Ford, 2021) embracing a "systems biology approach in which it is the interaction between components that determines system-wide outcomes (Johnson et al., 2021, p. 613). The British Psychological Society advocates " a recognition that we need to promote a whole range of ways of moving towards theory and practice that is not based on psychiatric diagnosis" (Johnstone & Boyle, 2018, p.14). This conjoins a growing discourse in the trauma therapy field (Fisher, 2017; Heller, 2012; Ogden & Fisher, 2015) contending that, there are "underlying transdiagnostic processes which underpin a range of mental

illnesses" (Hogg, 2023, p. 397) asserting that children with a trauma history display a wider range of symptoms that, Ford (2021) contends, should not be attributed to other psychiatric disorders. This correlation between early life trauma and child psychopathology where "the role of disruptions in threat processing as a central mechanism linking child trauma to multiple forms of psychopathology and identify protective factors" (McLaughlin & Lambert, 2017, p. 29) suggests that developmental trauma "may complicate or, in some cases, account for the mental health problems that lead to the diagnosis of several childhood/adolescent psychiatric disorders" (Cruz et al., 2022, p. 3). This developmental approach to early trauma or as termed 'developmental traumatology" (Debellis & Zisk, 2014, p.185) provides scope for a "systemic investigation of the psychiatric and psychobiological effects of chronic overwhelming stress on the developing child" (p. 185) suggesting an alternative framework for conceptualizing child trauma within a diagnostic framework. This perspective which documents a direct link between the child's trauma and the presenting behaviour is vital in how trauma symptomology is considered in the diagnostic process. This is significant in the light of this research where the systemic pressure to diagnose does not facilitate this more complex relationship.

In his recent updated work, Ford (2023) presents a new construct of trauma diagnosis as; Developmental Trauma Disorder (DTD), suggesting that DTD can be differentiated from PTSD (DePierro et al., 2019; Spinazolla et al., 2018). Ford (2023) contends that psychiatric comorbidity accounts for children receiving mental health treatment for multiple psychiatric disorders with DTD providing a construct for aiding and directing therapeutic interventions. Attempts to include DTD was proposed in the DSM- 5 to better address the developmental timing in which traumatic events occur and the impacts on children's self-regulation skills and relational capacities (Cruz et al., 2022). Although not adopted, advancements are evident with the development of standardized interviews and psychometric instruments accompanying the Developmental Trauma Disorder - Semi-structured Interview (DTD-SI), in an attempt to provide a valuable extension to the diagnostic framework of children impacted by trauma (Ford, 2018; Ford et al., 2021). An interesting preschool adaptation to the DSM is proposed by Cruz et al., (2022) for children (0-6 years) to encompasses a revised classification that emcompasses a "more developmentally sensitive" (p. 4) approach to children impacted by trauma, with a welcomed child centred alternative to assessment where, "symptoms naturally present

themselves in children's play behaviours and not necessarily in their verbal responses to the myriad of questions posed by assessors in standard clinical interviews" (Cruz et al., 2022, p. 4).

A "systems neuroscience approach" (Johnson et al., 2022, p. 610) to classification of trauma under neurodevelopmental disorders, joins the growth towards the developmental psychopathology to early childhood diagnosis. Using an Anterior Modifiers in the Emergence of Neurodevelopmental Disorders (AMEND) framework, Johnson et al., (2022) encompasses a wide vision for this trauma field, aiming "to reframe the field of prospective studies of neurodevelopmental disorders" (p. 625) by tracking early sensory and motor brain activity, and differentiating against later brain develops in children providing a "conceptual, statistical and methodological approach" (Johnson et al., 2022, p. 610) to disorder diagnosis.

Interestingly, a conglomerate of practising psychologists as part of The British Psychological Society makes a valuable contribution to the diagnostic debate. The Power Threat Meaning Framework (PTMF) offers a meta framework as a "structure for identifying patterns in emotional distress, unusual experiences and troubling behaviour, as an alternative to psychiatric diagnosis and classification" (Johnstone & Boyle, 2018, p. 5). The PTMF calls for a 'paradigm shift' in the existing diagnostic structures with "the need for a fundamentally different approach to pattern-identification in relation to emotional and behavioural distress and difficulties" (p. 7). This framework challenges the Western medical approach to psychiatric presentations, altering the enquiring perspective of 'What is wrong with you?' towards a shift in power, to understanding 'What has happened to you?'. Although the PTMF does not specifically address an approach that relates to children, it does present a framework, a lens, for adopting an individual line of enquiry that accommodates and observes, the subjective responses to adverse experiences.

The literature clearly displays the extensive attempts to synthesise a subjective understanding of a child's response to trauma within a recognised diagnostic frame. Additional challenges to alternatives perspectives are outlined below.

Challenges to Alternative Diagnostic Perspectives

The literature reviewed in this chapter widely demonstrates the distinct challenges that present, as clinicians attempt to place a diagnostic lens on child trauma (Hughes et al., 2017; Liming & Grube, 2018). Difficulties of adopting developmental and dimensional

approaches to the existing categorical diagnostic system, poses challenges in practice, where "large within-category heterogeneity, comorbidity, and difficulties in representing subthreshold symptomatology" (Gaebel et al., 2020, p. 15) are complex to determine. Although the implementation of threshold changes to diagnostic criteria in the ICD-11 Clinical Descriptions and Diagnostic Guidelines (CDDG) are welcomed, it is essential that within the diagnostic debate, research and practice does not lose sight of "variation of normal human functioning in order to prevent pathologization of normal behaviour" (Gaebel et al., 2020, p.13). Yet, the literature presents an awaiting challenge to develop frameworks that acknowledge and identify subtle forms of children's trauma-related coping (SAMHSA, 2014) whilst straddling the balance of child trauma complexity and existing diagnostic frameworks.

Holding this balance that acknowledges the complex needs of a child's trauma amidst the dilemmas of trauma diagnosis is considered one of "the most contentious issues in the field of traumatic stress studies" (McLally, 2003, p. 230). Although attempts of adaptations of the diagnostic medical model have been sought, little movement appears to have been adopting in practice. The Critical Psychiatry Network in the UK challenges the existing frameworks asserting that 'the DSM is incapable of capturing the full range of experiences of distress in the way that narrative formulation can'. (Johnstone & Boyle, 2018, p. 120). This acknowledges and demonstrates both a clinical and practice challenge, that in the absence of national and international child trauma studies, requires further research. Yet, addressing what clinicians 'do' with this lack of diagnostic structure when working with children impacted by trauma, appears to be startlingly absent in the literature reviewed. Within the expansive perspectives outlined in this review, it is essential that researchers and clinicians press towards research for action, for implementation. As Hyman (2010) emphasizes; "the goal is to advance research and clinical work rather than "reification of diagnoses" (p. 157) ultimately contributing to appropriate and timely interventions for children and young people impacted by trauma.

Conclusion

This review of the literature explores the concept of child trauma and demonstrates the complexity of how child trauma and disorder diagnosis is considered in the literature. This chapter identifies gaps and limitations, in Irish literature and research in child trauma, highlighting the significance of contributing to this understudied area of research. The

review demonstrates the “complex interplay” (Johnson et al., 2021, p. 611) between child trauma and diagnosis, highlighting the dilemmas and constraints of aligning the immense impact of child trauma experiences with the existing diagnostic frameworks.

The insight presented in this chapter provides a contextual understanding, within which this study’s participants are situated. The following chapter moves from this exploration of child trauma literature to the methodology used to conduct this research study.

Chapter 3: The Research Methodology

The only true voyage, … would be not to visit strange lands, but to possess other eyes, to see the universe through the eyes of another, of a hundred others, to see the hundred universes that each of them sees, that each of them is.

La Prisonnière, Marcel Proust, 1923

Introduction

This chapter outlines how this research study was conducted using a Grounded Theory approach.

Grounded theory methodology, "is based on a process of systematic observation" (Levitt, 2021, p. 6) which employs structured research principles. This chapter describes how these principals from a Constructivist Grounded Theory approach, as developed by Kathy Charmaz (2000) were implemented in the conduct of the study. This chapter accounts for the design of this research study, from participant data collection and recruitment, to data analysis and theory construction. Although grounded theory identifies "all as data" (Glaser, 1998, p. 8) Charmaz's constructivist grounded theory philosophy, positions the researcher with a distinct perspective. The epistemological and ontological stance of this methodology is discussed, and how this influences my positioning in conducting this study.

The ethical considerations and methodological challenges, experienced in the conduct of this study are also included. These are accompanied by reflective memo entries, (which are inserted in full, in the appendix) demonstrating the ongoing learning, in implementing this study, using a constructivist grounded theory paradigm.

For clarity, this chapter describes how the research was conducted under the following 3 headings;

- Constructivist Grounded Theory - The Philosophical Underpinnings and Researcher Positioning
- Implementation of Research
    i. Research Design and Participant Recruitment
    ii. Data Collection, Data Analysis
- Ethical Considerations and Challenges

How I endeavoured to implement the grounded theory evaluative tools, of credibility resonance, originality, and usefulness (Charmaz, 2014) in conducting the study, are considered later in the Discussion Chapter.

Constructivist Grounded Theory - The Philosophical Underpinnings

Although this study was conducted using a Grounded Theory methodology, situated within a constructivist paradigm as developed by Kathy Charmaz (2000) "the diverging approaches and positions adopted by the founding fathers, Glaser and Strauss, has provoked much discussion" (Mills et al., 2006, p. 25) since the 1960's. This constructivist approach emerges from the foundational work and original intent of grounded theory, of developing theory from data. The beginnings of a shift from classical grounded theory have been identified in the work of Strauss and Corbin (1998) with Mills et al. (2006) highlighting their work as possessing, "a discernible thread of constructivism in their approach to inquiry" (p. 9). There is much discussion regarding the ontological stance surrounding the development of Grounded Theory and it is within the context of the objectivist and constructionist debate that Charmaz (2000) identified the method of Constructivist Grounded Theory (CGT).

While there has been considerable diversity in the development of grounded theory, Charmaz (2009) contended that, although much like qualitative methodology in general (Denzin & Lincoln, 1994) grounded theory represents a "constellation of methods" (p. 135) yet holds many shared methodological concepts. Charmaz (2017) identifies with the pragmatist roots of GT, outlining that 'pragmatism offers ways to think about critical qualitative inquiry; constructivist grounded theory offers strategies for doing it" (p. 34). CGT adopts strategies of classical grounded theory, yet it is important to clarify the divergence and identify Charmaz' (2017) position as:

- Assuming a relativist epistemology
- Acknowledging you and your research participants, multiple standpoints, roles, and realities
- Adopting a reflexive stance toward your background, values, actions, situations, relationships with research participants, and representations of them
- Situating your research in the historical, social, and situational conditions of its production (p. 299).

Influenced by her sociological background, Charmaz (2017) "championed contextualization in what are arguably real social contexts" (p. 299). This relativist perspective and strong alliance as a social constructivist epistemology (Charmaz, 2017) guided this study's recruitment strategy towards a cohort of psychiatrists and psychologists that work in the real contexts of child and adolescent mental health services in Ireland. It was considered that this cohort could best inform how child trauma is considered when disorders are diagnosed in clinical practice, with children and young people impacted by trauma.

Key principles that influence my positioning and alignment with the ontological and epistemology principals of CGT are discussed below.

Researcher Positioning

Amidst the 'methodological spiral' (Low & Marigson, 2021, p. 632) of grounded theory, it was important to consider distinguishing factors underlying constructivist grounded theory, that align my positioning with this research paradigm and the methodological fit for this phenomenon. Lesch & Scheffler (2016) emphasizes the need for researchers to be aware of the impact of positionality on data, participants and analysis. Charmaz & Belgrave (2019) presses researchers to "acknowledge that language, culture, historical moment, perspective, and situation shape what we see or construct as data" (p. 743). The discussion below aims to demonstrate the rationale, for my positioning in selecting this methodology. It identifies 3 areas of influence (i) ontological and epistemological fit (ii) methodological framework (iii) principle of co-construction.

Ontological and Epistemological Alignment

Wuest (2012) in exploration of the use of research methods, highlights the influence of the researchers own epistemological lens on their chosen approach. Charmaz (2004) highlights the foundational importance of maintaining authentic curiosity (Blumer, 1969) in qualitative research. This chosen research study exploring how child trauma is considered in the diagnosis of disorders, represents an authentic interest congruent to my work in this area for many decades. Mills et al. (2006) explain this engagement where, "researchers, in their 'humanness' are part of the research endeavour rather than objective observers, and their values must be acknowledged by themselves and by their readers as an inevitable part of the outcome" (p. 25). It is within this relativist perspective, of working with complex trauma in marginalised communities that this research question emerged,

acknowledging that prior knowledge is already formative in my professional life world. McGrath (2014) identifies that many qualitative researchers share this as a major concern, with prior knowledge impacting what researchers see, hear, and ask. Therefore, the open positioning that highlighted this 'methodological self-consciousness' (Charmaz & Belgrave, 2019, p. 743) influenced my congruent alignment with CGT. This also symbolises the evaluative tool that Charmaz (2004) terms 'credibility' in CGT research which is expanded further in the final chapter, as the quality of this study is evaluated.

Methodological Framework

As a novice to the academic research field, CGT methodology with its' structured systematic yet flexible methodological approach to theory construction seemed fitting as I approached this research. Within the methodological structure of GT underlies a balance of guidelines and flexibility with Charmaz (2008) highlighting that "the flexibility of grounded theory is such that the method may be modified as necessary to fit the specific requirements of individual research projects" (p. 299). Charmaz (2014) further explains this correlation between flexibility and structured methodology explaining that 'where grounded theorists draw the lines matter, but the lines need not be rigid and inflexible" (p. 335). The procedural, systematic nature of CGT methodology, balances my passion and subjective investment in this phenomenon, ensuring that I stayed close to the participants data.

The research question sought to understand not only the 'what' and 'how' mental health professionals (psychologists and psychiatrists) consider child trauma in their diagnostic practice but more fundamentally the 'why' the participants interact with this phenomenon in the way that they do, as clinicians in this field. This CGT principle of pursuing theory from data based in practice, identified CGT fundamentally as the most effective qualitative research process of eliciting the underlying interactions to this phenomenon. It was considered that this interaction between data grounded in practice, could best inform the research objectives, and construct a contextually founded theoretical framework.

Co-Construction

Grounded Theory "evolved to account for a range of ontological and epistemological approaches" (Mills et al., 2006, p. 9) with CGT diverging from its foundational origins, in how it facilitated researcher subjectivity and co-construction. Levitt (2021) highlights this concept of co construction where "researchers and participants

co-construct meanings" (p. 11) and identifies a shift from the epistemological stance of 'classic' grounded theory to a co-construction of the research paradigm.

I identified with this living and active co shaping and co constructing, underpinning CGT, where Charmaz (2000) argued that our research findings "are not actual reflections of individuals experiences; rather, each is a rendering, one interpretation among multiple interpretations, of a shared and mutually constructed reality" (p. 523). This epistemological alignment with CGT methodology, seemed fitting to elicit the underlying practice of psychiatrists and psychologists with children impacted by trauma. The practical outplaying of this co-construction principal was challenged early in the data recruitment process, as I began initial conversations to source potential participants as illustrated in the reflection memo titled, '*Co-creation, Co-construction, or Power? A stance of not knowing, a bended knee'.* A conversation, with a consultant child and adolescent psychiatrist (see Memo A in Appendix).

Implementation of Research

This section documents how the methodological process of CGT undertaken to conduct this study, was implemented in practice. It demonstrates the key components of data gathering, the processes of participant recruitment and engagement. This outlines the inclusion and exclusion criteria, the interview process, and data management. It also identifies the rationale for the decision-making processes, with reflective learning from the implications of these methodological choices integrated throughout the descriptions below. Charmaz (2014) acknowledges that researchers are not value neutral as they approach their research but advocates for, "an inquiring mind, persistence, and innovative data collective approaches" (p. 22). Charmaz & Mitchell (1996) draws attention to *how* the researcher uses these tools, with a need for a "keen eye, open mind, a steady hand to bring you close to what you study" (p. 6) being more important than developing methodological tools. This balance between the flexibility and definition of boundaries where "taking reasoned risks needs to be acknowledged and encouraged" (Charmaz, 2014, p. 335) are demonstrated through the integrated reflexive memos, as the data collection process is documented.

The Participant Cohort - The Rationale

With the epistemological understanding of CGT, that theory is constructed through and grounded in the data, it was essential that acute consideration was given to who, and in what practice context, would best inform this study. Young people and children as service

users of the mental health services are a rich source of data regarding child trauma, yet, it is the service providers, the professionals working in the child and adolescent mental healthcare services who determine the diagnostic outcome of a child/ young person presenting for assessment. Dr Maria Corbett, CEO of the Child Law Project in Ireland drew attention on national radio to the increasing complexity of presentations in these services, highlighting that "child mental health services are seeing more complex cases where there is a mix of issues" (RTE, 2022). With the aim of CAMHS (Child and Adolescent Mental Health Service) "to provide timely high-quality assessment and treatment of mental health difficulties for young people and their families" (HSE, 2019), it was considered that the mental healthcare professionals who work in these services were the primary national resource, to provide a wide perspective on this research study.

With the national clinical pathway for children with mental health difficulties being directed by GP's referrals to Primary Care and then to CAMHS, it was considered that mental health professionals who hold the 'power' to diagnose in these sectors, would best inform this research question. Therefore, the data collection strategy focused on this cohort of child and adolescents psychiatrists and psychologists working in child and adolescent mental healthcare in Ireland. The organisations, CAMHS, Lucena Clinic, Primary Care Centres, Daughters of Charity Services were identified as primary services for recruitment. With consultant psychiatrists identified as being the clinical leads in paediatric teams (Finnerty, 2023) it was considered that this cohort, accompanied by child and adolescent psychologists, could provide very real contextual perspectives that would best inform this study. The national referral process for children and young people with mental health difficulties clearly outlines the significant role of psychiatrists and psychologists in this sector with "formal discussion and/ or assessment by the clinical responsible psychiatrist", formulating an ICP (Individual Care Plan) and a diagnosis, as directed by the HSE, Child and Adolescent Health Services Standard Operating Procedures (2019,15.5). It is these ICP's, assessments, and disorder diagnosis reports, undertaken by psychologists and psychiatrists that frequently accompany children and young people presenting to therapeutic practice. Therefore, this national clinical pathway for children and young people with complex mental health issues, highlights this participant group as well positioned to inform real life diagnostic contexts, providing rich practice-based data to inform the research study.

The Recruitment Strategy

Acknowledging the potential challenges to recruitment, I was aware that 'cold calling' or emails would have limited success, therefore the recruitment process began through my collegial networks in the field. Colleagues had been aware of the upcoming research and were eager to help. I was curious to whether participants were reserved or reticent, firstly to agree to participate, and then how open they maybe regarding this phenomenon, in the light of their employment in the mental healthcare professions. On initiating the recruitment, a colleague arranged 4 interviews within a multidisciplinary team in their organisation. An introductory email (See Appendix A) accompanied by information regarding the research (see Plain Language Statement Appendix B) with consent forms were forwarded by email. In anticipation of potential ethical difficulties, I clearly communicated to the participants in the Informed Consent Form (see Appendix C) that the interview data would be identified as being that of the participants own opinions, and views, and not communicated as that of their organization, service, or employer. I was curious to observe how this would work out in practice. These 4 interviews were due to be conducted in person onsite in the organisation.

Although I had outlined ethical approval from DCU in the research information, on the day of the proposed interviews management questioned the need for separate ethical approval from their organisation arose. The interviews didn't go ahead but the process provided much learning for the recruitment strategy ahead. I explored ethical approval from this organisation, but with it potentially taking several months I decided to employ an alternative strategy. The role of a 'third party' was vital in participant engagement with child and adolescent psychologists and psychologists in the field. These were colleagues and those in my networks, who contacted their fellow colleagues, and were indeed 'conduits' in the recruitment process, framing accountability, my accessibility to the participants.

Inclusion and Exclusion Criteria

The research question targets a very specific cohort of people who conduct disorder diagnosis assessments with children. This criterion identified the exclusion of the following groups and the potential considerations.

- Exclusion of GP's - (possible secondary inclusion was considered if difficulties in recruitment had arisen).

- Exclusion of therapists – although providing insight into the phenomenon, therapists do not provide disorder diagnosis to children and young people in the mental health services. Therefore, they could not directly inform the considerations of trauma in diagnostic practice.
- Exclusion of children – strongly considered yet limitations of time to implement ethical considerations excluded this cohort (expanded in Discussion)

Research Participant Profile

This study conducted, 1-1 semi structured interviews with 12 psychiatrists and psychologists working within child and adolescent mental healthcare in Ireland. It was considered that the data from 12 interviews would sufficiently allow for the CGT iterative and comparative processes, facilitating patterns and categories to emerge. This number was also considered attainable within the time limitations of the study and in consideration of realistic engagement of this busy cohort. Below outlines the participants' assigned pseudonyms and accompanied disciplines, with public/ private referring to their sector of work. (The years, refer to the number of years' experience as psychologists/psychiatrists).

Sasha: Child and Adolescent Psychologist: Public:15 years

Leah: Child and Adolescent Psychologist: Public: 6 years

Mandy: Child and Adolescent Psychologist (Counselling) Public: 2 years

Rick: Child and Adolescent Psychologist: Private: 30 years

Chloe: Child and Adolescent Psychologist: Public: 7 years

Helena: Child and Adolescent Psychologist: Private: 25 years

Shirley: Child and Adolescent Psychologist: Public Hospital: 28 years

Sara: Child and Adolescent Psychologist: Public: 25 years

Mike: Child and Adolescent Psychiatrist: Public: 4 years

Trevor: Child and Adolescent Psychiatrist: Training Hospital and University:14 years

James: Child and Adolescent Psychiatrist. Hospital:18 years

Chris: Child and Adolescent Psychiatrist: Hospital: 38 years (year of retirement)

Table 1. below outlines the participant profile,

Table 1. *Participant Profile: Child & Adolescent Psychiatrists and Psychologists.*

Participants	Psychiatrists	Psychologists	Total
No. of Participants	4	8	12
Gender	4 males	7 female/1 male	12
Ethnicity	3 Irish/1 non-Irish	6 Irish/2 non-Irish	9 Irish/ 3 non-Irish
Age range	30-65 approx.	28-68 approx.	28- 68 years approx.
Length of Experience	2-35 yrs.	2-25 yrs.	2-35 yrs.
Current Location of Practice	Dublin (4)	Dublin (8)	Dublin (12)
Primary Care	-	2	2
Child & Adolescent Services	1	3	4
Hospital	3	1	4
Private	-	2	2

Note:

- *In person interviews took place in neutral venue (2) and workplace (1).*
- *Length of experience refers to post training as child and adolescent professionals.*
- *2 psychiatrists working in hospitals also worked in training universities.*

This study's participants represent a diverse profile of age, gender, nationality, years of experience and context of practice. I had not set out to limit the profile to the Dublin context, yet this profile emerged. The importance of intersectionality was considered in regard to participants gender, demographics, and diversity of practice at different stages of the recruitment. I endeavoured to be aware of diversity of gender, noting that many of my initial participant were female psychologists. I was eager to recruit a balance of psychiatrists and psychologists, with a wide range of experiences, those at the beginning and end of their careers, in diverse organisations and practices. This was considered important to gain rich data that represented as diverse a perspective as possible. As the recruitment progressed I was alert to the imbalance of gender across the professions with

all 4 psychiatrists presenting as male. Identifying the absence of female psychiatrists was important, and I attempted to pursue this gap. Yet, the challenges to recruiting within this busy cohort within the time frame of this research places this limitation on the research.

A pattern of engagement emerged with recruitment of 6 participants closely together, than another 3, and the final 3 more slowly and selectively.

Participant Engagement

From practitioner experience, it was evident, that this participant sample, of child and adolescent psychiatrists and psychologists, working with children and young people in Ireland, were a 'hard to reach' cohort. A sense of caution had also arisen during initial research discussions with academic staff and practice colleagues as to how difficult it may be to access and engage this participant cohort, in this research phenomenon. On hearing of my selected cohort, many colleagues in the mental health field commented on the challenge ahead of me. Acknowledging the hierarchy of power and positioning of authority that is perceived within the sector also alerted me to what could potentially cause challenges to recruitment. This participant sample were also incredibly busy, moral was low, experiencing burnout, stress and staff attrition and were under huge demand from client and service needs (Finnerty, 2023). Holding this awareness, I continued to pursue this route to enquiry, identifying that this participant cohort could best draw light, and inform the question, of what is truly happening to/with a child's trauma history, when children and young people are diagnosed with a disorder.

The Interview Process

I was acutely aware of the limitations of services and resources in this sector and the overstretched position of professionals in this field. Therefore, at this stage I felt it more appropriate to request a 45-minute interview rather than the proposed 1hr, seeming more sensitive and accessible to this busy cohort. I monitored this closely, whilst conducting the interviews, with many participants once engaged, expressing a flexibility that extended to the hour. Therefore, outside of initial introductions and closures, the recorded interview itself was frequently 45 minutes, with informed consent secured before each interview. Sensitivity to participants time limits required me to extend considerable flexibility and adaptability to a context, time, location to facilitate participant engagement in interviews. The participants were offered a context that was best suited to them.

- In person, in a neutral venue with audio recording. 3 participants chose to be interviewed in person.
- On zoom with confidentially secured with a waiting room. 9 participants chose to be interviewed over zoom.

Of the 3 participants I met in person, I met one participant in their work context, waiting for a long period as they prioritised child clients, and another who facilitated the interview on their lunch break. The third was in a neutral venue. The other 9 interviews took place on zoom with 3 participants, requesting late interviews after 9pm.

Initially I sought to communicate with participants through an introductory email, supplementing information about the research study through an email attachment. Yet, I learned early in the recruitment process that these helpful third-party colleagues, needed all information about the research study in a concise email, rather than an attachment, that they could forward to the potential participants. They needed to know quickly, so they could communicate (a) what the research was about and (ii) what was required of potential participants.

Having learnt from an initial difficulty with ethics in an organisation, I needed to address the individual autonomy of participants confidentiality, and ethical concerns. Therefore, it was essential to place the line ‘it is understood that any comments, opinions and views are that of your own and not that of your organisation or employer’ in the direct contact email to potential participants. I also reiterated this verbally on meeting with the participants. This approach appeared to put participants at ease, as many commented that they appreciated my clarity in this area.

The recruitment began as purposeful sampling, yet a decisive shift emerged after 6 interviews. An option to adapt a snowballing strategy presented, as many participants enquired about my recruitment of participants, indicating their willingness to help. Yet, I chose to become more selective, as up to this point, I had only interviewed psychologists, many were young to the field and working in smaller practices. Therefore, I pursued potential contacts to recruit psychiatrists with diverse contexts of university or hospital practices. This was challenging with time and perseverance but proved fruitful. Three highly experienced psychiatrists engaged, contributing rich insights from their academic medical teaching perspective and their consultant practice working with children and adolescents in within hospital settings.

How the gathering of data gathering was implemented in practice is outlined below, under three sections, initial sampling, the audit trail, and theoretical frameworks.

Data Gathering in Practice

1. Initial sampling: 1-1 semi structured interviews were conducted with participants as a method of inquiry, forming the initial data collection process (see Interview Guide in Appendix D). Open questioning facilitated these initial interview questions asking the fundamental questions; Tell me about yourself? What does child trauma mean to you? How do you work with children impacted by trauma in your practice? Participants were keen to facilitate the research, acknowledging their understanding of recruitment challenges from their own research experience. Participants were open and engaging, keen to share their work experience and contexts. This initial enquiry allowed me to observe the participants interest and perspective towards the phenomenon. This was important for me to discern, as some participants 'wanted to talk' and others who were obviously time bound, were keen to be focused and directed. I observed a distinct variance in participants style in communication, with those younger in the field more nervous at 'being interviewed' in contrast to the flow of communication and freedom in the interviews with those who were longer in the field. Interestingly one participant (Trevor, psychiatrist) had asked if there were questions, they should be 'revising over' before the interview, as they were always used to being prepared for their medical exams. For Mike (psychiatrist) this was his first interview as a research participant. Interestingly, at the end of the interview, he remarked that he was grateful, that I didn't make him feel as though his practice, was under question.

   As I analysed these initial early interviews, my somatic understanding of what was happening, guided and focused subsequent interview questions and subsequent direction of data collection. The rhythm of the interviews shifted, as my confidence grew, and categorical patterns had begun to emerge. I began to enquire more of the underlying patterns of why this emerging tension between child trauma and diagnostic practice was arising. It was at this stage that an integration of my 'somatic alertness' as a therapist working with children and young people impacted by trauma helped facilitate a more insightful understanding of the data. Therefore, as an integrated positioning of trauma therapist and

researcher in the interview process, I was comfortable with the changes in tone and rising tension in participants. Th acute attention that I pay to embodied responses in therapeutic practice, allowed for an attention towards the systemic pressure, the difficulties in tolerating trauma emerge in the interview dialogue. This was instrumental in facilitating the dilemmas to emerge.

I noted a need to be alert to my potential alignment with participants. Charmaz (2000) advocates, "to new scholars, I say follow your passions when choosing topics of inquiry yet locate your passionate interests in social purposes that transcend idiosyncratic subjective experience" (p. 542). The passion and sincere interest in this phenomenon sustained the pursuit of enquiry, but also alerted me to a potential relational alignment and collusion with the participants perspective. I became aware of this from my first interviewee Sasha, who was warm and engaging, and had 'gone out of her way' to facilitate the interview, in a neutral venue on her lunch break. The need to balance the relational engagement and capacity to take a meta stance as researcher, to facilitate and pursue the research objectives was apparent early in the interview process. I became more discerning as the interviews progressed, focusing more acutely to the data and how it informed the emerging categories, yet maintaining a relational warmth. This facilitated the fit and filling out of emerging categories with new incidents from the data, observing patterns and variances in the data.

The concept of positioning and contextualising the research also took a wider perspective as I awaited an interviewee in a large mental health facility, waiting area. This gave me very real insight into the young people presenting to the services, the onsite facilities, and the busy physical work environment for this psychiatrist. Closure with the interviewees was important at the end of the interview, not only in expressing my thanks for their engagement. Open ended questions "Is there anything else you would like to say about this issue?" and "How has this interview process been for you?" allowed participants to reflect on their communication. Many expressed, almost in surprise, how they appreciated having time to talk and think about the presenting issues.

2. Audit Trail: An audit trail underpinned the research process, in practical hard copy format in the form of a notebook that was as though ‘a companion’ t throughout this study. This was anonymised and documented in two sections.
    - A structured systematic outline of the process, in timeline format. Step by step audit of process, practical steps taken, outcomes, rationale for choices and decisions made that directed potential future steps to be taken.
    - Documented field notes were taken directly after each interview with reflective memos later capturing the challenges, learning and observations. Charmaz (2017) principle in “taking a deeply reflexive stance called methodological self-consciousness, which leads researchers to scrutinize their data, actions, and nascent analyses” (p. 34) formed an integral approach and style to this study, informing and directing my approach to each subsequent interview. These insights were documented after each interview, encapsulating not only the verbal information exchanged, but the ‘felt sense’ of the interview and the interviewee. This was particularly informative at the beginning where the pace of recruitment gave limited time between each interview. Acute somatic alertness to the spoken and unspoken data allowed tentative emerging patterns and processes, to inform the ongoing interviews.

3. Theoretical Frameworks: This was generated during the interview process, by participants references to theoretical frameworks, training modalities documents/literature that informed and influenced the participants assessment /diagnostic practice and perspectives. References to the ‘medical way of thinking’, the DSM and ICD diagnostic frameworks, the reductionist philosophy, the concepts of cure and recovery, and authoritative uncertainty, was followed up and informed the analysis and emerging conceptual theories, that undergird the discursive context of the discussion chapter.

The Analytical Process

The analysis of this study sought to explore the multiple realities of participants’ experience (Creswell & Clark, 2007) of how this participant cohort consider child trauma in their diagnostic practice. This demonstrated ‘a bottom-up approach’ where participants

data was analysed through a hierarchical categorisation, observing patterns and processes that led on to the construction of theory. This was a pragmatic process guided by a step-by-step approach to analysis, "a set of general principles and heuristic devices rather than formulaic rules' (Charmaz, 2006, p. 2). This co-existence of openness and guiding principles that directed the foundational work of Glaser and Strauss (1967) form the analytical stages that are described below. The iterative comparative analysis of coding and categorizing, theoretical sampling and exploration of emerging theory towards construction, document how these were implemented in the course of this study.

Charmaz (2014) identifies data as "the materials we work with" (p. xv) advocating that "early analytical work expediates your progress towards your destination" (p. 1). Therefore, 'grappling' with the data began from the first interview. This first interview was in person, using a recorded device. I wrote field notes directly after each interview to capture the participants main concerns. These were accompanied by reflective memos on how I thought the interview went, noting my internal reactions and responses. Initially I asked the following questions of the data:

- What are the participants experience and main concerns?
- What is happening and what does it mean?
- What are my reactions to these?

I then began to implement the following analytical stages to participants transcribed interviews.

i. Coding and categorizing.
ii. Theoretical sampling and sensitivity
iii. Theory construction.

Coding is considered the "analytic skeleton" of grounded theory construction and "links collecting data with emergent theory" (Charmaz, 2014, p.19). A systematic process of coding was employed. I analysed, simply at first in an initial coding process, systematically line-by-line, studying the data closely, moving towards synthesising the data with focused codes. I began to colour code, to identify clusters, observing patterns across the interviews. This process of focused coding identified initial codes, that appeared significant, yet comparisons facilitated other codes to emerge. Focused coding helped to see the interconnected relationships and patterns that emerged. This required considerable separating, sorting, and synthesising the data "raising certain codes to tentative conceptual

categories" (Charmaz, 2014, p. 20). This process was at times 'clumsy', involving the lengthy procedural coding process reflected in the *Practice Memo: Clumsy - Beginning the Analysis* (see Memo B in Appendix).

This systematic yet flexible approach to analysis that "begins with inductive data, invokes iterative strategies of going back and forth between data and analysis, uses comparative methods and keeps you interacting and involved with your data and emerging analysis" (Charmaz, 2014, p. 1). Initially this analytical process had clarity and a natural progression with line-by-line coding advancing to focused coding, demonstrating the properties of trauma as *Subjective, Big, Knowing /not knowing* that supported subcategory of child trauma as *Movable* (see Line by Line Coding Sample: Appendix G). But the coding that supported the subcategory *Tolerating Uncertainty* was indeed uncertain and required much 'interrogation' of the data to ascertain the underlying actions of participants. Charmaz (2014) pragmatist foundations encourage us "to construct an interpretive rendering of the world we study rather than an external reporting of events and statements" (p. 339) This required much comparison and questioning of the unspoken in the data, to elicit "what was really going on' as this cohort expressed their challenges and dilemmas of engaging with a child's trauma as they diagnose. This iterative process of constant comparison and revisiting of data facilitated expansion of supporting properties, holding the awareness, in an attempt to not "*kind of swamped into kind of really complex things"* (James). I questioned the data, "moving beyond description through constructing new concepts that explicate what is happening" (Charmaz & Thornberg, 2021, p. 307) with an iterative questioning allowing theoretical concepts to emerge. This rigorous pursuit facilitated the concepts of 'fear' and 'tolerance' to emerge in the data that is indicated below in the theoretical sampling process. This analysis was informative in supporting the subcategories but also provided an interpretative understanding of the complexity to this phenomenon.

In practice the actions of interviews, analysis and recruitment were happening in tandem. Birks & Mills, (2023) highlights, this interactive approach and familiarity with the data as a relationship identifying "how you collect, generate and manage them that will determine their value to your final theory" (p. 139). Broad general patterns emerged after the first four transcribed interviews with a natural break in recruitment occurring after the sixth interview. This facilitated a welcomed slowing of the data collection process

providing an opportunity to attend to the 'data relationship' and to grapple more intensely with the richness of the data.

An excerpt from two memos at the time highlights the exploratory process.

> Memo: *16 Sept 2023: It is as though I see the data 'become alive'….as though a 'living acting organism'. I need to honour its life, and the generosity of its 'donors'.*
>
> *Memo: 20 Sept 2023: The aim of this study outlines: To explore how child trauma is considered in disorder diagnosis with children and young people in Ireland. To explore…. I need to keep exploring …. not so eager to 'find' and 'discover'! Reframe yes, but also refrain!*

Approaching the Data - Practice and Positioning

The analysis of the findings demonstrates the foundational philosophy of symbolic interaction, giving insight into the "dynamic relationship between meaning and action" (Charmaz, 2014, p. 345) that informed the theoretical framework of this study. This involved employing constructs of constant comparison of the data, of acute observation beneath the surface, identifying patterns, elevating, and surrendering categories, and a conscious endeavour to entertain the 'playful'.

In pursuit of staying close to the CGT methodology I found it useful to have a structured reminder of the primary principals of GT at this phase. I was keen to apply these principals to the data I had collected, ensuring that I didn't get lost in the data collection and move towards a more generic method slurring (Baker et al., 1992). In pursuit of comparative analysis, and in integrating the Charmaz (2014) methodological guidelines I placed a hard copy of questions on my desk, as I compared transcripts, and reflected on what concepts were emerging. The iterative, back-and-forth process of comparing initial codes moved to identifying emergent theoretical codes, required ongoing analysis, until there was theoretical saturation, or sufficiency to determine a pattern or process that supported a category. This analytical process is discussed below.

Theoretical Categories

Charmaz (2014) guides the framework for constructing theory, clarifying that "data, forms the foundation of our theory, and our analysis of these data generates the

concepts we construct" (p. 3). This section outlines the distinct components congruent to CGT that facilitated the emergence of a theoretical framework from the data.

This process helps identify "a core category as central for the integration of other categories into a conceptual framework or theory" (Bertero, 2012, para. 1). Therefore, the analytical process follows the development of coding and memo writing, where comparative patterns are observed allowing codes crystallise, relating meanings and actions in the data where categories can emerge. Placing codes in hierarchical relevance, yet maintaining openness to refining and rearranging, was essential at this stage, as new data emerged. As a visual learner, diagrams, mapping categories and clustering concepts practically on paper, facilitated ordering, identifying relationships, comparing, connecting, and integrating data to move the data to a conceptual stage.

A creative process emerged at this juncture in the study. Charmazian (2014) philosophy highlights that, "grounded theorists primarily use interview data to construct inductive conceptual categories" (p. 87) yet I adopted a constructivist approach where 'the data' analysis moved beyond verbal language. Acknowledging the implicit data that emerged was significant in this analytical process. Drawing attention to my " hunches and potential analytic ideas about them" Charmaz (2014, p.13) helped to guide and direct the methodological process. I approached the data with a somatic alertness, that informed the emerging theoretical concepts. How this 'unspoken data' informed the findings that supported the interaction between the subcategories, is captured in the following chapter.

Grounded theory methodology (Charmaz, 2014) advocates remaining authentic to the analytical principles of "remaining open, staying close to data, keeping codes simple, short, and precise, comparing data with data, and recording actions/observations as the reearcher moved through the data" (p.19). Balancing this analytical phase was at times challenging, not only in time but in attempting to stay true to CGT, not going ahead of the data but yet 'allowing' myself to participate and be a co construct in the process (See *Balancing the Methodology Phase* Memo C in Appendix).

Concept of Forcing

Maintaining data as informant and construct, requires a patient, trusting, emergent positioning when conducting this methodology approach. As Levitt (2021) highlights "a central function of this approach is to forestall researchers from grasping too quickly on a theory or moving towards verification of existing theories" (p. 5). Identifying concepts,

patterns, building, and awaiting theory to emerge, rather than forcing theory from the data or constructing from bias is an essential pillar of this methodological yet challenging to implement in practice. Charmaz (2014) emphasises how grounded theory principles alert "against forcing interview data into preconceived categories (Glaser 1978) and how researchers and their participants use language to form and enact meanings" (p. 94). Yet a conceptual memo entry '*Forcing in Practice - The Accountancy of Pharmacy'* (see Memo D in Appendix) identifies explicitly how I unconsciously compromised and forced the data.

Theoretical Sampling

Theoretical sampling forms a fundamental pillar of GT methodology and facilitated the active and integral engagement of participants, in this study's theory construction. Chun Tie, et al. (2019) identifies the purpose of theoretical sampling, "to allow the researcher to follow leads in the data by sampling new participants or material that provides relevant information," or revisiting previous data (p. 3). This principle acted as a tool to "obtaining further selective data, to define and fill out the major categories" (Charmaz, 2014, p. 20) which was coded in 'active language' displaying this iterative phase of analysis (Mills et al., 2006). In practice, a conscious movement to facilitate diversity of participants occurred after 6 interviews. I was alerted to the importance of comparative methods in the data collection stage, that guided the theoretical sampling, making "patterns visible and understandable" (Charmaz, 2014, p. 89).

Charmaz (2014) extends this concept by terming it "emergent connections - balancing between participants concerns and your analytical direction" (p. 99). This was a pivotal challenge in this co construction, where data as human experience, interacted with theoretical concepts that were emerging. This "balancing and bridging during the interviews," (Charmaz, 2014, p. 99) was fundamental, maintaining focus and clarity on how the data was supporting and directing the emerging theory. This theoretical sampling in practice also explored where the analysis looked beyond the factual narrative presentation in the interview data, informing the 'why' in subsequent interview questions. As Charmaz (2014) cautions, I curiously observed and questioned during the interviews, that I may have, "entered the implicit world of meaning but not the explicit world of words" (p. 98). Adherence to this guidance, required an alertness to nuances and inherent meanings inquiring, to 'what is really being said?' This was particularly evident in the conceptualization of the subcategory *tolerating uncertainty*, where gaining insight into the

dis-ease in the data, emerged implicitly, initially. This term 'dis -ease' emerged frequently in the data, depicting the somatic alertness, 'the felt sense,' depicting the uneasiness, that presented in the participants, as they communicated. This evoked a curiosity that required further questioning in subsequent interviews. The participant data revealed the more sensitive properties of 'fear' and 'tolerance' that raised the conceptual levels that supported *tolerating uncertainty.* This added an interpretive richness and an insightful perspective that informed a deeper understanding of the systemic pressure this cohort experienced, that influenced their diagnostic practice.

Theoretical Sensitivity

Moving research studies into theory construction, as advocated by Charmaz (2014) requires "stopping, pondering, and thinking afresh. We stop the flow of studied experience and take it apart" (p. 244). Seeing possibilities, establishing connections, and asking questions are necessary tools in constructing theory. This requires the inductive and deductive process, of 'theoretical sensitivity' (Glasser, 1978) where I asked open questions, to guide the emerging categories. These questions of self and the data were an ongoing process throughout the analysis yet becoming more selective and discerning as I attempted to question and confirm the interconnection between the subcategories. Reviewing and questioning deeper, expanding understanding, became an integral part of the interview process. As the analytical process progressed, the questions of enquiry in the interviews began to become theoretically sensitive. The analysis focused on "what inhibits the systemic capacity for a connection, a relationship between child trauma and disorder diagnosis?" Many interesting properties began to fill this line of enquiry, facilitating cohesion of collective incidents that informed the elevation of the category of *tolerating uncertainty* and further supported and sustained the *Contentious Balance* as the main concern to this phenomenon.

Frequently the methodological stage in CGT analysis, identifies further contact with the participants, after their initial interview, to "obtain further selective data, to define and fill out the major categories" (Charmaz, 2014, p. 20) to clarify and identify emerging theoretical categories. Initially at the end of the interviews, I had requested consent to potentially return to interview or clarify emerging theoretical concepts, with participants. Charmaz (2000) identifies this concept of theoretical sampling facilitating theoretical sensitivity "to define the properties of categories; to identify the context in which they are relevant; to specify the conditions under which they arise, are maintained, and vary; and

discover their consequences" (p. 519). Yet, with the restrictions of time, for this cohort, I felt this unsuitable and therefore returned consistently to the interview data, rather than the participant.

During the analytical process, I gathered a broad, conceptual understanding of what was happening. It was these tentative categories which began to inform the emerging theory. I observed the repetitive accounts, identifying the challenging pressures this cohort experienced, the tension, and juxtaposition of emerging properties *rigid/ fixed, movable/ subjective.* This was accompanied by a discord in participants communication between their very real compassionate understanding of trauma, and their underlying actions towards how and why, they formulated a *rigid/ fixed* diagnostic response. Sorting, integration, identifying and analysing the subcategories, facilitated the construction of a theoretical framework, *Holding - The Contentious Balance* that was grounded in the coded data, and held by the interrelations between the subcategories and their supporting properties.

Charmaz (2014) defines theoretical sensitivity as the ability to "discern meanings in the emergent patterns and define the distinct properties of the constructed categories concerning these patterns" (p. 161). A significant amount of time was given to this area; with the construction of theory not being a mechanical process, but requiring "theoretical playfulness, whimsy and wonder to see the novel in the mundane. Openness to the unexpected expands your view of studied life subsequently of theoretical possibilities" (Charmaz, 2014, p. 204). This juncture in the research process was a 'spacious activity' allowing the developing concepts from the data lead towards categories that supported the emerging theory. The practice challenge that this stage evoked was documented in both reflective and conceptual memos.

Attending to the 'process' yet aligning with the necessity for 'product' (theory construction), moving towards developing conceptual models, whilst balancing the emergence of categories, was in itself a contentious balance. The data was rich and active, evoking challenges that were depicted in the reflexive memo 'The Granite Quarry' *"I want to see the clusters of boulders, forming. A construction offering. When do I leave the quarry, or will I keep that lingering pull of entering and re-entering?"* (see full Memo E in Appendix). Despite the potential conceptual routes, to capture this phenomenon emerging, defining, and redefining the categories to identify the core category the *Contentious*

Balance, was essential. As Nagel et al. (2015) explains, "the constructivist grounded theory approach acknowledges that "perception of reality varies between individuals, and there are pluralities of reality experienced by different people exposed to the same phenomenon" (p. 367) but furthermore highlights the complex variations I experienced as an observer and interpreter of the phenomenon.

Theoretical Saturation -Theoretical Sufficiency

Theoretical saturation (Charmaz, 2014) identifies the stage in grounded theory research at which, no new understandings of how patterns varied is emerging. Maintaining a keen discerning eye, when no new concepts can be theorized, and research has reached theoretical sufficiency was essential. I had anticipated this 'halting' to be a practice challenge. In practice the guiding principle of theoretical saturation endeavours to facilitate the researcher in acknowledging when 'enough is enough'. Yet reflective memos, from two separate stages in the research process, demonstrates how I experienced this research practice challenge. The initial strategy and target of 12 participants, was useful in limiting the ongoing pursuit of further data. Yet, I also observed that fresh perspectives on the already existing data had the potential to reveal and contribute further insights. The continued use of existing data, returning frequently to the transcripts facilitated an ongoing process in clarifying support for the subcategories. The concept of theoretical sufficiency Dey (2005) was significant in drawing a close 'for now' to the ever-unfolding potential in the data. The reflective memo *Emersed in Methodology - Theoretical Saturation/ Sufficiency* (see Memo F in Appendix) demonstrates the practice challenge of this concept .

Ethical Considerations

Ethical approval for this study was obtained through the Research Ethics Committee of Dublin City University (see Ethics Approval Letter: Appendix E). The ethical application for this study set out to recruit 12 participants to engage in semi structured interviews with the initial strategy identifying the following ethical considerations:

- Management of data and confidentiality
- Specific concerns generic/ specific to the study.
- Risks and ethical choices

Every effort was be made to respect the privacy of participants, with strict adherence to DCU GDPR procedures where contact details were encrypted, and data retrieval content was stored securely on cloud-based storage on DCU Google Drive. DCU

Zoom data protection protocols for DCU researchers was followed for all online interviews. Specific safeguards were implemented to ensure that the appropriate Zoom security and privacy settings were activated, including end-to-end encryption following and waiting room facility. Identity was protected by de-identifying the data using a pseudonym for each participant. All interview recordings, transcripts and notes were stored in a secure folder uploaded on DCU Google Drive. The transcribed data (which was pseudonymised) was securely archived using a password system with only those in the research team having access to participant data.

The potential participant vulnerability was considered to be low, with the selected cohort being experienced professionals working in the field. The initial interview questions focused on the participants practice delivery rather than their lived personal experience thus limiting the participants' possible vulnerability. Yet, during a meeting with the external panel member of the supervisory team I had been encouraged to include this lived experience perspective in my questioning. Subsequently, it formed part of a follow-up to my initial question. Asking "when I use the term child trauma, what does that mean to you? What training, professional, or personal experience influences your understanding?" The impact of vicarious trauma on this study's cohort was also considered with many research studies (Mc Nicolas at al., 2020) highlighting the stressful impact and burn-out of professionals working with children with a trauma history. Acknowledging that this may potentially have been a factor that would emerge through the interview process, a list of debriefing contacts was included in email communication to support participants if required I had no indication of a need for this, during or after the interview process (see Debriefing Information in Appendix F).

Challenges and Learning

Unanticipated challenges and the learning emerged as I conducted the research and they are deemed important to document. The essential concepts of 'immediacy' and 'readiness for practice' that are formative in therapeutic training, surfaced early with participant engagement. These tools proved essential in the interviewing process. On contacting two participants by phone, they were eager to be interviewed immediately which I had not anticipated, nor scheduled. This developed a readiness and alertness that was useful for successive potential participants.

Charmaz (2000) highlights that "engagement, skill, and persistence" (p. 538) are required for the research process. This persistence or 'tenacity' was an unexpected necessary tool needed in this recruitment process. Accompanying this tenacity with a sensitive awareness to participants space and time, required a 'tentative balance', a concept that concurred with many elements that were to emerge in this study. I had envisioned that the recruitment, interview, and transcribing stage would take a long period of time, yet I underestimated the expansive resources of time needed in the administration of emails, follow-up, scheduling, and rescheduling. The collection process of this study pursues rich data, which is 'detailed, focused and full' (Charmaz, 2014, p. 23). How I engaged with the foundational CGT practice of reflexivity is outlined through memo writing as depicted below.

Memo Writing

Reflective memos were used throughout the conduct of this study integrating the personal challenges and operational processes of this research. Charmaz (2014) highlights how memos are at "the core of the analysis and record how you arrived at it, providing ways to compare data, to explore ideas about the codes, and to direct further data gathering" (p. 19). The practice of analytical memos on and in, all stages of the research, was an essential informant of this methodological approach. Involving reflective accounts of the process at each stage, field notes, reflecting the rationale for choices, with whom, and tracking my responses to and influences of these decisions, informed, directed, and provided creative space to interpret and construct and ground the theory in this study.

The style of these memos shifted, becoming more conceptual memos (Charmaz, 1997) as I transcribed the interview data and posed questions of the data. Charmaz (2000) outlines how conceptual memos enable the researcher 'to grapple with ideas about data, to set an analytical course, to refine categories, to define relationships among various categories, and to gain a sense of confidence and competence in their ability to analyse data' (p. 517). Categorising and sorting these memos were both challenging yet foundational, as what I had initially considered as important observations, were surrendered, as categories were elevated and took more prominence in the emerging theory.

Tracing the useful progression and the instrumental role memos played in the analytical process, as full memos or excerpt of memos are integrated throughout this thesis.

These reflective memos form a discursive thread in the Discussion, providing a transparent link between the findings and my role as co-construct in developing the emerging theory.

Quality of the Study

Seale (2002) hypothesises that "quality is elusive, hard to specify, but we often feel we know it when we see it. In this respect, research is like art rather than science" (p. 102). According to Glaser (1978) the criteria for evaluating the validity of a Grounded Theory study include the concepts of; fit, relevance, workability, and modifiability. Birks & Mills (2023) advocate that, "conditions that foster quality in research relate directly to personal and professional characteristics" (p. 46) further identifying the importance of evaluating my positioning and repositioning, in conducting the research study. For Charmaz (2014) the distinct evaluative criteria of credibility, originality, resonance, and usefulness, demonstrates alignment to the CGT research paradigm. It seems fitting that an evaluation of this study that combines these essential principles and the tenets of rigour and robustness (Yardly, 2000) is best reviewed later in this thesis under the final chapter, Implications and Recommendations. Here methodological and decision-making processes, that endeavour to demonstrate best practice, and adherence to CGT principles, are evaluated, alongside my positioning in the co construction of the research study.

Conclusion

This methodology chapter outlined the methodological framework of this research study using grounded theory principles as constructed by Charmaz (2000). Acknowledging my epistemology positioning here, is formative in how it influences the following chapters. This chapter demonstrated how CGT, guided the construct of this research, from data gathering and analysis, that facilitated the development and construction of the substantive theory: *Holding - the Contentious Balance*. The findings from this analysed data are presented in the following chapter, and document 'the life' of this research study. The following chapter gives a rich understanding to how child and adolescent psychiatrists and psychologists consider a child's trauma in their diagnostic practice. Reflexive memos, that inform the course of the study, are documented throughout the following work, acknowledging CGT philosophy, that the researcher is 'always on the corner somewhere' (Richardson, 1992, p. 104).

Chapter 4: The Findings

Introduction

This chapter outlines the findings of this research study, of how child trauma is considered when psychologists and psychiatrists make a disorder diagnosis with children and young people. The findings presented below, emerged as I attended to "the logic of discovery that becomes evident as you begin to code data" (Charmaz, 2014, p.127). It was the blend of the explicit and the implicit in the data, the usefulness of GT for "understanding invisible things" (Star, 2007, p.79) that facilitated the movement from the analysed findings of the twelve participant interviews, to constructing the substantive theory of Holding - the Contentious Balance.

The main concern emerged from the findings under the core category, the Contentious Balance capturing this sample cohorts perspective towards, and experience of, this phenomenon. It provides a conceptual account of the tense interaction that the participant child and adolescent psychiatrists and psychologists experience, in practice, as they endeavour to balance the complexity of child trauma, amidst the tension of existing diagnostic frameworks. This core category is supported by three interrelated subcategories, Movable and Fixed, Systemic Pressure and Tolerating Uncertainty. These subcategories, demonstrate the underlying dilemmas and challenges that this cohort need to straddle and contend with, as they consider child trauma in their diagnostic practice. The Contentious Balance conceptualises these three interconnecting categories, identifying the ongoing active process experienced by this cohort, of balancing the tension of these subcategories. The substantive theory Holding - the Contentious Balance proposes a concept of 'holding' depicting how this main concern can be resolved.

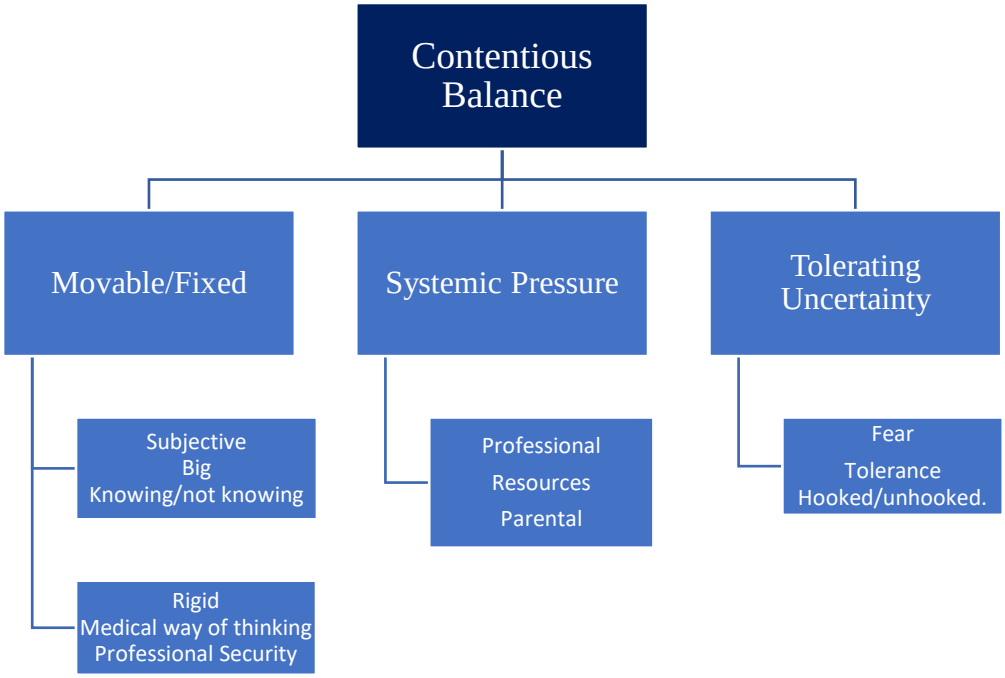
The properties that support each of these subcategories, are identified below, with exploration of how the participant data guided the elevation of each subcategory, which in turn, informed the substantive theory. Figure 1. below demonstrates the core category illustrating the subcategories and their properties.

For clarity, throughout this chapter, the findings are presented with the participants direct quotes placed in "*inverted italics",* the categories in underlined capitals, and the supporting properties of the core categories placed in *italics.* The inclusion of some elements of the data collection process in this section reflects the essence of CGT principles where the

findings were not clearly depicted in the narrative, but emerged as I paid somatic attention to the unspoken richness of the interviews. It was considered important to identify the process of 'finding the findings' in this manner that informed the development of Contentious Balance as the core category. As distinctly different to other forms of qualitative enquiry CGT is "an interpretation rendering of the worlds we study rather than an external reporting of events and statements" (Charmaz, 2014, p. 339).

Figure 1:

The Core Category: The Contentious Balance with subcategories and supporting properties.



The Core Category: The Contentious Balance

An Overview

This study's research question places two distinctly different concepts under exploration; child trauma and disorder diagnosis. The perspectives of two innovative trauma research practitioners in the field, bring insight to approaching the findings of this study. Siegel (2010,) asserts that "integration requires differentiation *and* linkage " (Keynote address: The neurology of 'we') with Fisher (2017) contending that "before we can integrate two phenomena we have to differentiate them and 'own' them as separate

entities. We can't simply act as if they are connected without noticing their separateness" (p. 242). The analysed findings present a tense interconnection between the two distinct components of this research study. The findings identify, that although this sample cohort acknowledge the differentiation between child trauma and disorder diagnosis, it is 'the linkage' between the two, that creates a Contentious Balance in practice.

The findings demonstrate how the participants consider the differing contrasting properties of child trauma and diagnosis, both in theory and in practice. The participants clearly acknowledge the individual Movable variability of child trauma and its immense impact on children. In contrast the tight restrictive Fixed constraints of trauma diagnosis are definitively recognised. The tension and dilemmas appeared in the data, when these two components intersect in practice. The study's findings identify the challenges that determine how psychiatrists and psychologists respond, when a child with trauma symptomology presents to their practice. The study identifies the very real practice contexts within which child and adolescent psychiatrists and psychologists work. A tense balancing position emerges for practitioners as they acknowledge the child's trauma but experience the Systemic Pressure to form a diagnosis. The data presents how and why, the participants, under systemic pressure engage in diagnostic practice, identifying underlying factors that influence practice. Participants difficulties in Tolerating Uncertainty when engaging with children with a trauma history, provides insights into the gaps in trauma training, illustrating the limitations identifying participants fear, in tolerating the complexity of child trauma. Furthermore, the findings present a participant cohort that demonstrate an uncomfortable dis-ease to their diagnostic practice, highlighting an incoherence in what they want to do, and what they appear under pressure to do, within the medical approach to trauma symptomology.

The substantive theory Holding - the Contentious Balance proposes a theory to resolve this tense, dis-ease experienced by this participant cohort, as they balance the needs of children impacted by trauma in their practice. The substantive theory proposes that mental health professionals, adopt the psychotherapy position of 'Holding' (Winnicott, 1953). It proposes that professions 'hold', 'contain' and 'balance' (Fisher, 2017) the very real tension of how to consider a child and young person trauma symptomology when they present in practice. The theoretical framework suggests that clinicians 'withhold' the systemic pressure to diagnose, observing the individual movable nature of child trauma presentations, towards a 'fluidity' to diagnosis. It proposes a 'holding' position that

requires '*mental flexibility'* (James) focusing on a recovery approach, rather than a fixed diagnostic approach, to children impacted by trauma. How the data informed and elevated this theoretical framework, is discussed later in this chapter, demonstrating grounded theory's "efforts to transform knowledge, social processes and grounded theory *as* practice" (Charmaz, 2014, p. 340).

Discussion of this substantive theory, the shift in practice it posits, and the accompanying challenges, is addressed in the subsequent Discussion Chapter. How the participant data informed the core category and emergence of the three interrelated subcategories, is demonstrated extensively below. The following section begins by giving a detailed account of how the subcategory Movable/ Fixed emerged, in, and from, the participant data, giving a contextual perspective of the differentiation and the linkage, of child trauma and disorder diagnosis.

Subcategory - Movable/ Fixed

The subcategory Movable and Fixed is a "common-sense category" (Kelle, 2007, p. 209) grounded in the participants understanding and perspective towards child trauma and disorder diagnosis. It is foundational in highlighting the participants perspective. The category label intentionally highlights the contrasting properties that emerged in the findings, that supported this subcategory. These are illustrated below, in two sections, (i) Child trauma as Movable (ii) Disorder diagnosis as Fixed.

(i) Child Trauma as Movable

The collective findings and elevation of child trauma as Movable emerged from the data with supporting properties of *subjective, big, knowing /not knowing*. Clear definitions and perspectives to child trauma quickly emerged, identifying the participants perspective on child trauma, giving a contextual understanding of child trauma in practice. The ACE criteria (Adverse Childhood Experiences), physical and emotional neglect, bullying, physical and sexual abuse were clearly identified. Sasha presented a definition of child trauma: "*it means that the child has experienced something that they can't process"*. A collective clarity in defining child trauma was coded initially as 'order'. Yet, the complexities of defining child trauma that "*are not the usual traumas or direct trauma*" (Mike), emerged. Sourcing meaning beyond the ordered definition, '*that aren't on the list',* presented a deepening exploration, as communicated by Leah, below.

> *Child trauma? Yeah, I mean, it means a variety of different things. And yeah, I suppose for me it really means a child, somebody from zero to eighteen having adverse life experiences that impact them, maybe emotionally, psychologically. So, what…. what exactly that looks like…it can, …there's the ACE, the ACE checklist. That kind of is some guidance in it for me. But at the same time, I know that there are other events in a child's life that can lead to trauma's that aren't on that list as well. (Leah)*

A contrasting sense of diversity began to emerge in defining trauma, expressing the complexity, of "*meaning so many different things, broadly speaking it's anything that happens to a young person that changes something in them, and kind a leaves a mark in a way that's quite damaging*" (Mandy). Reflection on participants language, drew attention to the participants growing discomfort as their conversations advanced. The responses were coded simply in child terms, as *Big* reflecting the combined presentation in tone and in words, of the size, weight, and complexity of trauma, as a concept, but also its profound impact on the participants, as illustrated in the comments below:

Yeah, so trauma is just absolutely enormous in terms of psychopathology (Chloe).

"*But trauma…. Yeah, trauma has a big connotation*" (Leah).

With the expanse of trauma and the impact of the child's developmental stage expressed below by James:

> *I think we're probably a lot more aware of smaller traumas at a highly important times having much more of a row, and I'm probably not representative of psychiatry as a whole working in liaison and perinatal, they're quite trauma heavy.*

A tense balancing of perspectives emerged in the data as participants demonstrated a constraint and caution of identifying and defining the child with a trauma history. The data presented the participants attempting to balance the usefulness of defining trauma. A tension emerged as Helena opposed the concept of a child with trauma experiences being termed *"the trauma child"*. This perspective contrasted with how participants highlighted the usefulness of trauma labels to "*shine a light"* (Shirely) on how trauma and its symptomology is understood. The identification of "*early attachment ruptures"* (Mandy) of "*developmental trauma"* (Mike) appeared to demonstrate the participants engagement with the significant impact of a child's early relationships. As the analytical process advanced, the exploratory openness to how trauma may be defined, emerged as Sasha's questioned "*Is trauma subjective*?" It was this aspect of subjectivity with a questioning of; "*child trauma who knows?*" that Mandy contributes, as she proposes that the "*child decides",* that evoked a sense of *knowing/not knowing* to the concept of child trauma. The

data suggested that participants appeared comfortable with this *knowing/ not knowing* property of trauma. Chloe, assertively supported this subjective, not knowing nature of trauma, stating with clarity; "*we're our own subjective.*" Expanding this subjective knowing, Chris explains very practically; *"what's trauma for Jimmy can be less trauma for Jane. But severe for Jennifer, could be less traumatic for…."*. Lending further reinforcement to the individuals own knowing of trauma. Helena, develops this understanding, commenting,

> *It doesn't mean one thing to me, OK, so it means…. I suppose. I hear trauma and my first thing is the huge range of what trauma can be, to a particular child. So, what is trauma to one child is not necessarily trauma to another child. And I think it's very important to always remember that… that even sometimes, what some would perceive as it's a minor incident, can represent trauma to one child and what might be what some would perceive as a huge incident, might not necessarily present as trauma.*

This understanding of trauma with a diverse range of meaning, as unique and individual to the child, was simply coded as *subjective*. Shirley combines this meaning making, with a parallel need for an individualised response, to trauma, presenting her opinion; "*my idea would be that each child and family is unique as they respond to the experiences that they've had… is unique, and we need to tailor and adapt our approach, our language"*. This presentation of the unique nature of child trauma challenges a response that is adaptable and tailored, depending on the needs of the child. This emcompasses the individual relative perception and lived experience of the child and was demonstrated in the findings as "*relative depending on your capacity to manage the life events that have presented themselves to you"* (Sasha). This understanding of the nature of child trauma was originally elevated and categorised simply as *subjective, all about me,* but as the data analysis advanced and the intersection between the *rigid fixed* properties of diagnostic practice emerged.

A tense contrasting relationship to the adaptive, flexible and relativity of child trauma emerged in the data. This needed to be represented in the categorisation and constructed in a term that encompassed this finding in the data. Although *subjective* was a clear property it appeared too weak a term to demonstrate the emerging tension and contrasting properties between trauma and diagnosis that was displayed in the data. Therefore, the term ***Movable*** given to this category best demonstrated a dichotomy alongside the term ***Fixed*** used below to depict the properties of diagnostic practice. In line with CGT terming the category Movable began to construct the tense balance and

emerging dis-ease between the properties of child trauma and disorder diagnosis in the data.Interesting variations emerged in the data, which interconnected the properties of trauma, adding richness and diversity to the findings, supporting the elevation of trauma to the subcategory ***Movable***. A strong concern around the use of the word 'trauma' was displayed, bringing alive Charmaz' social interactionism (2014) positioning of CGT, contextualising trauma in the societal framework of the data. The interview excerpt below demonstrates this interaction. As Sara ponders:

> *And I still hold a lingering…. Uh… ponderance of the word trauma and how it's being used* (pause*)…, and that it's a word I feel is in danger of being diluted. And in doing so a certain…. Disregard…. is probably a strong*… (pause as though in search of an alternative 'permissible' word).
>
> *PI: Let's keep the first word. Yes, disregard…?*
>
> *Sara: Maybe and minimising… and minimising of what life experience is.*

The findings also identified with the cautious use of the word trauma, questioning its casual use. As Helena highlighted "*So, I think we… I…. my thing would be to be careful around its use that it's not like a word that's bandied about".* This was communicated in a tone indicating a cautious respect and understanding of the profound nature of child trauma.

The participants spoke of their personal lived experience of trauma. Sara acknowledged her reflective growth from her experience of cancer, and Trevor experiencing the birth trauma of his child. James spoke personally of his baby, born premature, how it increased his compassionate response to the complexities of trauma. At the end of Ricks interview, he expressed his surprise on being so open about his own lived childhood experience of poverty. He spoke expressively of neglect in his home, *"of getting up without breakfast and picking up frozen trousers off the line."* The diversity of these participants lived experiences, acknowledged the varying patterns and impact of individual responses. This expanded and supported the properties of the *subjective, knowing/not knowing,* and *big* nature of child trauma, from participants lived experiences. This is expanded by Sasha, speaking from her professional context, (below) bringing a distinct perspective to understanding trauma.

> *Disability is trauma with physical disabilities. These kids with tubes coming out of them, hospitalisations, not really understanding what is happening and why this is happening …. Em...children who... that can't be comfortable in their own skin.*

This consideration of disability as trauma, that somatic entrapment of children being "uncomfortable in their own skin", extended the varying understanding and Movable presentation of trauma. In an interconnecting context, the variants extended, with James drawing attention to a growing population in Ireland impacted by trauma; *"increasingly we see trauma in a migrant population and so we see probably a lot of trauma there, and again that's some of …. that's…um..., childhood trauma"* (James). The inclusion of what Sara considers as "*the often-unrecognised impact of birth trauma*" is important as she speaks of the silence of mothers to speak of the experience of birthing, that "*unspoken collusion around mothers' trauma*" where "*in clinical practice we forget about the mother".* These variants of trauma *in* disability, and disability *as* trauma, in the diversity of the migrant population and the unspoken of birth trauma gives further prominence to the subjective and unique properties. These insights in the findings, present trauma as not so easily defined, but depict a subjective movement, representing a child's adaptations to their varying lived experiences. This subcategory Movable supported by the properties of *subjective, knowing/not knowing,* and *big* was further informed through the participants rich unspoken data which is expanded below.

Charmaz guides the analytical process and directs the researcher "to move beyond description through constructing new concepts that explicate what is happening" (Charmaz & Thornberg, 2023, p. 306). Observing the nonverbal dialogue, presented in the interviews, demonstrated how unspoken findings informed the meaning making of this phenomenon. Charmaz (2014) guides how this can guide the researcher "when your codes are concrete, examine them and ask what larger analytical story they indicate" (p. 124). Attending to the structure and the flow of the interviews, observing frequent 'ugh's'…em's…. and the unspoken in the interview process contributed unspoken data that informed this category. Participants somatic, and physical presentations, the juggling movement of hands, back and forth, were noted in attempting to communicate the concept of trauma. I observed the participants many pauses, repetitions, which suggested a wrestle or search for clarity as they displayed a hesitancy in defining their meaning of child trauma, as Chloe demonstrated "*No, I think (pause)… I think (pause) … it (pause)…. it's like anything, it's something that happened. But uhm…. (pause) it's something that happened to us".* Positioning myself with a somatic alertness in the analysis contributed a rich insight to the findings and is given further commendation in the final chapter. These observations were essential in understanding the reactions and actions of this participant

cohort to this phenomenon. This back-and-forth pattern was coded as *knowing/ not knowing*, evoked from a somatic sense of uncertainty an uncomfortable tension, demonstrated by their physical presentation as they engaged with the phenomenon. Chloe's summative comments below gave spoken voice and clarity to the properties of *Subjective, Big, Knowing/not knowing*, nature of child trauma, which undergirded the subcategory Movable.

> *But it doesn't define us. It's not fixed because it's our perception… So…… it's a subjective bodily experience of what it is…., it's never fixed, so it's movable... and our interpretations are which are key for our lived experience of expression.*

This moving beyond knowing, towards a not knowing, that's not definable, presented an element of movement to the meaning of child trauma in the data. As Helena argued "*So, the question is who's decided? It's trauma. As a word, I think just… it kind of… it means so many different things to different people.* The data presented an understanding of trauma that wasn't fixed and defined, but more about subjective perception and interpretation. I held this category ***Movable*** allowing a level of ambiguity in the conceptual formation (Charmaz & Thornberg, 2021). This movable, subjective, uncertainty of knowing, presented a conflicting contrast to the findings of how these participants communicated disorder diagnosis, as outlined below.

(ii) Disorder Diagnosis as Fixed

The contrasting properties of this subcategory emerged as participants communicated their consideration of disorder diagnosis in practice. The findings illustrate how the concept of diagnosis as Fixed emerged from the data and how it fits tenuously alongside Movable in this subcategory, depicting two very distinct differing concepts and their properties being balanced in practice for these participants. It provides insight into the contextual diagnostic framework that informs their practice.

The participants collective actions and interactions with the phenomenon became living and active as they engaged with their professional roles, in diagnosing disorders and identifying trauma symptomology. This analytical process identified the property of the *medical way of thinking* from the data, as outlined in Figure 1. above. Star (2007) highlights that "action constructs processes" (p. 197) and it is the participants interaction with a child's behaviour that informs their perspective on diagnostic practice. As Shirley explains, "*you know trauma is explaining why they're behaving right now*". It is the behavioural symptomology of child trauma that leads children and young people to present

to this cohort of child and adolescent psychiatrists and psychologists. The participants identified their use of the diagnostic tools, the DSM and ICD frameworks, trauma checklists and assessments. But congruent with CGT, it was essential I wrestled with the 'what was really going on' in their engagement, with assessment and diagnosis. How the interview data informed and shaped these findings is presented in the following section.

As the participants communicated their engagement with diagnosis, a rigidity presented as a property of this subcategory. A repeated pattern emerged in the data identifying diagnosis as being "*fixed to your identity"* (Mandy), with "*a lifelong diagnosis"* (Sara), suggested a permanency to disorder diagnosis "*that's for life"* (Mike). Shirley's interview demonstrates this "*fixed identity"* as a normative language of practice in diagnosis. She explains:

> Shirley: *One of the potential drawbacks for diagnosis is that it becomes a fixed part of your identity. And that this is part…. like what… it might be healthy at one point in time. It may not be helpful if it can change or if it's…. If it's so….*
>
> PI: *So, what happens in that change...transition? What is that about…is that from fixed to saying it can change?*
>
> Shirley: *Well, you see, I think a lot of times diagnosis is fixed and the way it's talked about is though… as though it's fixed……*

Shirley expresses her opinion here, questioning this fixed diagnostic perspective in practice. I became increasingly curious to the explicit clinical practice underlying this phenomenon. In observing data patterns and comparisons, I noticed that participants spoke separately about trauma, and then diagnostic practice, with a very clear disconnect between trauma and the diagnosis. This exploration required a need to be very specific to where, or if, a child's trauma history is situated when this cohort make a diagnosis. This was essential as it addressed the core of the research question, to gain an in-depth understanding of what actually happens, as to how trauma is considered in clinical practice, by this participant cohort. The philosophical underpinning of diagnostic practice began to emerge. Trevor presents an interesting perspective, indicating a 'packaging' practice and the implications for the child. Early in the interview Trevor terms this diagnostic package as a 'token', and then later clarifies; "*We…, we…. package somebody into a diagnosis. And that's almost like a currency and that follows somebody around".*

Mandy (below) spoke candidly in tone, bringing clarity to this practice rationale.

Mandy: *And it's, sometimes I feel like it's more for clinicians to have something to use, like, a bit of security or like, okay, I have this book, I can check, does it, you know, there's a bit of comfort or sort of safety and having a book or manuals or do this.*

PI: *Ok…. Holding on to the security, confidence, safety…?*

Mandy*: Yea…as a clinician, but I wonder, is it more… I guess…., maybe is it more beneficial to clinicians than service users sometimes in that quest?*

Participants engagement with the phenomenon of diagnosis, began to expand, as expressed in early codes as, *having something to use*, as, *security* or *safety*, with a sense of *comfort* emerging from the findings. In contrast being without a diagnosis, was disconcerting, insecure, or unsafe and uncomfortable. This concept was later coded as *professional security* (as outlined in Fig. 1 above). Utilizing Charmaz's (2014) guidance where "a constructivist tries to tap into his or her assumptions implicit meanings and tacit rules" (p. 95). I began to reconstruct my ongoing interviews with a bolder approach to enquiry. Thus, exploring the underlying thinking, related actions, and the impact of this property of '*professional security*' on these psychiatrists and psychologists in practice. As tension between the diagnostic practice and diagnosis as *professional security* developed in the findings, the '*medical way of thinking'* emerged as an underlying property to this Fixed subcategory. The psychiatrist's clinical diagnostic practice outlined in the interview excerpt below gives insight into this medical practice model.

Trevor: *So, within our diagnosis, everything gets compressed into the… into the diagnosis, because that's a medical way of thinking. Because that's, you know, in other specialties that works really well. You know because you know if you've…. you know, breast cancer but essentially breast cancer is breast cancer. So, it's definable, and it's left breast.*

PI: *Yes, yes, it's definable, yeah.*

Trevor: *And it's this type of cancer and that's it…. And we know that therefore we deploy this type of anti-cancer medication on the left breast and that's it. And I can talk to my colleague in San Francisco and get advice. I don't need to give any information apart from this woman has cancer in the left breast and it's this type of cancer and he'll go…. Yeah, give this a go…. great. Thanks very much.*

Trevor's diagnostic perspective evoked a theoretical sensitivity to the emerging theory in the data. If, this '*medical way of thinking'* where "*everything gets compressed into the diagnosis*' works '*really well in other specialities'*, does this medical way of thinking, work for trauma, which is movable and subjective? This urged the exploration of this question with later participants. The properties *professional security* alongside the

accompanying properties of the *rigid, medical way of thinking*, informed the elevation of *Fixed to* a subcategory in these findings. Yet, variations emerged to this fixed perspective in the data, which were to inform the combination of Movable and Fixed as a subcategory as depicted in the data findings below.

Chris challenged his psychiatric profession in the '*medical way of thinking'* as he ardently expressed,

> *and really, I would say, get training in cultural sociological understanding. Because our society is whole…., business is fluid. If you're uncomfortable with fluidity go into orthopaedics because it's either broken or it's not. But the human… the human condition is not binary. The human condition is fluid…. the child…. society is fluid and you just have to go with that.*

Chris's challenge to a fluid positioning of diagnosis, not only as a reflection of the medical model, but as a societal concept, presented a conceptual challenge to the fixed/rigid findings in the data, and presented an alternative perspective that was to later inform the theoretical framework. This strongly voiced perspective to adopt a fluidity amidst the rigidity of fixed diagnosis, further accentuated the balancing of diverse practice perspectives but also the tension held by, and between, practitioners in this field.

Distinct variations also emerged in the data identifying the usefulness of diagnosis, in practice. As Shirley illustrates,

> *sometimes it can really make people feel heard and understood. Helping them to make sense of their experience. This has been recognised. I'm impacted by this. This might mean more to them now because they have this name for it.*

This validation in diagnosis, the meaningful impact on children of being noticed, being seen, being named, came to the fore as Shirley expanded,

> *I suppose the idea sometimes we can like…. the... I… the whole…. is to look at and deconstruct it and look at it…. Is this helpful to you what does that mean to you? Is it useful to you… if it's useful to you? Having to acknowledge that they were experiences, you know…. It might be really helpful. If this becomes fixed in the idea that you have to in order for you to overcome this diagnosis, you have to do this…., I suppose it really depends on how helpful it is to them.*

A connection between diagnosis and trauma began to emerge, a subjectivity, the usefulness of diagnosis 'to you', as a 'meaning making' tool to the child, as explanation, as a child making sense of their experience. Sasha expands this concept, commenting on her practice "*when I think of them as people ...I always do…what's it like to be this child."* Adopting this child centred lens, shifted the emerging concepts of diagnosis beyond rigid and fixed, identified a subjective usefulness of diagnosis, for the individual child impacted by trauma.

Observing variations to this fixed perspective of diagnosis presented a potential movement in perspective that elevated the co construct of this subcategory as Movable and Fixed. The properties underlying this subcategory that support the elevation of both terms Movable AND Fixed represent the juxtapositions in the findings. This intense balancing of the differing properties of both child trauma and disorder diagnosis demonstrates the context within which these clinicians practice. These contrasting properties of this subcategory demonstrated not only the diverse theoretical perspectives but also a dissonance in how participants attempt to integrate these differing concepts in practice. The participants discomfort, dis-ease that emerged in the data, demonstrated a tension between the Movable and Fixed perspective to how trauma is considered by this cohort in diagnostic practice. The exploration to this line of enquiry is outlined below demonstrating the interconnecting subcategory of Systemic Pressure, experienced amongst this participant cohort as they attempt to navigate this Movable and Fixed dynamic of considering child trauma in their practice.

Subcategory - Systemic Pressure

The subcategory systemic pressure refers to the pressure that is experienced by participants as they work with children impacted by trauma. This subcategory is significant in providing insight into why psychiatrists and psychologists diagnose in practice, depicting the systemic dilemmas and challenges this cohort experience. The emergence of systemic pressure as a subcategory in the findings encompasses three supporting properties: (i) Professional Pressure, (ii) Resource Pressure and (iii) Parental Pressure. All three represent the systemic pressure to diagnose experienced by these participants. Participants engagement with these supporting properties is expanded below.

(i) Professional Pressure

The clinical pressure to diagnose emerged as Rachel spoke of her work context, commenting; "*if you don't diagnose, they will go to someone else who will*" displaying a sense of being undermined if she didn't make a diagnosis. This professional pressure was accentuated with a needing "to *get it right*" (James) and the hierarchical pressure "*that you do something*" (Trevor) because *"you can't just send them back to the GP"*. Trevor as an experienced psychiatrist, communicated this professional pressure with honesty and transparency, as the interview below demonstrates.

> *So, first of all, there's a pressure. There's a…. there's a pressure that when somebody comes to a psychiatrist that you do something. That's the first pressure, OK. Now doing nothing is doing something, of course, and often that's the best thing to do. And often that's the hardest decision to make to do nothing but….* (Trevor)

This acknowledges the action of 'doing by not doing', but also the internal pressure on this cohort. The systemic pressure to act or react, is evidenced here with clarity, not only in words but in the tone and pace of these interviews. Chloe communicated her pressured context, "*But when somebody's in crisis and in…., you know, and there's…. you know families at you, and everything is, you know, going on… Sometimes…. you will make a provisional diagnosis".* She continues to explain the clinical pressure connected with a societal pressure*: "but in terms of trauma, it's the societal need of being responsive"* (Chloe).

The collective actions in the data expanded this category to associate diagnosis with expertise. The need to have an expert. Attention was drawn to whether there was variance in the collective actions across the professional disciplines of psychiatrists and psychologists. It was interesting to note that the findings did not highlight differences in profession or by gender. The systemic pressure to diagnose experienced by this participant cohort appeared be experienced by all of the participants irrespective of their clinical profession. The findings below indicate the cross professional pressure experienced by the participants being dependent on the individuality of the clinician rather than their profession or gender.

When asked, what purpose does the diagnosis serve for the clinician? Chloe clarifies; *"I… it…. I suppose it depends on the clinician, you know, I suppose it's giving an answer showing expertise."* For Chloe, diagnosis demonstrates a need to be responsive, showing expertise, where Leah expresses the clinical perception *"if you don't get the diagnosis, you're not as competent and capable because you didn't see the subtle or the masking"*. Mike commented on the pressure (what he termed the '*Holy Grail'*) the DSM and ICD framework of diagnosis practice outside of Ireland, placed on clinicians where "*your diagnostic, your formulation must fit into a category that otherwise you're not going to get paid because there's no way for the insurance to reimburse you".* Chloe poses an interesting perspective questioning, whom diagnosis serves, *"you see… like the DSM is psychiatry led, which is the psycho form. So, you have to think, who are the stakeholders involved?"*

(ii) Resource Pressure

This resource pressure presented as a very real practice dilemma for the participants. I questioned the purpose of diagnosis and whom does it serve? This area of enquiry identified how diagnosis is "*Needed for resources"* (Helena) in order to facilitate children "*getting on a pathway ….to functionality"* (Chris). Mandy expanded the usefulness of a diagnosis to children adding, *"where the question comes…. is a diagnosis… may be helpful because it gives them access to certain additional supports that would make life much easier?"* This concept of pressure to diagnose, based on resources, surfaced quickly in the data, with Rick contributing a contextual insight of the *"impact of not having a diagnosis"* where Special Needs Assistants (SNA) were not available to children in schools, if not supported by a disorder diagnosis. Helen expresses her practice in a strong almost non-negotiable toned manner, "*I will always…. here's also the link to resources. So, if a child will get resources because there's a label. I will do that"* linking diagnostic labels to the availability of support resources.

(iii) Parental Pressure

The complexity to the phenomenon expanded from the data, when participants spoke of their experiences with assessment of children and adolescents in their practices. Parental pressure emerged, where participants were "*harangued by parents"* (Leah), to diagnose their children. With Chloe identifying the complexity of disorder diagnosis preferences; "*I find sometimes there can be reluctance to have that trauma as a diagnosis versus like a preference for neurodiversity and an autism diagnosis. So, parents come in wanting, in preference to your developmental disorder, because in some way it fits a kind of very neat box".* Mike as child and adolescent psychiatrist explains the complexity of how he tries to "*share your foundations around the whole systems*" attempting to explain the diagnosis with clients. Yet, "*you're sitting across from someone, some of them just want an answer, some people will just take that one line at this point in time, they don't want to consider everything that led to that person, to the big picture, to about why*". There was almost a sense of resignation in Mike's tone, a need to succumb to the parental pressure.

These findings supported elevation of the category ***Systemic Pressure*** illustrating the contextual pressure on this cohort to diagnose, so that children and adolescents, amidst limitations of funding and resources, gain access to support. It also demonstrates the

explicit but also implicit factors that these participants need to balance in their practice. The findings below extent this insight, giving further understanding to why these participants 'tip the balance' and move towards diagnosis, when presented with children impacted by trauma.

Subcategory -Tolerating Uncertainty

This section sheds light on the personal, interpersonal and professional challenges this cohort experience, when working with children with a trauma history. The findings demonstrate the participants difficulties in tolerating the child's trauma, presenting an uncertainty in what to do, which impacts the responses and interventions they make to child trauma, in their diagnostic practice.

The section below outlines the findings that support the elevation of *Tolerating Uncertainty* as a subcategory. The underlying supporting properties of *uncertainty, fear, tolerance* are presented, giving insight into the influential factors of how participants acknowledge the complexity of their Movable/ Fixed perspective of trauma and disorder diagnosis, and yet position themselves within the Systemic Pressure they experience in practice. Intentional use of the CGT methodology was needed here to determine, define, and clarify, participants meanings and actions, towards an "interpretive rendering" (Charmaz, 2014, p. 338) to gain a deeper understanding of the underlying influences on their practice. The fundamental properties of trauma, that James terms as, "*the hiddenness of trauma*" and Sara's reflection, on loss in trauma where, "*the child gets lost, loss is a theme all through trauma*" parallel with the hidden, almost lost emergence of the properties in the data, that support this subcategory. Iterative questioning of the data and the practice of theoretical sensitivity came to the fore, more extensively than in other areas of the data analysis, to determine the properties of this subcategory. The participants tentative positioning was identified below, illustrating these findings. Mandy demonstrates a position of exploration where, *"I suppose there is still a curiosity around. Well…, why did this come about in the first place?"* (referring to a child presenting with OCD). Helena gives a more tentative position, outlining,

> *But if I'm diagnosing a learning difficulty and I feel that there has been a significant event or trauma in the child's life I will mention that in the diagnosis. So, I would say something like…um…. from all the information gathered and the scores and parental interview and teacher interview, it appears that… or it's the scores suggest that…* (inferring a certain disorder diagnosis).

A suggestive property of *uncertainty* towards diagnosis began to emerge with a systemic gathering of information, informing practice. Insight from Mikes interview suggests variance, an incongruence, in practice, further supporting this property of *uncertainty* in practice. Earlier in the interview Mike communicated a biopsychosocial perspective to child trauma, yet later his positioning and demeanour changed as I explored how he , engaged with children, enquiring "so when a child comes in to you?" Mike shifted tone and perspective and strongly aligned with a medical 'cure' focused model when observing a child impacted by trauma. He commented, *"it's ...it's…diagnosis as in any field of medicine…diagnosis are for life* (firm tone). *As long as there's no cure ...you will have that diagnosis".* Mike presented a cure v recovery philosophy towards practice, which was new to the findings and conflicted with the movable subjectivity towards trauma. The implications and impact of this medical concept of cure linked to diagnosis, was explored with further participants. Despite the dismissive intonation of James' response "*that's just a straw man*" discouraging my initial pursuit of enquiry. As the tension in the data arose, and theoretical sensitivity advanced, I was alive to 'something' in this thinking that invited further exploration in my final four interviews. A conflict in perspectives towards practice appeared to emerge in the findings. Leah brought further context to how this cohort positioned themselves in their engagement with trauma, as she comments,

> *…the underlying…. the beneath of the difficulty in the relationship or the trauma…. It's not considered. It's kind of its….* (named organisation) *kind of thinking. Well, we'll deal with the mental health problem, yes. And then maybe outside services might deal with…. maybe the trauma part…. sometimes depending on….* (curiously, at this stage her strong tone began to shift) continuing gently "it's *all very… um yeah…. It's all kind of complicated.*

It appeared that Leah wished to apologetically retrieve what she had previously communicated. The rationale for these psychiatrists and psychologists to refer to '*outside services to deal with the trauma part*' suggesting that mental health was separate, or removed from trauma, invited further exploration. An uncomfortable, dis-ease to working with trauma emerged in the participant data. As theoretical analysis advanced, further practice and interpersonal dilemmas to understand '*why it is all kind of complicated',* substantiated the emerging theory. The findings identified a challenge to the participants engagement in working with child trauma and its implications on the practice of diagnosis with children. A restriction and caution, coded as *fear,* emerged as the data collection focused on clinical practice. Sara spoke with intensity of the personal and professional fear

of working with trauma, "*It's like a landmine, I'm sure to step on something."* Her insights also provided an understanding of her colleagues' fear of working with children, impacted by trauma. As communicated below,

> Sara: *They're afraid of it. I think they're afraid of…um…. To work with trauma. You have to have, …. I believe, worked on yourself. You have to be. …. You have to know what you're about. You have to know the limits of where you are at and where another person begins.*

I pressed the line of enquiry asking…

> *PI: What are they afraid of/ in the trauma?*
>
> *Sara: As when working with trauma, there's no doubt you will say or do or move forward some way that will trigger something. So, you have to be able to hold all of that.*

This tension between trauma and diagnosis that arose in the findings, with the property of *fear* supporting the subcategory of <u>tolerating uncertainty</u>, demonstrated a sense of personal, professional fear of, and a risk to, working with trauma in diagnosis.

The conceptual memo below, written after an interview, illustrates the emerging property of fear that supported the category of <u>*tolerating uncertainty.*</u>

Memo: 18/7/23 Fear

In this evening's interview (I mention evening here as I sensed a relaxed nature. They were at home, graciously fitting my interview into their busy family life). I was surprised by the strong identification with the concept of fear, an internal fear, a systemic risk, of insurance and the judicial consequence of being wrong.

As I tested this concept with additional participants it resonated. Yet a wider complexity to the concept of fear emerged. Fear of the trauma itself. What if…the clients opened up? As the participant exclaimed, "We only have 40 minutes to do something, we can't contain it in that time."

An understanding of the fear and complexity of considering child trauma in diagnosis was expanded by collective actions in the data, with an open honesty, as depicted in Trevor's interview below:

> *Trevor: That makes it difficult or yeah, that people move away from actually dealing with it because it's very complex and it's not definable.*
>
> *PI: Why's that...? I really appreciate that honestly because that's something I'm so curious about. What do you see is really happening there? Because I'm wondering.*

> *Trevor: Yeah. Because…. But you wouldn't …. you, wouldn't you… But you wouldn't want to uncover too much necessarily because you don't want to…. You don't open a box you can't close…. talking about something which is awful, and it really is awful".*

Trevor demonstrates his fear, of uncovering too much, with the complexity of trauma, its intensity, displaying an internal dis-ease. A question towards this cohort's capacity to tolerate this 'something awful' arose. This caution of engagement extended with wider intergenerational complexity, as Chloe identified: "*Yeah, so trauma is just even from a whole…. they say from a society level, even the earth. …. like the impact of kind of trauma and socioeconomic outcome…. Things… social outcomes, relationships, and also the fear of a kind of intergenerational trauma as well*". This addition of the fear of intergenerational trauma was new to the findings and contributed to the complexity of how this cohort attempt to navigate child trauma in their diagnostic practice.

The property of *tolerance* that had accompanied the participants *fear*, emerged with further clarity in the data. Shirley's interview contributed an emerging question early in the research study. She invited the exploration of Mason's (1993) position of 'authoritative doubt' to diagnostic practice with children presenting with trauma symptomology. Shirley suggested that clinicians consider a position where they question, review, and hold doubt and uncertainty in the diagnostic process. Yet, to adopt this position is challenging in theory and practice. An excerpt from a reflective memo excerpt (below) draws attention to the complexity of this perspective and its contribution to the construction of the core category that informs this study's substantive theory..

Memo 10/9/23 Tolerance

It was tolerance that was rising to the fore underneath the fear……could the participants tolerate the complexity of trauma? As my interviewee, gave a full resolve without being asked… *"it's nothing to do with experience or age…it's about tolerance*" she asserted.

Questioning, I ask myself, is this study emersed in the knowledge system of needing to define? Fixed or movable? Subjective or all knowing? Tolerance - Could we tolerate the doubt, of not knowing? Could we 'HOLD' the uncertainty, not just tolerate, but hold….

The findings also provided further understanding to these professions cautious engagement with children impacted by trauma, which undergirded this subcategory of Tolerating Uncertainty. The rationale for this caution and fear in working with a child's

trauma required further exploration. The findings presented insight identifying a significant gap in trauma training for these psychiatrists and psychologists. Mike expresses his learning, "*To be honest… the first time I've heard the term complex childhood trauma was when I was in the UK and this was just a year ag*o." Trevor, as a practicing and lecturing university psychiatrist presents insight on his psychiatric training.

> Trevor: W*e're not trained to deal with trauma.*
> PI*:* Ok
> Trevor: *First of all, I've never got training to deal with the trauma.*
> PI*:* Really?
> Trevor*: Not... No, no, nothing apart from, you know If you consider sitting in front of people who are telling me about it. So, on the job training, but no official guidance on it.*

A questioning sense of 'what do we do' in the light of not being trained in trauma emerged from Trevor's tone. Therefore, I enquired further, *"where does the trauma go then, in the diagnosis?"* questioning where trauma was positioned in the diagnostic process. This was important to understand the impact of this lack of training on the research question, to how trauma was considered in the diagnostic practice. Trevor continued to demonstrate the positioning of diagnosis in the trauma, "*like …. well, the diagnosis stands on its own."*

This psychiatric practice is illustrated more explicitly, by James as he explains; "*for we're not the ones treating it. So, it's just passing it on."* Fear of time constraints were also identified, where; *"It's fear it's a…. Fear of wasting too much time on this, I've got 40 minutes, and I don't have the time to open this box and you're not getting a diagnosis at the end"* (Trevor). A hierarchy of importance is suggested here, as though the diagnosis is the essential conclusion to the process, with the fear of opening the trauma box, influencing practice. These findings, suggest a cohort with a fear of trauma, who are under systemic pressure to diagnose, yet practice within a mental health profession that demonstrates a lack of trauma training.

The elevated category of Tolerating Uncertainty with its properties of *fear* and *tolerance*, was supported by the limitations in trauma training, and the property of *uncertainty* which depicted the underlying dis-ease with how this cohort considers trauma in their diagnostic practice. James extends this conceptual understanding of uncertainty with an additional risk, as rationale for "putting up a lot of barriers" in practice. He highlights, "*and so again, I see why they would just turn around people with emotional dysregulation who are going to present a huge level of risk that would be carried by the*

psychiatrist and with very few interventions the psychiatrists can do, that are in any way meaningful to this person. And so, I do see why teams put up a lot of barriers".

These findings evoke questions, with an enquiry towards the implications of these findings on practice. If the data presented indicates these professionals are finding it difficult to tolerate the uncertainty and complexity of trauma, to whom is it (trauma) passed on? What role does psychotherapy take in this movement or 'treatment'? The reflective memo below demonstrates my response to the findings, with further discussions in the following chapter.

Memo: 30/9/23 Questioning…. Why does child trauma get boxed packaged? (training, funding…fear, complexity, resources). If this were the focus of my research this is where I would stop, the exploration would end here. YET, I have already connected the two (trauma and diagnosis) by my enquiry and research question. There is something in the very essence of my intentional research here that is in tension in my findings and in practice. It is named out loud... when I enquired 'where does trauma fit in the diagnosis?... Responding "*Diagnosis stands on its own….*

This is what appears to happen in practice. Where is the child? Where do they get lost?

"and everyone becomes like a box. Every box. Everyone becomes like….. a token is right…. they have…… they are this token that can be….. you know easily moved around". (James, psychiatrist)

The Contentious Balance - "Putting the pieces together" (Sasha)

This section outlines the intersection between the subcategories Movable/Fixed, the Systemic Pressure and the subcategory Tolerating Uncertainty that informed the theoretical framework. The findings demonstrate a tension that undergirds each of these subcategories. A presenting discomfort, a dis-ease, presented in the data. The findings identified the participants navigating a tentative balance, of being on "*the real edge of stuff…. when we're talking about trauma…. on a real fenced to edge"* (Leah) yet being under systemic pressure, whilst also attempting to tolerate the uncertainty of their diagnostic practice. The following presentation of the findings is interspersed with reflective memos, indicating the exploration of theoretical concepts that elevated the core category The Contentious Balance, which informed the substantive theory, that attempts to resolve the participants dilemmas and concerns.

Charmaz & Thornberg (2021) guide researchers "to discern explicit and implicit processes in their data. To make processes explicit, grounded theorists study actions as well as meanings and show how they are connected" (p. 308). Therefore, I approached the data holding the contrasting properties of the subcategories, the movable/fixed presentations of trauma and diagnosis, with the challenges of systemic pressure, alongside this underlying tolerating uncertainty in the data. A persistent questioning of the correlation between the existing findings followed. James' interview provided an insight to connecting the complex dilemmas that this cohort navigate. He commented on needing to "*hold it all in balance*". This concept of balancing seemed to 'fit' the contrasting dilemmas and challenges that were represented in the subcategories. Through exploring patterns and constructing a hypothesis for this concept of balancing, an interaction emerged, yet posited with a disharmony. Rick highlights this sense of discomfort, expressing his practice of '*conniving with the system',* to explain his use of diagnosis, to navigate the pressure, to gain resource hours for children in primary school. This 'uncomfortable' sense of tension in the data, evoked questions as contemplated in the memo below.

Memo: 20/5/23 Questioning the Discomfort

I sense an incongruence in practice. The discomfort of what they have to do and want to do… I need to press onwards.
What dilemmas does this present as child and adolescent psychiatrists and psychologists respond? How do child and adolescent psychiatrists and psychologists navigate these dilemmas as they engage with presenting children? Or do they?

As participants spoke of engaging with diagnosis and the present DSM diagnostic process, a sense of 'charged energy' emerged. James speaks of his psychiatric practice: "*I'm not a huge fan of the DSM, it's driven by money and a gimmick to fund insurance companies."* With a similar pattern of thought from Trevor as he communicates strongly about DSM disorder diagnosis, "*I know I shouldn't say this*…. (Pause) *It's all just 'bullshit'*." Observing these very charged findings in the data demonstrated the contended role of the DSM, in trauma diagnosis with children. A sense of incongruence also emerged between participants clinical practice and their personal philosophies. As Rick, explains, *"I would hide that what other people would say oh, ADHD…. cos it's like…. long, because I didn't quite believe in it".* As these clinicians expressed their practice in very real

contexts, the tensions and balancing of actions required and integral values came under question for these participants.

James who had earlier suggested this sense of balance, contributed to this pattern of charged contentious energy in the debate. He boldly speaks of the limitations of funding and personnel resources, *"Like you're not solving any of this until you double or triple the number of mental health teams and you could definitely load them with a lot more psychotherapists and a lot more psychologists…..but like when they're that under resourced, I see why people are saying, I'm not treating personality disorders, that people with psychotic depression are now waiting months."* This intersection with the subcategory Systemic Pressure was reiterated by Sara presenting the need "to *work harder and longer"* within her service to accommodate the limitations of resources. Although interestingly Rick later dismissed this 'as *an age-old dilemma',* where diagnosis has become funding and resource led. The balance to how child trauma was considered in disorder diagnosis was clearly one that was charged, with clinicians working under systemic pressure to diagnose, demonstrating a contentious interaction between their tolerance of trauma itself and the professional challenges. This was further demonstrated with observations in the data suggesting that a child's trauma needs are set aside to accommodate a diagnosis, with a sense of a hierarchical or reductionist approach to diagnosis. Trevor's practice as a child and adolescent psychiatrist presents an approach that emcompasses, '*cutting out everything'* in order to '*get the diagnosis right'*. The interview excerpt below explains:

> Trevor*: Like medical diagnosis are…. Is it inductive or deductive? I can never remember which one it is, but either way, it's cutting out everything and coming down to something.*
>
> *PI: In our system?*
>
> Trevor*: It funnels it…. funnels it down whereas…. You know, trauma doesn't fit that box at all. Trauma has to be taken out of that box and put on the side. So, you cannot think about the trauma, so you can focus on everything else and get the diagnosis right.*

Trevor's comments on practice draws interconnection between all the subcategories, being suggestive of a Fixed diagnostic practice, which doesn't accommodate the subjective movable nature of a child's trauma. This is expediated by the professional pressure experienced by this cohort 'to get the diagnosis right'. Although the question arose to whether this phenomenon can accommodate '*provisional diagnoses'* (James) the international debate on the use of the DSM to formulate a diagnostic criterion for child

trauma, was repeatedly observed in the data. The potential impact of this is powerfully reflected on by Mike in the excerpt below:

> Mike*: So, if something like child complex trauma…. gets into there*…. (DSM) *I think that would be a lifelong*… (silence…pause…)
>
> PI*: …go on… can you finish that word….*
>
> Mike*: …a lifelong diagnosis*
>
> PI*: Ok, I'm curious…*
>
> Mike: *I think so …I think so, cos' you can't take that away, it's like souls' history*

Charmaz (2014) speaks of working with the quotes that 'won't leave you alone' (p. 194). This definitive response above of '*souls' history'* continued to 'niggle at me' throughout the data collection process, in a somewhat disturbing manner. I continued to pursue practice responses with the participants. A caution arose of *fixing* trauma *to* and *with* diagnosis. Sara spoke with exclaim regarding the potential inclusion of child trauma on the DSM, declaring it "*a crime*". As the practice conversations with participants pursued, the tension between the categories increased. The impact of this interconnectedness between the Movable/Fixed subcategory where child trauma is considered movable and diagnosis as fixed, is expanded in the reflections below:

> *And I suppose sometimes trauma can be viewed as something that's internal to the person. Yes…. and that you know that it's part of them and it's going to be part of them for the rest of their lives and it's… they have to…. You know rather than thinking about something that could be…. um…I suppose adopted or by their relationships… or could be changed in some way, or that a better context might have an influence.* (Shirley)

This reference by Mike to trauma as '*souls' history'*, and the permanence of Shirleys reflection of being '*internal to the person'* and '*part of them for the rest of their lives'*, displayed the significance for the child, of this tense interaction between a child trauma and their potential diagnosis. The intersecting components explored throughout the findings above, demonstrate a tense interplay between the subcategories that were grounded in the participant data. The discomfort and dis-ease experienced by the participants as they navigate the movable /fixed presentation of trauma and diagnosis, the straggling of the systemic pressure and the complexity of tolerating uncertainty supported the elevation of the '*contentious balance'* as core category. This 'balancing' was depicted in the data is a process, an active engagement that presents dilemmas for this cohort as they

engage with child trauma in their practice. This balancing concept, presented not as an 'achieved homeostasis' but a tense interplay of being " *on the real edge of stuff when we're talking about trauma*" (Shirley) demonstrating the complexity and uncomfortable properties of how participants consider child trauma, in their diagnostic practice.

Constructing the Theory: Holding - the Contentious Balance

As outlined above the findings presented three subcategories, Movable /Fixed, Systemic Pressure and Tolerating Uncertainty with distinctive properties. A tension undergirds each of these three categories, each sitting with a dis-ease, a conflict in theory and practice. The subcategories depict this cohorts attempt to navigate this phenomenon in practice. The findings illustrate the practice challenges, experiences, the interpersonal dilemmas, and contributing factors, as the participants engage with child trauma in their diagnostic practice. It demonstrates how psychiatrists and psychologists experience a *Contentious Balance* as they consider trauma in their diagnostic work with children and young people. Yet, Charmaz (2014) guides this juncture in theory formation, with the direction that "writers must address the 'so what' question" (p. 292). Therefore, holding these summative findings, I pressed towards exploring alternate possibilities grounded in the data that would move towards resolving the participants dilemmas and concerns. Alternative viewpoints to this phenomenon were explored that would guide and inform the construction of theory. A reflective memo gives a context to my exploration.

Reflective Memo*: 20 Nov 2023* Constructing Theory

What if we could tolerate the complex subjectivity of child trauma. Even though we're afraid and it exposes our lack of expertise. The safety of fixed rigid identity of diagnosis with the limitations of resources. Is there another way? Authoritative doubt, safe uncertainty, tolerating the unknown. If child trauma is subjective, with a movable relativity to the child. Then can we hear each individual child's story and be adaptable, responding with flexibility. So that each child can grow in 'their capacity to manage life events' (Chris). Can we as professionals withstand the systemic pressure, straddle the contentious balance of trauma and the diagnosis, and tolerate that uncertainty?

These findings facilitated the construct of a conceptual theory that presents the challenging capacity to resolve the main concern, the presenting core category. The Contentious Balance represents the dilemmas that this cohort attempt to balance in practice. The substantive theory Holding - the Contentious Balance, suggests a theory, to resolving this tense balancing experience. The significance of 'holding' is expanded in the following discussion chapter, but it is important to explore how the data informed this theoretical framework of 'Holding' and how the data suggests this alternative approach to the phenomenon.

Chris presented an alternative approach to diagnosis, challenging his fellow clinicians to move "*up or down the axis of your thinking"* to consider a more fluid concept to diagnostic practice. Rick supported this concept, proposing a reframing of diagnosis as *"a temporary condition that the child is suffering from".* Where rather than a fixed position that was evident in earlier findings in the data, Helena proposes a flexibility towards diagnostic practice. She advocates using language in diagnostic assessment, that is more fluid rather than fixed, such as "*at the moment, at this time, the reading ability needs to be checked again…, so to go back and do it, reassess"* and suggests the usage of "*it appears that, the score suggests that*". These collective perspectives evoke an openness to exploration of alternatives, towards a tentative holding of diagnosis.

Shirley contributed a significant variation to the findings where *"the idea, that the possibility that people could come unhooked from their diagnosis".* This concept of a child coming unhooked from their diagnosis challenged the rigid fixed properties of diagnosis and posed questions for how this might inform practice. A continued flexibility towards diagnosis presents possibilities to relieve the tense interaction between trauma and diagnosis. James suggests that psychiatrists and psychologists speak to children with diagnosed disorders (and their parents) and, "*kind of tell them to hold them* (diagnosis) *tenuously".* These findings presented possibilities that attempt to address the fixed nature of diagnosis to which participants appeared uncomfortable. The findings suggest a practitioner positioning where clinicians adopt a more flexible approach to diagnosing children impacted by trauma, whereas Shirley indicated, children, who had been given, or 'hooked' to a diagnosis, could become 'unhooked'. Rick further developed this temporary positioning of diagnoses, as he explained; *"So, I would write in the report that this is a temporary condition that the child is suffering from".* James contended that the practice implications of adopting this alternative 'hooked /unhooked' diagnostic framework

required '*mental flexibility'* for psychiatrists, that he cautiously presented as a potential dilemma that could "*tool or hinder*" the diagnostic process. Helena expands this proposal for mental flexibility in the field, presenting a movable individualised approach to practice that supported the practice philosophy of the substantive theory, of holding of a contentious balance towards, and in, practice with children impacted by trauma. Helena explains,

> *Celebrating individuality is great, but it actually should be…. Celebrating individuality <u>and</u> looking for individual interventions and formulations, and if somebody does have a sensory need, what about just meeting that need rather than a need for such a broad, overarching label?*

A call for this individualised response to a child's trauma in diagnostic formulations also emerged with Sasha illustrating her underlying philosophy of practice. "*It's a limited piece of work …. when you really feel you can do something right, just by accompanying them through the journey."* This openness to a concept of hooked /unhooked presents an alternative approach to the certainty of fixed diagnosis and suggests a positioning within the systemic pressure that accommodates a tolerance of the uncertainty experienced by this cohort. The fluidity towards diagnosis proposed in the data, acknowledges the core category the <u>Contentious Balance</u> as the main concern, but the substantive theory presents an invitation, proposing a 'Holding' of this Contentious Balance. It acknowledges the underlying challenges and dilemmas outlined in these findings yet proposes that mental health professionals tolerate alternatives adapting and facilitating a process that "*is not problem saturated but needs assessed*" (Shirley) when the individual child presents with a trauma symptomology. For, in line with a recovery approach to child trauma, rather than a fixed diagnostic model, responses to trauma must "reflect an attempt at adaptation, rather than evidence of pathology" (Fisher, 2017, p. 1)

Exploring the Substantive Theory

<u>Holding the Contentious Balance</u> between the subjective movable nature of child trauma, whilst adopting a more fluid framework to the fixed rigidity of diagnosis is complex. This final representation of the findings demonstrates how the participants informed, but also responded, to the emergence of the substantive theory, that suggests resolving this cohorts practice dilemmas through a 'holding' position.

Sasha displays a measured integration of the child, in this 'holding' proposal. She explains her practice:

> *I love putting the jigsaw pieces together and then I can say ok this is my formulation diagnosis. They've delays here, they've strengths there, and then just putting that together and we wonder what this is about …. Is there specific language disorder or is it because of intellectual disability or is it autism.*

This development of a relationally communicated formulation, where trauma could be considered as "*part of the jigsaw, of a biopsychosocial perspective*" (Mike) to the diagnosis, presented as an alternative in the data. It was implicit in the data as though looking for what Helena, expresses as, "*the light from the shade*", because "*sometimes when you're a psychologist you don't get to see a range of typical children, you're seeing a particular cohort*". James acknowledges the individual child and subjective experience of trauma requires the clinician to "*side more with recovery*" but advocates for *"a medical model that runs in parallel."* This tension of holding the properties of 'wonder', of moving beyond a formulaic diagnostic framework, where a child's unique 'jigsaw pieces' could be put together alongside a curious questioning, *"is there, or is it' (James)* requires a steady psychotherapy principle of 'Holding' of the <u>*Contentious Balance*</u> that is proposed in this theoretical framework. The tenets of this 'Holding' environment are expanded later in the discussion chapter, establishing a workability of this theory in practice.

The collective findings presented an alternative, of tolerating movement in diagnostic practice, requiring a mental flexibility. Where <u>*tolerating uncertainty*</u> would require this participant cohort to *"think again, to understand that it probably is more of a spectrum rather than just a severe end"* (Sara) when a child presents with trauma symptomology. This suggests that psychiatrists and psychologists working with children impacted by trauma consider a theoretical concept where diagnostic assessment moves beyond definitive diagnostic frameworks but towards an individualised recovery approach where *"it's all about functionality*" (Chris). Yet this requires a *"holding in balance"* (James) the medical need of certainty, for '*cure'* (Mike) that embraces possibilities for children and young people to become *'unhooked'* (Shirley) from their diagnosis. Sara speaks profoundly and authentically, summarising her understanding of the complexities for her professions, in 'holding' this contentious balance towards child trauma and diagnosis.

> *Sara: You have to have the confidence as a clinician to allow yourself to mess up. So, you have to be able to hold all of that, or when that happens and there's a*

dysregulation or there's a complaint, or there's a... "what's that woman doing? She hasn't a clue. She's upsetting everybody." You know, knowing what that can be about, and holding it.

PI: And what is that about?

Sara: I *think for some, it's a defensive practise and it's for others…. they… they… not everybody has the capacity for deep self-reflection. The interest for deep, self-deep reflection to the other, or an awareness that that can happen or is required.*

PI: what impact would that have?

Sara: *I'm…. I'm circling back to your doubt. The tolerance of doubt. That actually things aren't wrapped up in nice packages.*

Sara presents the summative challenge of 'holding' the findings of this research phenomenon. The contentious balance of acknowledging the subjective nature of trauma for a child, which cannot be "*wrapped up in nice packages"*, whilst holding the systemic pressure of the *rigid fixed* nature of diagnosis, is complex. Sara identifies the conflicting tensions of straggling these very contrasting properties, proposing a need for, a tolerance of, uncertainty. These findings and the underlying properties highlighted earlier, supports the proposal of the theoretical framework of Holding- the Contentious Balance as a resolve to this complex phenomenon. This proposes adopting a recovery approach that "extends, transcends and challenges (existing) dominant ideas" (Charmaz, 2014, p. 308) which is discussed further in the following chapter.

Conclusion

The findings presented here, form "the theoretical axis or skeleton' (Byrant & Charmaz, 2007, p. 211) that inform the substantive theory of Holding- the Contentious Balance. The research question enquires how child trauma is considered in disorder diagnosis, with the study's findings presenting a complex, interaction in how participants engage with child trauma in their diagnostic practice. Several underlying factors influence this engagement documented as the subcategories, Movable and Fixed, Systemic Pressure and Tolerating Uncertainty. The accompanying properties are foundational in supporting the elevation of the core category, The Contentious Balance. The findings identify a cohort that acknowledges the immense impact of trauma on a child and its movable subjectivity. Yet, the study highlights the systemic pressure experienced by this study's cohort and the underlying factors that limit their capacity to tolerate the uncertainty of how to respond. These dilemmas present the participants in an uncomfortable balancing position,

attempting to meet the complex needs of children impacted by trauma, within a ‘a medical way of thinking’ that is diagnostically focused.

The substantive theory Holding - the Contentious Balance grounded and constructed through, and in the participants data, challenges mental health professionals to ‘hold’ the balancing process depicted in the data, to hold the tension, to hold the uncertainty. To “hold, frame and bear” (Casement, 1985, p.133) the child’s individual responses to trauma, rather than ‘holding to’ a fixed diagnosis, requires a flexibility to existing mental health structures. Navigating this conceptual theory in disorder diagnosis with children and young people impacted by trauma, presented here, is a theoretical challenge, but also a clinical practice challenge. The following chapter discusses this conceptual theory, grounded in the data of this research study, and in the context of existing literature, highlighting its implications for the psychotherapy field, and beyond.

Chapter 5: Discussion

Introduction

The purpose of this research study was to explore the perspectives of professionals working in mental healthcare in Ireland, on how they consider child trauma, as they make a disorder diagnosis, with children and young people. Grounded theory methodology directed the research process, guiding the researcher to 'discover the participant's problem and generate a theory accounting for the processing of the problem' (Glaser,1998, p. 11). Based on the findings, this study presents a substantive theory of Holding - the Contentious Balance that proposes to resolve the problem identified here as the Contentious Balance. This main concern depicts the tense and conflicting practice dilemmas that participants balance as they engage with children impacted by trauma. The interlinked subcategories give insightful understanding to the underlying contexts, experiences and perspectives that identify the Movable and Fixed nature of child trauma and diagnostic practice, the Systemic Pressure this sample cohort experience, and the challenge of Tolerating Uncertainty when a child with a trauma history, presents to child and adolescent psychiatry and psychology practice. This discussion chapter aims to give an interpretative explanation of the findings that support this theoretical concept.

The discussion below locates and evaluates this theoretical framework and its significance, in existing literature. This chapter expands how the findings impact practice, exploring the possibilities and complexities of adopting and implementing this substantive theory. The discussion also examines "how the analysis fits, extends, or challenges leading ideas" (Charmaz &Thornberg, 2021, p. 322) in the field of psychotherapy and beyond. The subsequent chapter further explores the implications and recommendations this substantive theory has on, and in practice, with proposals to further research in this expansive area.

Reflexive memos are integrated throughout the discussion. As highlighted earlier in the methodology, memos are an integral part of CGT, tracing the researchers' conceptual explorations, towards the emerging theory. Their inclusion and integration in this discussion represents the internal discussions with self, the 'play with the dilemmas' that reflect not only a vital psychotherapy tool but demonstrate a discursive critical analysis of

the very real dilemmas that emerged in the findings. I hope that they also contribute to a sense of living human engagement, in this discussion.

The Holding Concept

It is important to establish the significance of the concept of 'holding' to this substantive theory. The underlying subcategories of Movable and Fixed, Tolerating Uncertainty, and the accompanying Systemic Pressure present with a sense of instability, of polarity, displaying conflicting concepts that demonstrate participants needing to navigate an uncomfortable Contentious Balance in clinical practice. In contrast, '*holding*', evokes a secure, safe containment of these categories, a need that is fundamental in all work with children and young people impacted by trauma (Fisher, 2017). The concept of '*holding*' documented in the prominent work of Winnicott (1955) depicts the physical and emotional holding environment required by children. This holding is indeed a significant element of trauma recovery for children, where a physical holding, a nurturing by significant others, is needed to repair and restore the absence frequently experienced by children who have experienced developmental trauma. Accompanied by this physical holding is the clinicians capacity to emotionally hold, 'the big feelings' (Goodyear Browne, 2022) of the child or young person who is frequently overwhelmed and dysregulated by their trauma experiences. This is both an emotional and psychological holding when working towards recovery with children impacted by trauma and is the " metaphorical holding" (Ogden, 2004, p. 1352) on which the substantive theory of holding, in this study is based.

This process of holding has a dual focus, as Yogev (2008) explains, "one of having a double, deontologized use, in which holding is both an experience and a necessary activity" (p. 376) It is the '*holding*' of this Contentious Balance in practice, that enacts the functionality of this substantive theory. Yet, the findings indicate a complexity, towards the '*holding'* of this substantive theory, with challenges presenting initially from the contrasting Movable/ Fixed properties of trauma and diagnosis, accompanied by very real practice dilemmas that place Systemic Pressure on clinicians that influence and determine their diagnostic practice. The concept of 'holding' outlined here challenges existing medical models towards diagnosis. The findings depicting that the current diagnostic frameworks give participants a sense of professional security, indicate that the concept of holding which this study presents could potentially dysregulate clinicians. The fluidity and

broad thinking required to adopt the holding, contrasts significantly with the fixed diagnostic criteria.

Advocating that participants extend their capacity to 'hold' these dilemmas, amidst the challenge of Tolerating Uncertainty in diagnostic practice, is considered the key component that stabilises the workability and viability of Holding - the Contentious Balance as a resolve to this phenomenon. This theory presses towards 'holding' the individual needs of the child as a priority. This requires mental health professionals to adopt a shift in practice that aligns with the new ambitious Sharing the Vision governmental strategy (2024). This urges a movement from the security of a defined diagnostic outcome, of the medical model, towards holding what can be a more uncertain perspective, for the clinician. This uncertain, open questioning perspective focuses on the individual needs of the child. This study's concept of 'holding; aligns with this vision that frameworks "should enhance the inclusion and recovery of people who have complex mental health difficulties…. in partnership with service users and their families to facilitate recovery" (Sharing the Vision, 2024, p. 12)

The section below discusses participants perspectives as identified from the findings, and contextualises the discussion, in the light of how these findings are positioned in the current literature, but also the theoretical concepts they evoke.

Holding Philosophical Positions - Contextualizing Trauma and Diagnosis

This study depicts an analytical account, explored "as emergent interactions through a mutual exploration of the interviewee's experiences and perspectives" (Charmaz & Thornberg, 2021, p. 317) attempting to bring insight to this phenomenon. The cultural and societal influence on the concept of child trauma and diagnosis as potentially "in fashion" (Wilkinson, 2022, p. 504) reflect the positioning of this study, grounded in this period of social, and medical history in the field of mental health professionals, in an urban Dublin context, in Ireland.

The subcategory of Movable and Fixed reflects an underlying perspective, a philosophy of practice, demonstrating a dichotomy that this study's participants balance as they consider child trauma and diagnosis. Despite the study exploring the perspectives of two disciplines, psychiatrists and psychologists, the findings present a collective understanding of the Movable subjective nature of child trauma. This is coherent with the

literature which comprehensively identifies and acknowledges children's variance and individualised responses to their early life stress. Despite the many attempts in literature to define child trauma, and its symptomology, the participants responses provide a coherent voice, that support Perry's (2008) conclusion, that there's no one label for child trauma, but we follow the child's individuals response to the trauma. Yet this collective positioning that advocates for a subjective perspective to a child's trauma, comes under question when considered alongside the juxtaposition to diagnosis that emerged in the findings.

In contrast, the Fixed category, with the supporting property of *a medical way of thinking* points to a social construction, sited in the construct of mental health professionals working as child and adolescent psychiatrists and psychologists, where disorder diagnosis is criteria led. Contextualizing the influence of the *medical way of thinking* on how child trauma is considered, is important. This fixed, criteria led, positioning of diagnosis through the DSM and ICD frameworks, emerges in contrast to the Movable nature and subjective properties of child trauma. Acknowledging this philosophical positioning is essential to this discussion, as it identifies the participants approach to practice, to influential factors on interventions, giving foundational understanding to how and why the participants engage with the research question.

Movable and Fixed - Balancing the Tension

The findings present distinct philosophies of practice that underly this Movable and Fixed subcategory. The contrasting differencing properties, identify distinguishing approaches to diagnostic practice with children impacted by child trauma. Participants named this positioning as '*cure or recovery'*, identifying contrasting approaches to diagnosis in mental health. Although deemed as a controversial '*straw man'* in the findings, the energy with which the findings were presented, supports the core category of Contentious Balance indicating a tension in the field, rendering this concept important for discussion. In practice it determines what participants do with the complex and tense dilemmas depicted in this study's findings. The contrasting cure or recovery approaches, contextualises the balancing of medical perspectives that the participants need to, or choose to, navigate as they practice. Furthermore, the invitation to hold the substantive theory, suggested here, is challenged by this underlying philosophical positioning, when considering how and if, the participants engage with a Fixed diagnostic framework or a Movable subjective individualised approach to children impacted by trauma.

The identified Movable subjective nature of trauma presented in the findings aligns with a recovery perspective, allowing for a flexible and child focused approach towards intervention, of developing functionality, for the child impacted by trauma. The identified Fixed category supported by the properties of *rigid*, and indicating a *professional security*, a *medical way for thinking* aligns with a cure centred approach to diagnosis. Understanding these approaches in the light of literature that integrates practice, is essential in gaining further insight towards the participants perspectives.

The recovery literature (SAMHSA, 2012) presents a non-fixed, non-dualistic philosophy to engaging with child trauma, that concurs with this study's Movable category and its properties. The individual, the self, is foundational to the recovery approach where recovery "is person driven, occurring via many pathways" (SAMHSA, 2012, p. 4). Yet, the challenge presents where participants indicate that a '*mental flexibility'* is required to adopt this approach to practice. This requires clinicians to adopt the property of *knowing / not knowing*, to question and contemplate alternative rationale for symptomology so that "individuals optimise their autonomy and independence to the greatest extent possible" (SAMHSA, 2012, p. 4). Deegan (1988) highlights the distinction between the contrasting medical practice perspectives, that of cure, or recovery, that underly the subcategory of Movable and Fixed. Deegan clarifies, "recovery is not necessarily about becoming 'cured' but rather about living beyond the disabling effects of the mental health condition" (p. 11). This Movable flexible perspective to mental health, as a recovery person centre process, rather than a Fixed cured approach, provides insights to why and how these participants navigate the tension posited in this subcategory.

Recent literature elevates the significance of this individualised recovery approach to mental health , advocating for, "the importance of a rights-based approach" (Barlow, 2024, p. 45) as acknowledged by the WHO mental health day (2023). This concept of a person's right to recover (Leete, 1994) is in line with Charmazian social constructivist foundations (2014), where the person is co construct in the recovery process. Underlying the Fixed category of diagnosis, the findings illuminated the property of *professional security* indicating how professions feel the need to observe the diagnostic criteria and '*get the diagnosis right'*. This balancing of practice perspectives that of cure or recovery, the reductive process of '*funnelling down'* (Chris) the symptomology to meet the criteria of defined fixed diagnosis, or adopting the subjective recovery that gives both the

child/young person and the clinician the "dignity to risk" (Deegan, 2000, p. 11) is both challenging and contentious.

These contrasting cure or recovery perspectives to trauma and diagnosis, that emerged in the findings, indicate a dis-ease in participants practice. This tension and discomfort towards diagnosis and trauma is also reflected in the literature, with a contentious history between psychiatry and psychology and interrelated fields being the subject of much literary debate. The historical tension between the fields of psychiatry and psychotherapy is also widely acknowledged (Kaffman, 2009) presenting a chasm between a biomedical and biopsychosocial model of practice (Ritro & Cohen, 2013) that influences approaches towards diagnosis and interventions. It is perhaps the acknowledgment of the dominance of this medical perspective towards diagnosis, as documented extensively in the literature review of this study, that urges those working in the child trauma field (Ford, 2021; Perry, 2017) to exert pressure, for a restructuring of the current diagnostic DSM 5 and ICD 11 frameworks. The tension, the back and forth, dilemma of the Movable and Fixed subcategory, parallel with that tension in literature, of the on-going debate towards the inclusion or exclusion of child trauma in the diagnostic criteria of DSM. D'Andrea et al. (2012) argues for inclusion of an appropriate developmental diagnostic criteria for children under DTD (Developmental Trauma Disorder), demonstrating a recognition, in line with the findings, of the enormity of how '*big*' the impact of early life stress is, on children. Although international literature strongly (as referenced in the Literature Review Chapter) advocates this movement towards inclusion of child trauma, through a medically recognised diagnostic framework, the findings present a more cautious approach which is expanded below.

The differentiating exploration of child trauma in the findings, demonstrates an openness to diverse, subjective expressions of trauma, a non-dualistic positioning. Yet, overt concern was expressed at needing to comply with the DSM framework, to adhere to funding, and potential insurance constraints. A divergence in support of the Fixed diagnostic positioning of child trauma, evoked a conflicting dis-ease that contributed to the core category Contentious Balance in the findings. Although earlier embracing a wide encompassing position to child trauma, a reductionist philosophy emerged. The findings draw attention to the "two opposing trends happening in the field of mental health" (Weinhold, 2015, para. 4). This was identified in the data, where a suggested hierarchical approach to "*getting the diagnosis right*" was prioritised over the individual needs of the

child. This evidences the pivotal core of how this samples cohort manage the complex balance. Under the contributing systemic stress factors, depicted in these findings and attempts to tolerate the uncertainty of trauma with limited trauma training and fear of trauma itself, participants form diagnosis. It is as though 'the balance tips' towards diagnosis under these dilemmas and challenges that strongly influence their practice. The findings indicate that participants uncomfortably adopt a reductionist approach, aligning with a 'medical way of thinking' where, as James concludes, *" there are few quick wins*".

Balancing existing reductionist diagnostic models that reflect a medical way of thinking towards a more fluid approach requires "interventions that shift the paradigm around problematic behaviours to allow for therapeutic growth and healing" (Goodyear Brown, 2022, abstract). The work of Johnson (2021) contextualises the reductionist culture to diagnostic practice in the field of child and adolescent mental health. Johnson, explains, "reductionist approaches are very common in biomedicine, in which it is assumed that a single underlying genetic, neurochemical, cognitive or behavioural component will be sufficient to explain and treat a given condition" (p. 611). This biomedical construct to practice, challenges the co-existing nondualist perspective supporting the subcategory of Tolerating Uncertainty that advocates for a more fluid perspective to diagnosis. Yet the contextual landscape for change appears challenging in the Irish mental health services. Niall Muldoon ombudsman for children in Ireland has advocated for a radical shift in mental health practice for children yet, that over his 10 years in office "I find myself still listing many of the same issues with no progress, and even regression to show for the passing of time" (Dunphy, 2024, para 4).

Ivor Browne (1929-2024) as pioneering psychiatrist in Dublin, adds comment to the conflicting 'fit' of the reductionist approach as a framework for the subjective experience. In an interview with the Irish Times, Browne comments, "mental illness is seen as a disease caused by either a disturbance in our biochemistry or by genetic influences – but this is a myth. This view of mental illness arises from a reductionist scientific concept ... and it breaks down when applied to living creatures such as ourselves" (Gilsenan, 2017). This subjective approach to trauma recovery, supporting the Movable and Fixed subcategory, indicates a reluctance to place child trauma on a fixed diagnostic framework. The evident caution that emerged in the data towards implementing the fixed rigidity of the DSM diagnostic approach to a child's trauma symptomology indicates a watchfulness to this phenomenon that accompanies the thinking of Søren Kierkegaard (1813-1855) who posits that "once you label me you negate me". This is an important consideration, where the

child and their individual needs get lost in the use of diagnostic labels, and the child's identity is reduced to "*the trauma child*" (Helena). This points again to the reductionist labelling practice potentially challenging the child's human rights and dignity and presses towards "the complex relationships between trauma and ethics" (Davis, 2017, p. 19). This study presses towards the ethical challenge of voicing the needs of the child impacted by trauma. It advocates that clinicians hold a broad conceptual mindset when faced with the presentations of children with trauma histories. The section below extends this challenge amidst the existing reductionist practices.

The findings under the subcategory Tolerating Uncertainty question the reductionist practice, advocating for a tentative holding, of the presenting trauma symptomology of a child. The findings suggest a positioning where diagnosis is held tenuously, adopting a fluid conceptualisation towards symptomology. This embraces a movement towards addressing the recovering functionality of the child, which in both theory and practice conflicts with the fixed nature of a reductionist, medical way of thinking. This reflects an important recognition that challenges the power and authority given within the existing hierarchy. This repositioning, outlined by the Power Threat Meaning Framework (PTMF) advocates, "that we need to promote a whole range of ways of moving towards theory and practice that is not based on psychiatric diagnosis. (Johnstone & Boyle, 2018, p. 14).

Holding the contentious balance of both perspectives, communicated with energy in the study, demonstrates a challenge to dualistic positioning. It is well documented in this thesis that children impacted by trauma present with complex symptoms. The response to these symptoms, is where this study's theoretical framework comes into play. Mate (2019) contributes to this debate contending that "cleaving into two that which is one, colours all our beliefs on health and illness" (p. 3), thus acknowledging the intersecting complexity of a child with a trauma history and their symptomology. This representation of the conflicting balancing of both positions within the same subcategory, movable and fixed, demonstrates the disparity and diverging philosophical perspectives towards practice. This is also evidenced in the findings, as participants indicate that what they 'have to do' in practice, being incongruent with what they 'want to do'. This conflicting incongruence depicted in the findings, is also documented in a recent survey of psychologist's attitudes to the DSM. Raskin et al. (2022) report that nearly 90% of psychologists used the DSM despite being dissatisfied with it. The question arises as to why? The discussion below

presents some possible alignment between this practice and the systemic pressure highlighted in this study. This complex straggling of practice dilemmas further evidences supports for the presenting substantive theory, where existing practices demonstrate a contention, that this cohort balances in practice. A concept memo, (below) captures an interesting trauma therapy parallel, that emerged as I interpreted the emerging theory.

Concept Memo 21/11/23

Incongruence, or is it Disconnection /Fragmentation?

The profound consequential nature of making, and then establishing, a concrete connection between child trauma and disorder diagnosis, (through the DSM criteria), rose to the fore in the data. Van der Kolk (2014) brings light to this connection or indeed disconnection, explaining that, "Dissociation is the essence of trauma. The overwhelming experience is split off and fragmented" (p. 66). This dissociation and fragmentation between child trauma and disorder diagnosis in the data, parallels the very essence of trauma. It demonstrates the remarkable managing mechanism of children, to develop a means of separating and disconnecting from their experiences so that "fantasy replaces painful fact" (Mate, 2019). I hold this awareness, keen to not let the child get lost.

As the subcategories developed the complex interrelated factors that influence this participants engagement emerged that fundamentality depicted how they responded 'in practice' to a child presenting with a trauma history. The section below discusses the impact systemic pressure has on this phenomenon.

A Profession Under Systemic Pressure

The accounts in this study present a cohort who are under Systemic Pressure. This subcategory indicates a professional top-down and a bottom-up pressure, from those systemically engaged with the presenting child. The findings depict how the subcategory Systemic Pressure is supported by properties that indicate the impact of professional, resource and parental pressure on clinicians as they consider child trauma in their diagnostic practice. The section below informed by the literature, provides a working context to the professional pressure experienced by the clinicians in the findings. It

highlights the systemic thinking that potential informs and influences this busy cohorts, diagnostic practice.

Despite the absence of literature, documenting the dilemmas in diagnosing children impacted by trauma, the literature documents the medical context within which these diagnostic decisions are made. Groopman (2010) informs the discussion, by illuminating how medical practice, formulates decisions and influences diagnostic practice, so that, as the findings indicate, clinicians "*get the diagnosis right*" (Mike). Groopman, challenges the "training in metacognition, the thinking about our thinking" (p. 57) in his insightful work "What Is Missing in Medical Thinking", giving an insider understanding to diagnostic practice. Groopman (2010) explains how medics, "look for a single unifying explanation. The problem is people often have two things going on at the same time. We work under tremendous time pressure, and we work under conditions of uncertainty with limited data at hand" (p. 54). This illuminates the challenging properties of professional pressure that underly the subcategory of Systemic Pressure. This highlights where doctors, under time pressure and in their thinking framework, take the initial or partial information about the presenting problem to anchor their decision (Tversky & Kahneman, 1974). The consequences of this concept of "thought- in-action" (Schön, 1930-1997) of anchoring, in medical practice, accompanied by a philosophy of cure that contends with a recovery approach to trauma, highlights the additional complexities influencing this phenomenon, where psychiatrists and psychologists form diagnosis 'under pressure'.

Tolerating Uncertainty

The findings indicate that the capacity to hold the Contentious Balance and tolerate the Systemic Pressure and the uncertainty of trauma presentations, is weighted in two determining and interconnected dilemmas. The properties of *tolerance,* towards the complexity of trauma, and *fear,* of opening the '*trauma box*' that support the subcategory of Tolerating Uncertainty, provide interesting insights into the relationship between child trauma and how it is considered by this cohort, in diagnostic practice.

The work of Carl Jung (1875- 1961) draws attention to this concept of tolerance, that is fundamental to upholding this study's theoretical framework. Jung contended that people experience unnecessary suffering, due to an inability to accept the 'legitimate suffering that comes from being human" (1966, p. 92). Tolerating the complexity of

trauma, particularly as a child presents before you in practice, is difficult. As the findings explicate, the necessity of professionals to have engaged in their own transformative interpersonal work to enable the holding and containment of the early life stresses of a child's world, is paramount. Siegal's (1999) neurological concept of the 'Window of Tolerance' brings a contextualised framework to these findings. This concept not only explains the delimiting capacity, the dysregulation symptomology of trauma, but also acts as a tool that guides recovery and functionality. Being able to tolerate, to hold the pain of trauma experiences expressed by children, requires professionals working in this field to be able to stay within their window of tolerance (Ogden et al., 2006). Winnicott (1955) seminal work, advocating for the importance of this "live human holding" (p.147) environment for children, significantly cojoins the concepts of tolerance that emerged in the findings and the proposal of 'holding'. A primary understanding of 'holding' as "an active search" (Yogev, 2008, p. 375) is fundamental for the viability of this proposed theory, to a cohort that are under pressure to respond to the complex needs presented in the symptomology of children impacted by trauma.

Suggesting that clinicians provide a holding environment is not viable in practice, if clinicians cannot tolerate and do not have a wide window of tolerance to a child's trauma experiences (Goodyear Browne, 2014). The fear of a child's trauma that emerged in the findings, accompanied by participants challenge to tolerate the uncertainty, strongly influencing how the clinicians respond. The findings presented participants cautious fear of the trauma itself, expressing a need of being careful, of stepping on '*a landmine'* and not wanting to open the '*trauma box'*. This evokes a question, as to why? Is this fear, a personal capacity to tolerate a child's lived experience trauma? The literature indicates the expansive comorbidity of trauma presentations in children, demonstrating the complex symptomology of children presenting with a trauma history (Teichor & Samson 2016) which presents complex challenges to the clinicians who are 'expected' to respond. Miller (1891 - 1980) gives eloquent insight, writing, "chaos is the score on which reality is written", with this chaotic reality presenting in clinical practice, with children struggling in their capacity to function in relationships, at school, in their life worlds (Perry, 2014). So does the question of tolerance point to a systemic, societal capacity, a fear of not knowing, of tolerating the uncertain, subjective movable chaos of child trauma?

The concept memos below reflect my ongoing internal response to the fear that emerged in the data, and its parallel contribution to this research and to practice.

Conceptual Memo: Fear 11/9/23

I am alerted to the word fear that is emerging in the data. What is this? My own response is sadness. Why are professionals so afraid of trauma? If we are so afraid, we externalise it. We see it beyond ourselves, and so we push it away. Trauma is not a 'thing' but something living and active. And so, as trauma lives inside the children and young people in our practices, how can we respond with fear? These children are already afraid. What are we as professional adults truly afraid of….not being good enough, professional enough....not knowing?

Children who have experienced complex trauma need the basic sense of safety. Can we as professionals bring an uncertainty that is, safe. Led by the child, hearing the descriptions of their trauma experiences, holding them, tolerate not knowing, in safe uncertainty. Until they themselves dare to begin to know…. what they wanted and tried desperately to keep unknown. For that is the nature of trauma "one has to hasten slowly - Festina lente- to create a safe context within which a person is able to face a painful past" Ivor Browne. Music and Madness (2008, p.126).

Fear …uncertainty…Is there another way that sits more comfortably with these participants….or is being uncomfortable an intrinsic part of this dilemma?

Reflective Memo 16/2/24. Fear – A New Perspective

Yet perhaps fear is so apt. I hear a shift in my perspective. Fear can also mean to respect, to honour to acknowledge. As though a righteous fear. Acknowledging the significance of early life stress in a child's life. Perhaps this fear is indeed congruent with the data that sees trauma as big and enormous. What I perceived as fear as a negative response is perhaps more honourable to this phenomenon and to the children we endeavour to support.

And so, I too hold the contention balance of Fear and acknowledge the uncertainty of not knowing what Fear really meant here. This is the opening for curiosity for learning, for Lifelong Learning as Ward (2009), says that "we not once formed forever formed but always being changed and in dialogue with other and in life".

Was I reductive too …..perhaps I too 'anchored' too early.

Following the seminal work of Tversky & Kahneman (1974) on decision making and judgments under uncertainty known as Prospect Theory, perhaps it can be contended

that this fear of trauma of tolerating leads to reductionist, anchoring practices towards diagnosis. This perspective contends that we make decisions, we anchor, from what we know, particularly when under pressure, as the findings indicate is experienced by this busy participant cohort. It can be argued that the fixed, rigid, and structured, frameworks of diagnostic practice are indeed attempts to place order on the chaos of trauma, within the constraints of existing practice. An attempt to contain the disordered complexities presented by trauma on early life. In the absence of documented literature on this aspect, this potential rationale attempts to bring understanding to the participants fear and capacity to tolerate the enormity and complexity of children presenting with a trauma history. The literature (as noted in the Literature Review of this thesis) documents the tension of diagnostic frameworks in appropriately addressing trauma symptomology in children, yet with no reference to the tension and caution of working with trauma in practice, that these mental health professionals in this study demonstrate. A question arises for further exploration to the underlying reason for this literary absence.

In the light of the findings, the following section attempts to explore contributing factors that influence the participants positioning towards this phenomenon.

Holding and Withholding the Pressure

The findings provide evidence to the complex practice dilemmas experienced by this cohort, and present concrete challenges to the holding of the suggested substantive theory in their work. As outlined previously the subcategory *Systemic Pressure* demonstrates the pressure experienced by these participants in diagnostic practice from three distinct contexts - professional pressure, resource pressure and parental pressure. The following discussion provides a discursive exploration of the influences of these pressures on diagnostic practice. It also suggests a clinical positioning to these pressures, in an attempt to move towards a recovery approach that supports the substantive theory.

Belcher (2020) identifies the professional pressure that is alive in this cohort's practice experiences, "where doctors should practice at the top of their license" (p. 228). This practice outlined in the findings, drew attention to a participants reluctance to refer a child back to the child's GP, or the absence of freedom to refrain from making a diagnosis, without it challenging the participants professional capacity. This professional pressure indicates an expectation to maintain a professional hierarchy in the field contributing to what was given the property of *professional security* in the findings. This professional

pressure unites significantly with an extended systemic 'bottom up' pressure depicted in the data, from parents, schools, and a wider societal pressure towards diagnosis, where diagnosis is considered a '*currency*' (James) to resources. Copeland et al., (2007) and van der Kolk (2016) draw questions to the increase in disorder diagnosis in children impacted by trauma which underlies the exploratory aim of this study's research question. The insightful participant data that provides a very understanding of the discomfort and tension in the practice field, could suggest a possible correlation between this increase in diagnostic practice and the very real top-down and bottom-up systemic pressure experienced by these participants to form diagnosis.

Higgins (2008) report on 'The Recovery Approach Within the Irish Mental Health Services' suggests a need for measurement of recovery, of developing tools to measure recovery. As outlined earlier in this chapter, the essence of the recovery model is a flexible, subjective, and responsive approach to the individual needs of the child. Yet this flexibility appears to be refuted in this report, with a recovery criterion entering the debate. Surprisingly this suggestion appears to lean support towards a fixed measurement, not unsimilar to diagnostic criteria. This conflicts with the findings of this research study which favour a more individualised response to a child's unique needs, that is acknowledged under the subcategory Movable with the property of subjective. The proposed substantive theory Holding - the Contentious Balance supports the recovery model that focuses on developing a child's capacity to function in their life world, rather than constructing a criterion to measure a child's recovery. Yet, the underlying rationale for the implementation of measurement tools "was considered critical to ensure that the concept achieves its potential and can satisfy the national requirements for accountability and value for money' (p. 47). This accountability to the use of funding, linked to accessibility of resources, aligned with the research findings. As incited in the data "*so, when diagnosis is so closely aligned with funding, everything changes"* (Rick) referring to a Special Needs Assistant (SNA) not being allocated to a child in school as they do not meet the diagnostic criteria. The culture of medical pressure, societal pressure, and financial implications of diagnosis, equating with access to services, further expediated the underlying understanding, that this cohort were indeed balancing conflicting dilemmas, in their practices. This financial pressure, to measure recovery, presents frequency in psychotherapy funding. Documenting outcomes from intensive trauma therapy recovery work is a challenging process, especially for children (Ardolino et al., 2012). Trauma

therapy presents a non-linear approach to trauma recovery "which may happen in 'fits and starts' and, like life, have many ups and downs. Recovery is not about 'getting rid' of problems but seeing beyond a person's mental health problems" (Jacobs, 2015, p. 117) towards the potential for increased functioning. Yet, holding this subjective recovery approach requires expansive funding which accentuates the systemic pressure identified in the findings.

Holding the properties of the moving subjective recovery approach to the complexity of a child's presenting trauma symptoms, is indeed challenging. 'Holding' although active "is concerned primarily with being and its relationship to time" (Ogden, 2004, p. 1362) requiring a focus on the process of restoring functionality for the child rather than determining a measurement of symptoms that determines a diagnostic disorder. In alignment with these findings, recovery is a movable approach rather than determined by a fixed diagnostic criteria. With attempts to straggle the pressure to define quantitative outcomes in terms of numbers and funding constraints, with respectfully honouring the child's "*recovering functionality and their capacity to manage life events"* (Chris), it appears that participants are indeed contending with oppositional difficulties. Although this study acknowledges these systemic pressures outlined in the findings it also questions the rationale that although "Ireland is considered of the wealthiest countries in the world, we are consistently told we have to tighten our belts" regarding funding for children"(Dunphy, 2024, para. 2). The consequences of 'with holding' funding for children to facilitate the slower more individualised recovery approach presented in this study, is potentially alarming where children need to await adequate and timely supports. This evokes a further exploration of the power of money in how child trauma is considered in diagnostic practice. Further research opportunities await.

Holding Uncertainty

Exploring the importance of uncertainty, to the recovery approach, of this substantive theory, is given further expansion below, supported by the literature, ahead of suggesting how this theory might be applied to, and in practice, and the challenges it could potentially present.

The subcategory Tolerating Uncertainty embraces the dichotomy of the Movable and Fixed subcategory. The concept of 'safe uncertainty' developed by Mason (1993) undergirds the subcategory of Tolerating Uncertainty that emerged from the findings. Mason (1993) in his work with social workers in child protection, suggests the development of a "different kind of inquiry, away from trying to find the 'true way' " (p.

38) that tolerates an unknowing, an uncertainty in practice. Adopting a concept of safe uncertainty urges those working with children "to usefully reflect on what they are doing and develop more practice confidence towards taking a position of authoritative doubt" (Williams, 2019, p. 4). To considering this uncertainty and to doubt, in the light of diagnostic practice, suggests a professional challenge, to those in authoritative 'expert' positions. Mason's concept challenges the findings of this study, to professional identity, to participants expertise and credibility that were illuminated in this study, challenges to tolerate the unknown in practice. The question arises as to what does develop a 'practice confidence' that Williams mentioned above, look like, in the light of these findings and the presenting substantive theory? This study's findings demonstrate that a child's lived trauma experience, intersects uncomfortably, with the professional's capacity to tolerate, the fear of the trauma itself, and not knowing, within absence of trauma training, creating a tension in practice. This presents an uncertainty of how to consider the complex presentations of trauma, when under systemic pressure of diagnosis. The memo below reflects on this concept.

Concept Memo: 25/11/23

This substantive theory suggests that mental health professionals adopt a position of uncertainty, as they consider disorder diagnosis with children impacted by trauma.

This evokes questions. Is it safe to be uncertain? Is it ethical? Can we tolerate that dilemma? Conflicting value systems and ethical dilemmas. If we truly work in a child centred philosophy, as questioned in the data, who is the diagnosis for? Is there another parallel here to the presentations of trauma. Uncertainty …Are we being asked to work with trauma in this unknown state, of not remembering with words, not memorise or recall, or recognise? That leaves us as the data indicates- vulnerable. Does this mean we are working with blurred vision? Or ethically, should we?

Yet, Masons theory continues to align with this study's theoretical proposal, and speaks to this very issue of professional identity, suggesting the efficacy of holding a position of 'authoritative doubt'. This is not a passive positioning as Mason (1993) affirms, but presses towards "the ownership of expertise, in the context of uncertainty" (Williams, 2019, p. 4). The *knowing /not knowing* properties of the Movable category concur with this

concept as advocated by Chris in the findings as he commented "*always be mature enough to be able to think for yourself and always be big enough to be able to get it wrong*". The foundational concepts of safe uncertainty are focused on professionals straggling these two positions. One of knowing and expertise, and the second of 'not knowing', of curiosity and uncertainty (Williams, 2019). This is identified by Mason (1993) as crucial, so that a position of 'premature certainty' (p. 191) is not reached too early. Adopting this perspective towards this phenomenon, in diagnostic practice with children impacted by trauma, is pivotal. As Mason (1993) explains,

> for useful change to happen we sometimes need to become less certain of the positions we hold. When we become less certain of the positions we hold, we are more likely to become receptive to other possibilities, other meanings we might put to events. If we can become more open to the possible influence of other perspectives. (p. 195)

Adopting this positioning of uncertainty speaks to the foundational construction of this substantive theory. Holding this antithesis of authority and uncertainty, further reinforces the tentative balance, the juxtaposition posited by the findings of this study. Yet tolerating this uncertainty that emerged in the data, allows for movement in a clinicians response to a child. These are essential theoretical and practical frameworks towards embracing the substantive theory of Holding - the Contentious Balance. The section below further examines how holding a recovery approach to children impacted by trauma impacts practice.

Holding a Recovery Approach

This study acknowledges the serious challenges placed on this cohort as they navigate the core category the Contentious Balance, as they consider diagnosis with children impacted by trauma. The dilemmas and challenges, to adopt a new perspective, beyond the fixed rigidity of diagnosis, to consider the possibility of Carl Jung's (1875-1961) perspective where "in all chaos there is cosmos, and in all disorder a secret order" may seem intolerable or even unbalancing, in practice. Dr Maria Corbett, as CEO of the Child Law Project in Ireland, drew attention on national radio to the complexity of children's mental health, and the widespread practice of placing the traumatic issues experienced by children, into defined boxes. Corbett highlighted that, "child mental health services are seeing more complex cases where there is a mix of issues. We need to stop putting children in boxes and expecting we can put them *neatly* in boxes" (Corbett, 2022).

This study hopes to contribute an alternative perspective, towards resolving this practice tendency, that the participant data depicts. This study's substantive theory Holding the Contentious Balance proposes a movement beyond the fixed rigidity of diagnostic practice that presents uncomfortably to this cohort, in their practice with children impacted by trauma. As noted above, the substantive theory suggests adopting a recovery orientated approach to children impacted by trauma. the section below provides a contextual understanding of this approach as identified in the literature, but also how this might apply to practice.

The concept of recovery entered the debate in the 1980's (Jacobson & Greenley, 2001) with interesting findings from an Irish study. 'A Recovery Approach Within the Irish Mental Health Services, (Higgins, 2008) draws attention to the terminology used to position recovery, in the field of trauma. The report contends that the term 'model' creates a "potential for confusion with other more defined scientific approaches to care such as nursing and medical models" (p. 40). The report argues that this oppositional tension may be helpful but undermines the subjective person-centred approach to mental health care. Tension in the field was further demonstrated by the wide debate considering the use of 'recovery approach or philosophy' with term "recovery-oriented service" (2008, p. 5) considered to be more appropriate to this cohort. It suggests that even a move to a recovery concept towards trauma is not without an underlying contentious debate in the field.

The recovery approach involves movement towards collaboration, extending beyond "the tenacity of self-contained systems" (Kuhn, 1976, p. x) of not knowing, the definitive outcome, that presents with diagnostic criteria. This requires the clinical and '*mental flexibility'* that was identified in the findings, to facilitate movement beyond the safety of what is known and what is existing diagnostic practice. It requires a "shift from a traditional medical model approach to a more developmentally sensitive, neurobiological guided perspective" (Perry, 2009, p. 248) This requires a wide window of tolerance, to encompass the complexity of a child trauma experiences and symptomology. The fundamental principles of Charmazian grounded theory, viewing data through a social constructivist lens comes to the fore, as this substantive theory intersects with the medical way of thinking and fixed approach to diagnosis, indicated in these findings. Jacobs' (2015) assessment of "psychiatric models that tended to view recovery from mental illness similar to that seen in physical diseases" (p. 117) reinforces the tension experienced by this

cohort, as they hold the rigid properties of diagnosis and endeavour to implement a "non-linear, recursive process" (Mental Health Reform, 2013, p. 6) to trauma recovery, with children and young people. It is perhaps Krupnik (2019) that best describes a functioning alterative, that "overcomes the dichotomy between the highly inclusive dimensional and the categorical PTSD-bound views of trauma" (p. 258) and is best fitting to the substantive theory of this research study. This flexibility suggested through a "hybrid dimensional/categorical" perspective (Krupnik, 2019, p. 258) holds the contentious balance of working within the existing diagnostic framework, yet also considers the complex implications of child trauma.

This study's substantive theory of Holding the Contentious Balance as child trauma is considered in diagnostic practice, indeed challenges existing practice. Yet this theoretical framework emerged from the findings, grounded, and constructed with and through, the very cohort who not only implement, but potentially influences practice. The substantive theory evokes a question. Could the wider mental health, educational, social, contexts of a child (Bronfenbrenner, 1979) impacted by trauma, be invited to move beyond the fixed, to a place of tolerating uncertainty, towards a position, as indicated in the findings, of "*holding diagnosis tenuously"*? This research demonstrates that we, as researchers and clinicians working in mental health care settings, have "found ourselves caught between competing realities" (Hummelvoll et al., 2015, p. 2) endeavouring to balance the complexities of these findings, which present as a disorientating dilemma (Mezirow et al., 2009) to the existing fixed diagnostic framework.

Multiple questions arise to how this study can inform practice. Could mental health professionals, as this study suggests, balance the complex and conflicting dilemmas of considering child trauma in diagnostic practice? What if the field of psychiatry and psychology didn't experience the pressure "*to connive with the system"* (Rick) with their concerns around the rigid, fixed complexity of diagnostic practice? How can the findings contribute to a wider multidisciplinary debate. What do we do with the findings? How do we respond? What does recovery look like in practice? There is essential foundational work to consider as the collective, 'we' moves beyond our cognitive communities (Merton, 1968) and fields of practice to answer these questions. As highlighted by the Irish Mental Health Commission, there is a pressing need towards adopting an integrated response, that priorities "effective interdisciplinary communication" (Higgins, 2008, p. 49) facilitating a

cultural shift, a movement towards a different philosophy of knowing, and tolerates uncertainty amidst the multi-dimensional and systemic complexity of trauma. The implications of these questions on practice and recommendations for practice are considered in the following chapter.

Holding the Challenges

This substantive theory poses challenges to theory and practice. Some are presented below in a curious, memo like format, as where they originated. Within the limitations of this study, the challenges are not definitive or resolved, but add to the ongoing debate and potential for expansive interaction in the research and practitioner communities**.**

Within the important challenge of adopting the theoretical framework of this substantive theory, also lies a potential risk. If we hold the contentious balance between trauma and diagnosis, and don't label child trauma under a diagnostic disorder, is there a risk that the impact of trauma won't be recognised? Cruz et al. (2022) identifies this concern that "a wide range of medical and psychological comorbidities frequently go unnoticed with classical PTSD diagnostic approaches, and, therefore, are often underreported and, in turn, untreated" (p. 2). This research study identifies the complex representation of children impacted by trauma, being distinctly different to that of physical presentations, where pathways to care for cancer, or a broken limb, would present clear directions towards recovery and functionality (Chris). Yet questions arise that without the symptomology of trauma, coming under a disorder diagnosis, "there's no impetus to create a path to treat them" (Beem, 2024, para. 2). Therefore, the caution arises, under current practice, that without a diagnosis, children's trauma presentations may not be given the due attention, and emphasis for intervention.

The findings illustrate how participants experience parental pressure to diagnose. The findings draw attention, concurring with the widespread literature, to the significant impact of early attachment trauma on a child's functionality (Perry, 2014). Yet, a tense dynamic influences this dilemma. Early childhood trauma is frequently at the hands of a child's primary caregivers which frequently "remains unrecognized both in our diagnostic systems and in our dominant treatment paradigms" (van der Kolk, 2016, p. 267). Working with parents' "guilt and shame, knowing their responsibility for a child's condition" (Barlow, 2023, p. 43) is fundamental. Yet, overcoming the stigma for parents,

acknowledging their deep underlying accountability for the attachment ruptures, is sensitive work, undergirded by relational trust. Functional recovery pathways, as suggested in the findings, as an alternative to diagnosis for children impacted by trauma, need to include functional pathways for the child's parents and their families.

The subcategory Tolerating Uncertainty is supported by an unexpected property that appears to influence this cohort's engagement and tolerance towards a child presenting with a trauma history. The findings identify a significant gap in training, indicating a need for this cohort to access child trauma training, so that they can indeed 'stay with' their patients rather than 'passing them on' as the findings indicated. Mate (2019) highlights the influence of training on practice contending that that there are "built in hidden biases of the medical orthodoxy that most physicians absorb during their training and carry into their practise (p. 3). The question arises as to what influence does this limited, or absence of trauma training, as the findings indicate, have on practice, on the professional and on the patient/client? Ludwik Fleck (1891-1961) as a pioneer of the contemporary social constructionist movement, contextualises the influence of training on practice, identifying that "during their training and specialization, future specialists adopt a given thought style and learn to see reality in accord with it" (Groodman, 2010, p. 10). Integrating this understanding, indicates that without training in trauma, these psychiatrists, and psychologists experience "an intrinsic constraint" (Kuhn, 1976, p. x) and stay within a thought collective, that aligns in practice, with their training. Although Gibson et al. (2019) advocates that "specific medical training enables individuals to think systemically and to go beyond the superficial presentation of a problem" (p. 134). The minimal half/1day trauma training accounts in the data, suggests a limited capacity for this cohort to address the multiplicity of presentations that undergird early life trauma. This gap in trauma training, points to a significant challenge in adopting the proposed theory which leads towards recommendations, in the following chapter.

The challenging subcategory of Tolerating Uncertainty that is undergirded by the fear of engaging with the trauma, displays new insights into how psychiatrists and psychologists perceive and experience working with child trauma. The findings contribute a clear understanding to the inhibiting factors influencing psychiatrists and psychologists' engagement with child trauma as they diagnose. The surprising lack of training in trauma, for this cohort, indicates a felt sense of not being equipped and as indicated in the findings as lacking 'professional security' in practice. As Perry (2009) advocates that all

professionals in the field "must become fully developmentally informed to understand and address the problems" (p. 241) related to trauma experiences. Thus, presenting a professional challenge, to this cohort who are frequently seen as experts in mental health care. The expansive trauma literature provides no documented evidence to support these findings, yet the findings presented here documents active practitioners engaging in the real-life worlds of children impacted by trauma. This presses towards pursuing further research evidence.

This movement towards adopting a recovery approach that embraces uncertainty, presents challenges to professional identity. Higgins (2008) documents these difficulties acknowledging that "professional resistance may occur in different forms and can include concerns about the fundamental power shift implicit in the recovery model, attitudinal barriers, and possible resistance of mental health professionals, may have difficulty moving from a paternalistic approach to care, to one that involves more equal partnerships" (p. 42). This awareness and sensitivity to a professional's capacity or expertise is fundamental in proposing collaborate change.

Holding this Phenomenon

The findings represent important learning for my own therapeutic practice, and to the wider audiences, in psychotherapy, that all mental health care professionals, awaken to conversations, of risking the difficult dilemmas, towards this phenomenon. Acknowledging the complexities this study's cohort face, their underlying challenges of working within a medical way of thinking and the presenting limitations to resources, for children without a diagnosis, is essential. With a growing awareness in therapeutic practice of the critical impact of children's early traumatic experiences (Goodyear Browne, 2019; Levine & Kline, 2019; Siegel, 2012), the following chapter will include implications and recommendations, evidenced from these findings, that can inform therapists but also for those working with child trauma, 'within and beyond their disciplinary origins' (Charmaz, 2014, p.16).

This study's explicit and implicit responses demonstrate a cautious tension to how participants work with child trauma in their diagnostic practice. It can be suggested that this is not from a lack of 'definitive knowing' by this highly competent cohort. But perhaps points to an attempt to communicate the significance and complexity of this research phenomenon as a "profoundly serious issue" (Maskey Report, 2022) in Ireland. This

positions this research study as timely. In the light of national advocacy for children on national radio, Ailbhe Conneely reported that, the "Government has been urged to prioritise children who are subjected to physical and emotional abuse, neglect, household violence and other forms of trauma" (Conneely, 2022). This research undoubtedly acknowledges the significant dilemmas of child trauma in practice, with the substantive theory suggesting an opportunity to 'hold', to embrace, the opposing properties representing the contentious balance, towards this phenomenon. The findings indicate that holding the subjective Movable nature of child trauma in tension with the Fixed rigidity of diagnosis is indeed a Contentious Balance that is strongly impacted by the systemic pressure that these participants experience.

National media recently drew attention to alternative perspectives, that lend support to the substantive theory of Holding the Contentious Balance. What is interestingly termed the "revolutionary potential of precision medicine" (Lowery, 2023) explains that person centred approach that is referenced in the data, as the differential diagnostic model. This perspective aligns with the recovery approach to considering an alternative positioning to a fixed diagnostic framework, to a differential diagnosis, which flexibly aligns with the presenting individuality of a child's trauma experience. This approach proposes an ability to balance diagnostic practice, holding the contentious balance between the child's subjective presentation and the need to formulate pathways of care for the child. It requires a clinical positioning, that considers the impact of the child's trauma experiences, that "prioritises reflection and responsibility, over instant reaction" (Kahneman, 2011, p. 135) that gives way to the systemic pressure of fixed diagnostic practice.

Conclusion

Holding -The Contentious Balance proposes that mental health professionals working with children impacted by trauma, widen their window of tolerance, of discomfort, towards this phenomenon to "become fully developmentally informed to understand and address the problems" (Perry, 2009, p. 241) that this study presents. Although the literature locates the predominance of this phenomenon in a contentious debate of the DSM and ICD diagnostic frameworks for children impacting by trauma. The substantive theory of Holding the Contentious Balance, extends that debate, inviting conversation, towards integration, a co construction of the existing medical model towards a recovery model to trauma and diagnostic practice. This necessitates a tolerance, of

flexibility, and movement towards all fields adapting a recovery approach that can be 'uncertain' and 'unbalancing' but that focuses interventions on "human characteristics rather than medical or psychological diagnoses" (Satchwell et al., 2020, p. 874). This posits a shift in practice for all fields working with children impacted by trauma, collectively 'holding' a valued position that, "what is essential to understand about recovery, is that a person's unique experience, is the starting point for all actions" (Hummelvoll et al., 2015, p. 2). Adopting this theoretical proposal requires a shift in philosophical thinking, in positionality, of risking to straggle the known, and the unknown, to stay open.

It challenges all those engaged in child and adolescent mental health care, to embrace the wise words of Rumi (1207-1273) "There is a field beyond right and wrong …I'll meet you there."

Chapter 6: Implications and Recommendations

Introduction

This chapter summaries the main implications of this study. It outlines the potential contributions this study can make to practice, in psychotherapy and the wider systemic field of professionals working with children impacted by trauma. This chapter evaluates the quality of this study as outlined by Charmaz (2014) addressing the strengths and limitations of this study. Recommendations for potential future research and study are included throughout. Reflexive memos are integrated throughout the chapter, acknowledging the principal of co construction underlying this CGT, of the inter-connectedness of practice and research, where "*your preparation for the real world is not in the answers you've learned but in the questions, you've learned how to ask yourself"* Rainer Maria Rilke (1875 – 1926).

Key Contributions of the Study

This study draws attention to the complex interaction between child trauma and disorder diagnosis, as demonstrated through the practice of child and adolescent psychologists and psychiatrists in Ireland. In aligning with this study's aims and objectives, this study explores the practice perspectives of how psychiatrists and psychologists working in the field of child and adolescent mental health, consider child trauma in their diagnostic practice. It is the first known study to address this perspective, making a contribution to a field that is predominately focused on a retrospective approach to adults impacted by trauma. Many international studies, as reviewed in Chapter 2, have documented the significant impact of child trauma on the child, advocating for the need for child trauma to be reconsidered in the existing diagnostic frameworks. Yet, no studies have given exploration to the underlying influences and factors, that emerge, as practitioners in the field engage with the existing diagnostic frameworks, in their work with children and young people impacted by trauma.

This grounded theory gives an understanding of the challenges and dilemmas that these mental health professions experience, as they balance the tensions of the diverse properties and contrasting concepts of child trauma and diagnosis, in practice. The findings indicate that psychiatrists and psychologists working with children and adolescents

impacted by trauma, straggle very real systemic pressure, from their profession, and from children's parents. This is accompanied by a mental health and education system that is dependent on a disorder diagnosis, for the provision of service and resources, for the child. As discussed in Chapter 5, the contrasting philosophical and practice approaches to the subjective movable nature of child trauma, and the fixed rigidity of disorder diagnosis, that is criteria and symptom led, place these concepts not only in tension theoretical and philosophical, but more significantly create tension and dis-ease in this sample cohort in their practice.

The review of national and international literature documents the concerning increase of disorder diagnosis in children, many with a complex trauma history. The literature also highlights the constraints of the current diagnostic framework to account for the complexity and individualised movable nature of child trauma, displaying a tension in the field, that advocates for a restructuring of more appropriate child centred dimensional approach, to child trauma diagnosis. The findings of this study stand apart, as it captures this tension, evidenced and grounded in the participants data, and contextualised through their practice. Although the findings highlight the straddling and balancing these child and adolescent psychiatrists and psychologists, contend with, as they work within the systemic pressures, the findings depict further complexity underlying this phenomenon. The study also displays an uncertainty to how this sample engage with trauma, influenced by their limited trauma training, and their capacity to tolerate the intense complexity of a child's trauma experiences. Categorized as Tolerating Uncertainty this new insight generated in and from the data, not only emphasises the contributing factors that these participants need to contend with, and attempt to balance, as they engage with this phenomenon, but also contextualises an alternative, a resolve for these dilemmas. It presents a potentially more fluid perspective, and practice approach to diagnostic practice, that suggests a shift to current practice with child impacted by trauma. The question arises as to how this study's findings and theoretical proposal, contribute to the field of psychotherapy. These implications are explored below.

Implications of Study

Charmaz (2000) challenges researchers to " make a difference in the realm of ideas and in practical action" (p. 542). The section below attempts to illustrate this contribution

situating this study within existing practice contexts. Implications of this study on practice, and potential impact for interdisciplinary collaboration is explicated.

Although there is expansive literature on the diagnostic frameworks that are considered appropriate for child trauma identifying an "increased awareness of trauma's detrimental effects on development, as well as on behaviour and engagement" (Dermody et al., 2020, p. 10). This study contributes to the absence of research, that explores the practices of mental health professions who work with these diagnostic frameworks, as they engage with children impacted by trauma. Trauma is, as van der Kolk (2017) explains, "not the story of something that happened back then. It is the current living imprint of pain, horror and fear living inside people" now (p. 197). The aliveness of the data correlates with this concept of trauma. This study captures the active engagement with this phenomenon, and it is this positioning in the 'real life worlds' of mental health professionals that gives this study its greatest strength.

Implications for the Field of Psychotherapy

Hernandez et al., (2024) advocates that "the healthcare system should establish bridges, and actively engage in their strengthening processes to enhance the outcomes, between psychotherapeutic interventions, mental health services and clinical settings within the healthcare system"(p. 1). As this study intersects between disciplines, I would like to consider this study presents an instrumental bridge, from the field of psychotherapy, towards the field of psychiatry and psychology. This suggested claim is significant, as, it is indeed, a complex interaction where, although movement has been made to integrate the fields "no firm footing has been found" (Ritvo & Cohen, 2013, p. 892). The anticipated reluctance and resistance that external colleagues had suggested I would find, as I attempted to recruit, and then interview, did not follow through in this research study. The research process and findings were to the contrary, with participants engaging with honesty and openness, and a spirit of generosity towards their practice and this phenomenon. The data provided a rich insight dismissing the *"idea that psychiatrists don't care about recovery, they're very concerned about those things. But trying to hold them in balance along with treatment, along with the fact that there is some evidence of a medical model that runs in parallel, and also just with balancing of human rights, yeah"* (James). This rich engagement supported by this study's findings, and the open manner in which this participant sample engaged in this study, suggests very concrete evidence that

acknowledges a bridge of shared understanding between the fields "despite periods of competition and challenges to integrating approaches" (Ritvo & Cohen , 2013, p. 891). The accessibility of this cohort stretched beyond expectations, creating possibilities for conversations and bidirectional learning (Hernandez, 2024) towards integrated interventions, for children impacted by trauma. The memo below reflects on this tension, between the professional fields working with children and adolescents impacted by trauma, but more importantly on the opportunities for interconnection between the fields of practice.

Memo: 7 Oct 2023 (excerpt)
I awoke this morning with the concept of 'positioning'. Not that its new but shifting.

Further research could explore the positioning of psychotherapists in the child trauma diagnosis dilemma. What do therapists do with disorder diagnosis? How do they relate to psychologists and psychiatrists in the field? What about an integrated approach of service delivery towards recovery?

Have I colluded with this separatist approach, mono profession approach. I question have I been blind sighted? As I speak with therapists in the field, they frequently comment on their interest in my research ''ooh…. so needed'. It is as if 'we all know' …But what do we know?…. I need not collude, but next time ask, why? This is research in and of itself.

Potential Repositioning: This research highlights where psychotherapists can position themselves in this complex field. Gives an understanding of the contextual landscape of diagnosis and trauma. What is frequently considered a top down….WE diagnose and then YOU (therapists) work with it. This research also rebalances the power. As I was exploring the research question, I was told, by the academic field, don't go there, 'I wouldn't go next or near your research". I persevered, despite other psychotherapists also commenting, "That's going to be very difficult". "I'm sure you'll have some resistance".

I had much to reconstruct, to reclaim. A possible recovery between the fields…research in action?

The recent Mackay Report on CAMHS in Ireland (2023) acknowledges the deficits in mental health care, for very vulnerable children. As noted in the recruitment section of the Methodology Chapter, much needs to be done to encourage these mental health professionals working in an already stretched field, where "*it is demoralising*, *…there are very few quick wins* (James), and "*so you work harder and longer*" (Sara). In the construction of this substantive theory, I would hope that an opportunity for

interdisciplinary discussion, grounded in the data also reconstructs, and socially reconfigures this cohort as generously accessible, giving insight into the straggling diverse and challenging dilemmas in practice. Goodyear- Brown (2019) in her significant work with children impacted by trauma, speaks of the myriad of trainings for professionals and adults working in the child's systemic world. She posits that "none of these is as important as the holding environment created by the clinician" (p. 72) to contain the child's 'big' feelings, as they wrestle with acting out their trauma experiences. This study gives insight into a participant cohort that appear under immense pressure, and perhaps too need to be 'held' before they can endeavour to hold the complexity of children's trauma experiences. "Recovery occurs via many pathways" SAMHSA (2012, p. 5) and a recovery between the fields, that begins with a shared understanding of the complex dilemmas this cohort experience, is a formative place to begin.

Implications for Psychotherapy - A Systemic Approach

The central role of recovery in child trauma underlies the substantive theory of Holding- the Contentious Balance which aligns with the Irish Mental Health Reform Strategy (2023-2028). This intersecting relationship between 'holding' and 'recovery' is fundamental to psychotherapy practice, where psychotherapy positioned as a recovery approach, is often held in tension with the medical model of diagnostic criteria (Ritvo & Cohen, 2013).

Children impacted by trauma have "somatically, emotionally, cognitively and relationally encoded trauma responses" (Goodyear-Brown, 2019, para. 2) and present to therapy with challenging behaviours and complex symptomology. Many already present with diagnosed disorders, with limited access to the psychiatrists and psychologists who form these diagnoses, beyond the assessment report presented by parents, or requested by the therapist. Although "demand for therapies among users and service providers, should be regarded as a fundamental component of basic mental health services, rather than viewed as additional options" (Mental Health Policy, 2020) significant gaps persist. Belcher (2020) as a practicing psychiatrist, contributes to this debate contending that "psychotherapy is the sine qua non of psychiatry", as frequently the clients full story is "inadequately captured by the diagnostic criteria" (p. 229). This advocacy towards intersection of practices is significant, and Belchar (2020) further contends the interrelationship between the fields, advocating "that not all psychotherapists are psychiatrists, but indeed all psychiatrists are psychotherapists" (p. 229). Yet much

therapeutic intervention for children takes place separately to CAMHS and Primary Care services, where a child was initially referred by their GP. Therapists frequently work 'in between', the waiting for appointments, after discharge, or at times, before referral to these services. This study's findings concur with my supervisory and family therapy practice which observes the growing societal and parental pressure, to identify the child's presenting behaviours in a disorder diagnostic framework. The concept of 'holding' in this study's substantive theory proposes and advocates for psychotherapists to press towards the complexities of ethical considerations and complex interactions, to work alongside these Primary Care services, where children with trauma symptomology, first present to services. This systemic approach undoubtedly provides an opportunity for child and adolescent psychiatrists and psychologists, to work together with psychotherapists, integrating strategies that inform a child's pathway to recovery.

As highlighted throughout the discursive implications of the findings, the impact of trauma presents in a subjective diverse manner, in each child. Subsequently therapeutic recovery approaches need to adapt likewise, with individual, child centred practice. Yet, the complexity arises when funding enters the field of recovery (Ritvo & Cohen, 2013) with a systemic pressure similar to that experienced by this study's participants. Trauma therapy can be a long process, requiring a safe contained space, with intensive training for the therapist and a trusting relationship for the child. 'Holding the contentious balance' of funding is difficult, where certainty of outcomes and the measurements of therapeutic sessions is unknown. Communicating these factors of trauma recovery to the child's wider systemic life world of children, is essential. This balancing of limited resources, funders, and expectations, be that parents who are paying privately or in services offering short term interventions 6/12-week sessions, is difficult. It is concerning that "economic factors and corporate influences continue to threaten the practice of psychotherapy within child and adolescent psychiatry" (Ritvo & Cohen, 2013, p. 892). It is again a tentative balancing process where long term early life stress, requires long term therapeutic recovery, which requires long term funding.

This study presents an insightful lens, emphasising that "the intergenerational nature of adverse childhood experiences necessitates a paradigm shift" (Dube, 2018, p. 3) in how child trauma is considered in existing diagnostic practice. This study presents a very real engagement with a mental health field that is balancing the complexities of child trauma, whilst working under systemic pressure and the challenges of a medical model,

that promotes diagnostic outcomes. This new understanding of the underlying difficulties this cohort experience or inhabit, when working with children impacted by trauma in their practices, gives opportunity for shared interdisciplinary communication. This gives potential for debate, opening multidisciplinary collaboration in, and with, other fields engaged in a child's lifeworld. Jacobs (2015) contends that "health professionals often have reduced expectations" (p. 119) towards recovery. Yet, as the findings indicate, a wider systemic network have contributed to the expectations and pressures required of child and adolescent psychologists to "*do something*" to indeed "*fix*" (Trevor). For as evidenced in this study, the systemic factors that influence how "diagnostic decisions in real clinical contexts may be influenced by patient preferences, clinician biases and pragmatic considerations" (O' Connor et al., 2020, p.1112). Further work is needed to expand the understanding of this systemic influence on practice, to provide a more evidence base to informing a wider cohort in this debate.

Implications - Trauma Recovery, Policy, and Politics

Employing the workability of this substantive theory draws attention to the policy and political issues that may arise as mental health professions contend with the constraints and systemic pressures that emerged in the findings. The acknowledgement of child trauma as "a grave psychosocial, medical, and public policy problem that has serious consequences for its victims and for society (Debellis & Zisk, 2014, p.185) indicates the timely relevance of this study. Yet, suggesting change to a mental health structure "means a battle against the dominating ideologies of evidenced-based medicine originating in the medicalisation of mental distress (Hummelvoll et al., 2015, p. 5). Wong & Laird (2023) press towards the conceptual holding of this substantive theory, advocating for a practical shift in mental health beyond the medical model, "a movement from a symptom based, clinical treatment model, that adheres to a particular school of thought but towards integrating multiple modalities" (p. 7). Thus, acknowledging the movable subjectivity of a child's trauma experience and recovery needs.

The Mental Health Reform (McDaid, 2013) also presents a valuable, practical insight into the cultural shift required in our Irish context, towards advocating the recovery approach that undergirds the substantive theory proposed in this study. The report indicates the need for collaboration with the primary carers of children and young people in understanding a recovery orientated model. This forms a vital role in managing

expectations of all those engaged in the systemic world of children, “rather than seeking cure and stability at all costs” (McDaid, 2013, p. 28). The recovery model views mental illness from a perspective radically different from traditional psychiatric approaches. Recovery is often referred to “as a process, an outlook, a vision, a conceptual framework, or a guiding principle” (Jacobs, 2015, p. 117). The Mental Health Reform (2013) approaches mental health recovery with an interesting balance, respecting the subjective individuality of trauma that aligns with this study. It advocates for a joint approach to recovery where all professionals work in mental health services as facilitators, ‘coaches’ or ‘guides’ in partnership with the person with mental health difficulties, to support their recovery. Thus, not undermining professional competency and expertise, but acknowledging the challenge that mental health professionals may need to “let go of a long-held ethos and embrace the recovery paradigm, to soften their expert role, and to recognise that there are many types of expertise” (Mc Daid, 2013, p. 28).

This policy perspective, that invites a ‘letting go’ of the pressures of fixed diagnostic paradigms, allowing for a co joining, an integrated approach and “development of policies that involve multisectoral participation” (Hernandez et al., 2024, p.1) to diagnosis and recovery. Yet challenges await as outlined by Higgins (2008) in the Irish National Mental Health Strategy, acknowledging that “the major barrier to promoting (the recovery model) is the inflexibility of a paternalistic and powerful medical model which has held sway in determining the philosophical and practical direction of mental health services for the past hundred years’ (p. 41). This presents a key challenge in implementing the proposed theoretical approach, where trauma training is limited and “oddly enough, even though neurodevelopmental principles impact all child-related disciplines, we rarely teach the core concepts and facts of neurodevelopment to our trainees in education, social work, medicine, law, paediatrics, psychology, and psychiatry” (Perry, 2021, p. 253). The consequences of theses absences and gaps in developmental trauma training, are significant, and can be suggested, that without which, the existing contentious and complex practice balancing for mental health professions, will continue. It appears fitting that Holding – this Contentious Balance has the potential for “greater benefits in recovery when these actions are integrated within the sociopolitical context” (Hernandez et al., 2024, p. 1) where the diverse interdisciplinary fields, engaged with children and young people impacted by trauma, work colaborately.

Quality of the Study

With the implications and potential challenges of the study outlined above, evaluating the quality of this study is essential, in assessing its contribution to the field of research and practice. Although criteria for evaluating the quality of a grounded theory research study can vary (Charmaz & Thornberg, 2021) in the light of this study grounded in the Constructivist Grounded Theory approach, the criteria of credibility, originality, resonance and usefulness (Charmaz, 2014) will be applied to this study.

Credibility

Evaluating credibility refers to the strength of the study's application to CGT methodology. It assesses the precision and coherence to the tenets of CGT, that are distinctive to this qualitative research approach. Credibility was established by applying CGT methodology to each transcript with intensive analysis of the data beginning early (from first interview). Each interview was transcribed within days of being conducted, attending to the 'aliveness' of the data. These transcripts were printed out, frequently noting observations differed in hard copy, than on the computer screen. Attending to the data, applying line by line coding, coding for implicit and explicit actions and meanings, observing patterns and variations across the transcripts. An iterative process of comparison, going back and forth between manuscripts, allowed tentative categories emerge, with theoretical sampling increasing depth and support for categories, elevating theoretical concepts but also collapsing categories which weren't adequately and accurately supported in the data. Memo writing provides a comprehensive understanding of processes, of reflexively attending to the emerging relationships between the categories. Employing these CGT analytical methods rigorously increased the creditability this study, of being truly grounded and constructed from and in, the data.

Originality

Evaluating the originality of this research has been given considerable attention in the contributions and implications above. In evaluating originality, it is important to reiterate that this study is the first research (known at present) to make a contribution to this limited area of study. The insights into the practice perspectives of mental health professions on this tense and increasing phenomenon in child and adolescent mental health, is understudied, nationally and internationally. The potential capacity for these findings to promote increased understanding of the very systemic pressures and the

professional gaps in trauma training that impacts this sample, is yet to be unfolded. Yet, as noted above, this study's findings, grounded in evidential insight, provides opportunities to bridge and interconnect conversations between multidisciplinary fields. The substantive theory presented here opens the debate to consider alternative approaches to the existing frameworks, when clinicians across the mental health fields, parents and services, account for the symptomology of children impacted by trauma.

The 'somatic alertness' that was employed as a tool to analysis, presents an original approach to this qualitative research study. The integration of my therapeutic training in sensory motor psychotherapy (Ogden, 2015) and my extensive experience of 'listening to' the unspoken in therapeutic practice, was instrumental in discerning the implicit, in the interviews and interpreting the findings. Trauma recovery therapy requires this somatic attunement, an embodied alertness to the exchange, to 'the unsaid' between people. It allows for a dept of understanding, a 'felt sense' and frequently requires 'risking' the exploration with 'the other.' Many years of practice, working with children, young people and their families impacted by complex trauma, has equipped me to trust this powerful engagement and to use it as informant, in the therapeutic recovery process. The unexpected emergence of this somatic alertness as a significant resource and tool in this research, sets it apart as an exploratory model for further qualitative research.

Resonance

Resonance in research refers to the quality of the research being deep and full so that it portrays the studied phenomenon and the proposed theory as recognisable and relatable. It is the ability of the research findings to 'click' or 'strike a chord' (Baden & David, 2018) with the participants or relevant field.

The questioning of the data and of self, in the analytical process was pivotal in developing resonance in this study. Reflective memos that developed into conceptual memos as the tentative categories emerged kept me 'in check' interpreting meaning from the participants data that was representative of their perspective, rather than viewed through my own positional lens. Adapting the interview questions to applying theoretical sensitively in subsequent interviews gave an opportunity to 'test' the resonance of meaning, I was giving to analysed data. This was instrumental in assessing the 'fit' of the emerging theory to the participants experience and perspective. Acknowledging my experiential resonance to the studied phenomenon was formative from the beginning, as the research topic was selected and as the aim and objectives were developed. Evaluating

how the categories authentically represented this cohort practice was essential, by being attentive to the tension illustrated in the trauma and diagnostic literature, by speaking with colleagues in the field, critically evaluating their perspectives in the light of the emerging findings. Resonance as agreement and resonance as action (Ruthven, 2020) emerged in the analytical process as theoretical saturation developed. This was particularity relevant in evaluating the receptiveness of the concept of contentious balance, that depicted the conflicting dilemmas that this sample needed to contend with, in their diagnostic process. Where data sufficiently supported the emerging theory, it was indicative of a resonance that captured participants experiences and perspective.

Usefulness

Usefulness refers simply to the purposeful use of the analysis and findings, and the workability of the substantive theory. The strength of this study's usefulness is its location in the real-life practice contexts of mental health professionals working with children and adolescents impacted by trauma The substantive theory is a construct situated in existing perspectives not retrospective, or third-party observations. The inclusion criteria to this study represents those clinicians that consider diagnosis with children and young people as daily professional practice. Its usefulness is determined by the challenging resonance the core category of Contentious Balance has for this cohort, acknowledging the significant dilemmas they face in considering a child trauma in their diagnostic work. The category tolerating uncertainty, both illuminates the absence of, and the need for trauma training for these professionals so that they can both engage and tolerate, the real live worlds of the children impacted by trauma, presenting in their practices. These very practical influences have not been documented in any of the reviewed literature, and so this study places value on advocating for increased training and awareness to the systemic factors that may influence the increase in disorder diagnosis in children and young people, presenting with a trauma history.

It is also considered important to draw attention to the objectives of this study. It is considered that the aim to consider the perspectives of mental health professionals was fully met. The objectives as set out in the introduction to this thesis were considered to be realistic and coherently, yet objective 2, 'To explore how mental healthcare professionals' respond to a child/young person's trauma in the assessment process" was effectively considered in the subsequent objectives. Exploration of the assessment process and diagnosis consideration appeared to overlap in the interview process and so could

potentially have been collapsed into one objective. I had initially questioned the need for the first objective "To examine the meanings of childhood trauma, from the perspectives of psychologists and psychiatrists". Yet this objective was instrumental in establishing the participants contextual perspective on this phenomenon, which formed the common-sense category of understanding trauma as Movable.

Limitations of Study

This study presents cultural limitations. Conducted by a white middleclass, educated professional in the therapy field, with a sample from an urban Dublin setting in Ireland, gives this study an inherent perspective. All but one, of the participants were from a Western Culture, which gives a pre-determined western-ethnocentric (Wong & Laird, 2023) perspective on how trauma is perceived, experienced, and communicated. The concept of diagnosis also carries a cultural influence where attention to diagnosis assumes attention to symptomology, within a funded medical practice that supports this attention. The understanding of trauma presented in this study is predominately an individual, subjective response to a child's experience or environment. Yet, concepts of trauma may have been very different if conducted with a sample exposed to collective trauma, war, natural disasters or with differences in language or medical developments (Alisic, 2011). The transferability and viability of the substantive theory also depends on a joint collective understanding of the impact of trauma, assuming a pursuit of alternative best practice for advancing responses to child trauma. This again is culturally bound but also economically situated in a Western culture where basic subsistent living is assumed.

This study has focused on the trauma as individual to the child and young person yet undergirding this study is the understanding of the significant impact of community trauma. This is beyond the scope of time and focus of this study but awaits further exploration. For community trauma evokes a community response, "recognizing that many individuals cope with their trauma in the safe or not-so safe space of their communities, it is important to know how communities can support or impede the healing process" (SAMHSA, 2014, p.17). The interconnected role of community on trauma and community on recovery requires a cohesive 'joined up thinking' implementation strategy and to provide a safe, secure 'holding' for children and young people impacted by trauma. Future research on how community trauma contributes to trauma symptomology and how/ or if, it is considered in practice, awaits.

Inclusion and Exclusion -The Child

Alisic et al., (2011) highlights the absence of 'child trauma theory' in the research field with the innovative work of Levine & Kline (2019) Siegel & Bryson (2012) making significant contributions to theory, practice, and research in the substantive area of child trauma. Acknowledging that creative, child centred, and international development is slowly advancing across the academic sector and therapeutic fields, initial literature research findings indicate an absence in child trauma theory, with underdeveloped academic study in this field. Campbell (2019) qualifies the importance of this integration of theory on practice, advocating that, "theory serves a variety of purposes directly related to empirical research and interventions, such as interpreting new research data, responding to new problems, evaluating solutions, discerning priorities, interpreting old data in new ways, and identifying new research directions" (p. 45). Therefore, the development of child trauma theory is essential for theory and practice, regarding assessment, diagnosis, and treatment interventions for children. The philosophy that "grounded theory has generated innovative ideas since its earliest beginnings", is inviting as I position myself as novice researcher, and displays the potential its concepts can contribute, "within and beyond their disciplinary origins" (Charmaz, 2014, p. 16). Although this study did not set out to gain a child's perspective to trauma and diagnosis, I was acutely aware of the absence of the child's perspective throughout the study sampling and in the write up. The review of the literature conducted for this study did not draw insight on how the child or young person would express their trauma experiences but displays terms in the literature that are used by external adults or professionals, experiences of children. The reflective memo below illustrates the wrestling, the limitations on the positioning I took, with the exclusion of the child, in the research process.

Parallel Pressure - Memo 15/2/24 *I have sensed the systemic pressure too. A top down. We may call it academic rigour but a pressure to move beyond looking at the child. As Mike says, "to funnel everything down and get the diagnosis right". Have I also succumbed to a similar pressure to 'funnel down the child's perspective' to get the research process right? Have I colluded with a reductionist approach to research? The process, the product…but what about the person. The child? I keep moving the section I had written about the child's voice in literary research around from chapter to chapter, reviewing where it will fit. Is this what happens in practice with children impacted by trauma.*

The recovery literature speaks of the rhetoric of "fighting to recover", this is what I do as a trauma therapist with children. I fight for extended sessions, fight for a shift in culture towards funding for long-term sustainable model of interventions. Not a once done therapy, fixed modality. I work with the children's parents', draw in the often-absent parent, their teachers, project workers. Did I fight enough to have their voice heard in this research study. Did I tolerate the external pressure and resistance and hold the contentious balance to move beyond the ethical dilemmas of engaging directly with children. The questions linger. Yet, I reflectively answer. I know that the experience has been incongruent for me. It sits parallel to that of the participants.

Further research awaits in this field, to intentionally, ethically, and sensitively, include a child's perspective on their lived trauma and how this is included or taken notice of, in both their diagnostic and recovery process. It is understood that this study is indeed a preliminary research study in this field, which I hope will contribute to my learning in pursuing post-doctoral research in this complex, but limited area of study.

Holding - The Contentious Balance: In Practice

The question arises as to what this substantive theory means in practice? How does it relate to clinical practice for professionals, as children and young people come to services with "differing presentations of trauma related disorders" (Cruz et al., 2022, p. 2) that are frequently accompanied by a history of trauma. The substantive theory proposes a linked-up approach to service, to envision a biopsychosocial approach, a nondualist thinking, a movement beyond an either or, but a both/and engagement with the complexity

of a child's trauma experiences. A capacity to embrace the knowing and not knowing in diagnostic conceptualisation of trauma symptoms. A holding of the tension and contention that this study's sample attempt to balance. Perhaps, we as professionals need to tolerate the uncertainty, the complexity of child trauma that presents as a very real contentious balance for this study's participants. Yet, to embrace this proposed theory generated in this study, requires not only systemic changes, but a shift in the intersection of our personal and professional capacities to tolerate the trauma, to be heard and held (Angelou, 1969) in our practices. For, " holding requires a lot of self-holding on the analyst's part. And holding patients usually isn't gratifying; it can feel oppressive, limiting, and can leave us thinking that we're not doing enough work. It's not only our patients who need holding" (Slochower, 2018, p.113-114). The challenges to adopt alternative approaches to existing diagnostic structures has been discussed extensively here, in the light of the literature and this study's findings. Yet the challenges to self, as mental health professionals in practice, are equally significant, contending that for children impacted by trauma "life is not an outcome" (Davidson et al., 2012) but can provide flexible opportunities, to be held, in recovery.

Conclusion

The underlying philosophy of Constructivist Grounded Theory (Charmaz, 2006) is illustrated by Tennyson, "*I am a part of all that I have met*" (Ulyssess, 1833) encapsulating the relationship between my role as researcher and the research. This study challenged by positionality, my perception of 'the medical way of thinking', providing deep insight into how, and why, this cohort experience a contentious balance, as they consider child trauma in their diagnostic practice. The substantive theory Holding - the Contentious Balance acknowledges and presses towards the intersecting dilemmas that invites all mental health professionals working with children and young people, to tolerate the uncertainty**,** of working in "this complex context where cause and effect aren't linear. It recognises that we can't know everything whilst allowing us to recognise our own strengths and value" (Williams, 2019, p. 4). 'Holding' the conflicting challenges of this study's findings in balance, envisages the potential of adopting a flexibility to diagnostic practice, in theory and practice, allowing the "child dance towards and away from the trauma" (Goodyear - Browne, 2019, p. 19) towards recovery.

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Appendices

Appendix A: Introductory email

9 March 2023

To whom it may concern,

Thank you for taking the time to read this introduction.

I am currently undertaking research studies towards my Doctorate in Psychotherapy in DCU, School of Nursing, Psychotherapy and Community Health and I would like to invite you to consider engaging in my research study.

Trauma has become a controversial topic. Media coverage in our Irish context has predominately presented it retrospectively, in response to institutional abuse (Reilly & Dolan, 2016), with Kaffman (2009) identifying child trauma as a *silent epidemic*, in our society.

Having worked in the education, community, and psychotherapy sectors for the past 30 years, I have observed children and young people presenting to my work as a family therapist, with increasing complexity. Many of these children and young people present with diagnosed disorders and an underlying history of trauma.

As a practitioner researcher, I value the crucial role psychiatrists and psychologists working in mental healthcare play in assessment, disorder diagnosis, and interventions, for many of these children and young people.

With very little known of presentations of children to psychiatric services in Ireland (Maguire et al., 2020), this study seeks to gain the perspective of mental healthcare professionals, on how child trauma is considered in their diagnosis process, with this complex cohort.

If you are a psychiatrist or psychologist working in child and adolescent mental healthcare in Ireland and are open to exploring the possibility of engaging in this study, through a 1-1 interview, or would like to know more about the study, I would welcome you to contact me @ joy.winterbotham4@mail.dcu.ie

All contact will be in the strictest of confidence and obligation to partake is not assumed. It is also understood that your potential engagement in the study, with opinions and responses being that of your own, and not a representation of your service, organisation, or employer.

I would also appreciate it if you would kindly forward this invitation email to other mental healthcare professionals in your network, who may be interested in participating.

Your time, amidst what I can imagine is a busy work schedule, is much appreciated.

Kind Regards,

Joy Winterbotham

Joy Winterbotham B.Ed., M.Sc., M.

Appendix B: Plain Language Statement - What is this research about?

Research Study Title

How is child trauma considered in disorder diagnosis with children and young people?
A Grounded Theory Study of the perspectives of Child and Adolescent Mental Healthcare Professionals in Ireland.

Who is conducting this study and why?

The Research Team:

- Principal Investigator: Joy Winterbotham, Doctorate in Psychotherapy Candidate, DCU, School of Nursing, Psychotherapy and Community Health. joy. winterbotham4 @mail.dcu.ie

Supervision Team

- Dr Gemma Kiernan, Associate Professor in Psychotherapy; School of Nursing, Psychotherapy and Community Health, Dublin City University. Gemma.Kiernan@dcu.ie

- Dr Mark Philbin, Assistant Professor in Health and Society; School of Nursing, Psychotherapy and Community Health, Dublin City University. Mark.philbin@dcu.ie

This study aims to gain an understanding of how child trauma is considered by Child and Adolescent Mental Healthcare Professionals in their disorder diagnosis with children and young people in mental healthcare in Ireland. Semi -structured Interviews, will be reviewed and analysed using a grounded theory methodology to form a constructive theory that contributes to practice with children and young people who present with disorder diagnosis.

Participant Engagement

Participants will be invited to partake in a 45-minute, 1-1 semi structured, audio recorded interview with the researcher, in a context that is best suited to the participant. Involvement in the research study is voluntary, and participants may withdraw consent from the study at any point. Participation in the project will end, at the point of withdrawal. All/ partial data can be withdrawn without reason. If withdrawal needs arise, please contact the Principal Investigator directly.

Use of your Data: **Privacy and Confidentiality**

- The principal researcher acknowledges DCU as the Data Controller and will observe all DCU privacy and data protection protocols in relation to the data you provide.
- It is important to highlight that confidentiality of information provided cannot always be guaranteed as "Confidentiality of information can only be protected within the limitations of the law - i.e., it is possible for data to be subject to subpoena, freedom of information claim or mandated reporting by some professions." I will communicate clearly with you if this arises.

- Any identifiable data in the interviews will be anonymised prior to being transcribed. This transcribed interview will be used to inform the emerging theory, using grounded theory methods of analysis.
- It may be necessary to clarify details, or potentially request a second follow up interview to further develop and inform the study. (Consent is requested in the Informed Consent Form)
- Any personal data, clinical practise, views, opinions, and direct quotes will be anonymised before use in analysis and Doctorate findings write up.
- It is understood by the principal researcher that the participants' data, containing views, comments, and opinions, are that of the participants own, and not that of their service, organization, or employer.
- Your data will only be shared with the named research supervisors (above) for the purpose of guidance and supervision of the study. Your data will be confidentially destroyed / deleted after a 5-year retention period, (starting from the researchers Doctorate thesis publication, and presentation of findings to DCU's External and Examiner, (Projected September 2024 - September 2029).
- It is important to highlight that the Primary Investigator acts as the Data Processor and may hold or process personal data but does not exercise responsibility for or control over the personal data, in relation to the external transcription service, or Google Drive as a software hosting site.

Your Data Protection Rights

- It is not foreseen that data will be transferred outside the EEA (European Economic Area). Yet in the light of the data's potential contribution to publication articles or presentations Internationally, the data once transcribed will be desensitized and anonymized, prior to analysis and theory construction or possible dissemination.

- Participants have the right to access their own personal data at any stage. If required, please contact the Principal Investigator directly or alternatively DCU Data Protection (details below).

- If you should have any complaints or concerns regarding the use of your data, the DCU Data Protection Officer–Mr. Martin Ward can be contacted (data.protection@dcu.ie Ph.:7005118 / 7008257) or contact the Irish Data Protection Commission.

If participants have concerns about this study and wish to contact an independent person, please contact:

The Secretary, Dublin City University Research Ethics Committee, c/o Research and Innovation Support, Dublin City University, Dublin 9. Tel 01-7008000, e-mail rec@dcu.ie

Appendix C: Informed Consent Form

Title of Research Study:

How is child trauma considered in disorder diagnosis with children and young people? A Grounded Theory Study of the Perspectives of Child and Adolescent Mental Healthcare Professionals in Ireland.

I, (print name) ……. have read this study's plain language statement and understand the study's aims and objectives.

Please read the statements below carefully and tick the box to give your consent. If you have any questions or any clarification is needed, please ask the researcher.

- ☐ I agree to an audio recorded 1-1 interview with the researcher and understand that I may be asked to contribute to further questions or interview by the researcher at a later stage.
- ☐ I understand that my personal data will only be shared with the principal researcher and their research supervisors.
- ☐ I understand that the researcher considers all views, comments, and opinions to be that of the participants own and not that of their service, organization, or employer.
- ☐ I understand that my views and opinions and direct quotes may be presented in non- identifiable form in the final Doctorate thesis, and I consent to the use of my anonymised data for future papers/ presentations, and potential use for publication.
- ☐ I understand that participation in this study is voluntary, and I can withdraw consent or use of my data at any time.
- ☐ I understand that every attempt to protect confidentiality will be adhered to within strict DCU's GDPR guidelines, yet *"Confidentiality of information can only be protected within the limitations of the law - i.e., it is possible for data to be subject to subpoena, freedom of information claim or mandated reporting by some professions."*
- ☐ I understand that my data will be securely stored on DCU's Google Drive and all data in digital or hard paper form will be permanently deleted and confidentially shredded by the researcher after a retention period of 5 years (September 2029).
- ☐ I have read and understood the information in this consent form, and I consent to take part in this research study.

Participants Signature: _____

Name in Block Capitals: _____

Contact details: Email: _____ Mobile**:** _____

Date: _____

Appendix D: Interview Guide

Participant Interviews -Protocol/Checklist 28th March 2023

- ✓ Introduction. Thanks/Appreciation
- ✓ Tell a little about self. Interest Topic Children young people and families 30 years/ education/ community/psychotherapy sectors
- ✓ Plain Language Statement
- ✓ Recorded interview- 45 mins? Anonymised, data desensitised.

Reminder: Understood that all views, comments, and opinions are that of your own and not that of their service, organization or employer.

- ✓ Consent Form
- ✓ Any questions?

Interview Questions

1. Your Role: Informational Facts:

- What is your current role in the mental healthcare profession? *How long?*
- Tell me about your previous experience/roles and training.

2. Child Trauma Meaning/ Concept

- When the term/concept of child trauma is used. *What does that mean to you?*
- What informs your understanding of child trauma? Any literature, life experiences, training that informs you?

3. Child Trauma and Assessment

- In your practice how do you/ *or do you* determine/identify if the child/young person has experienced trauma? Any criteria?
- In your practice, What part *if any* does a child's trauma history take in your assessment processes with children and young people? *Is it included?*

4. Child Trauma and Disorder Diagnosis- How/ Whether/ Significant?

- What role (if any) does child trauma take, in your work in diagnosing disorders in children and young people?
- On a scale of 0-10 how significant would you consider child trauma, when making a disorder diagnosis. (10 being highly significant).
- Would you like to say more about why you scale it in this way?

5. Challenges/Changes to practice in this area - (if any)

- What challenges are you and other professionals facing working in this field with children and young people impacted by trauma?
- What changes (if any) would you like to see, in Child and Adolescent Mental Healthcare, in regard to working with these children and young people who have a trauma history/ and are diagnosed with a disorder?

6. Open Exploration/Comments

- Are there any additional thoughts/ opinions that you would like to contribute to this study?

Appendix E: Ethics Approval Letter

Ollscoil Chathair Bhaile Átha Cliath
Dublin City University

DCU

Dr Gemma Kiernan
School of Nursing, Psychotherapy and Community Health

19th January 2023

REC Reference: **DCUREC/2022/235**

Proposal Title: **How is child trauma considered in disorder diagnosis with children and young people? A Grounded Theory Study of the Perspectives of Child and Adolescent Mental Healthcare Professionals in Ireland**

Applicant(s): **Dr Gemma Kiernan, Dr Mark Phibin, Ms Joy Winterbotham**

Dear Colleagues,

Thank you for your application to DCU Research Ethics Committee (REC). Further to expedited review, DCU REC is pleased to issue approval for this research proposal.

DCU REC's consideration of all ethics applications is dependent upon the information supplied by the researcher. This information is expected to be truthful and accurate. Researchers are responsible for ensuring that their research is carried out in accordance with the information provided in their ethics application.

Materials used to recruit participants should note that ethical approval for this project has been obtained from the Dublin City University Research Ethics Committee. Should substantial modifications to the research protocol be required at a later stage, a further amendment submission should be made to the REC.

Yours sincerely,

DCU
Research & Innovation

Taighde & Nuálaíocht Tacaíocht
Ollscoil Chathair Bhaile Átha Cliath,
Baile Átha Cliath, Éire

Research & Innovation Support
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E research@dcu.ie
www.dcu.ie

Dr. Melrona Kirrane
Chairperson
DCU Research Ethics Committee

Note: Please retain this approval letter for future publication purposes (for research students, this includes incorporating the letter within their thesis appendices).

Appendix F: Debriefing Information

As a result of your participation in this study you may experience a need to debrief. Or you may experience stress, or discomfort, that you consider outside the normal range of engagement in your work. If you find this emerges during, or after participation in this study, please contact the following services for help and support.

Your engagement in these services is confidential and independent of this research study, with no known relationship between these services and the Principal Investigator.

- **Healthy Living Centre**, DCU Glasnevin Campus.
  - Contact: the Healthy Living Centre at 01 7007171 for an appointment. At your first appointment you will be given an opportunity to speak with one of the practitioners and you will then be offered psychotherapy, or you may be referred to a more appropriate agency.

- **Samaritans:** For After Hour Support including 24/7 helplines please contact: http://www.samaritans.org/branches/samaritans-dublin-branch
  - Telephone: **116 123** (A national 24/7-hour helpline) For 24-hour confidential email Listening Support
    email: **jo@samaritans.org**

- **Your Mental Health** A national HSE 24/7 mental health information and support services information helpline. Telephone: **1800 742 444**

- **Aware** A national support helpline for issues relating to depression and anxiety. http://www.aware.ie/

- **Pieta House** Telephone: 1890 303 302 Pieta House, Preventing suicide and self-harm. http://www.pieta.ie/contact-us Telephone: 01 8831000 - Dublin North

Appendix G: Coding Sample

Coding "line by line, clump by clump" (Morse et al., 2021, p. 5)

The first area of inquiry was focused on Objective 1: To examine the meanings of childhood trauma, from the perspectives of psychologists and psychiatrists.

Below demonstrates excerpts from 4 interview participants, with my questioning of the data (in blue) and my initial coding (on the left) to the question: When you hear the term/concept Child Trauma – What does that mean to you?

the sizing /measure of trauma depending on the child

SASHA: 11/4/23… "means that…the child has experienced something that they can't process properly… so trauma I'm thinking of it quite broad. So unfortunately, we have a very high correlation between disability and what you think of trauma. So, in the narrow sense like abuse em… traumatic birth, traumatic hospitalisation trauma, traumatic, can also be, depending on the child can also be like sudden separation or postnatal depression. All those things where it's not just the one huge event that causes trauma. Not just one cause of trauma large. It can be a lot of small events."

Defining trauma Offering tools for guidance Identifying unlisted events The dance of knowing not knowing Uncertainty Confusing Attempting to clarify Sizing

LEAH 14/4/23 "Child trauma? Yeah, I mean, it means a variety of different things. And yeah, I suppose for me it really means a child, somebody from zero to 18 having adverse life experiences that impact them, maybe emotionally, psychologically. But trauma. Yeah, trauma has a big connotation. So what, what exactly that looks like…it can, ..there's the ACE, the ACE checklist or the 8th question there. That kind of is some guidance in it for me. But at the same time, I know that there are other events in a child's life that can lead to trauma's that aren't on that list as well". Just over time, a parent not being emotionally available, you know, not understand, not communicating their understanding, maybe dismissing their child's feelings. That kind of emotional. And are they are not….. It's not abuse that's happening. It's just the maybe emotional. …I think neglect is probably too strong word even for it, because it's not neglect, it's… the parents are trying. You know you can see this, this, this dance. The parents are not…. They're… they're... they want to. They're trying to fix the emotional problems that the child has, but they're just not… maybe…not understanding or not knowing how to…. Spawned in a way that's…. Constraining for the adolescents or the child. (Later in interview) I mean, I suppose you kind of maybe… and maybe this is kind of where I get little, uhm…, and I do think maybe I get a bit confused with kind of child trauma. I'm not confused….., but that there is difference between child trauma or is there a difference in child trauma and attachment? You know ruptures and……

Size of trauma Perception of trauma Inability to define. Cautioning around defining trauma

Helena: 27/4/23 It doesn't mean one thing to me, OK, so it means…..I suppose. I hear trauma and my first thing is the huge range of what trauma can be, to a particular child. So what is trauma to one child is not necessarily trauma to another child. And I think it's very important to always remember that that even sometimes, what some would perceive as it's a minor incident can represent trauma to one child and what might be what some would perceive as a huge incident might not necessarily present as trauma.

Moving back and forth in uncertainty

Finding resolution in trauma being subjective

Mandy: 20/4/23 Yeah, I guess it can mean….. yeah, can mean so many different things, I suppose. Broadly speaking, it's probably anything that happens to a young person, a child that is so upsetting that it changes something in them, that there…., it kind of leaves a mark in a way that's quite damaging, or,….and I think it's not just about the actual event that happened, but it's so much about how it was what happened afterwards, in terms of…I suppose, how it's processed if it's something like… sometimes a child might have experienced the same thing as another child. But if there's certain things not in place around the child to support with processing that event, it could kind of manifest itself in a more kind of traumatic way. I think trauma is very subjective.

Hesitation, halting uncertainty in defining.

Labelling as constraining

Societal isolation of labelling the child

Internalizing the concept of trauma

Cautioning Permanency of label

Presenting alternative perspective of change in labelling

Shirley: 27/4/23 I suppose because there's so many ideas and different approaches to looking at trauma, and I suppose there's ideas about trauma, informed trauma focused different, you know. I suppose to differentiate between a trauma focused approach which is specifically focused on an idea that people need to process trauma in a particular way and then there's trauma informed. Which is maybe informed about different ideas about trauma. So I suppose I wouldn't in terms of the trauma focused idea I would see it as one potential avenue to go with children. But not the only way or it would be I suppose there's. …it was just…. I suppose there's no gold standard approach exposed to working with trauma. That my idea would be that each child and family is unique as they respond to the experiences that they've had, is unique, and we need to tailor and adapt our approach our language…. you know….our positioning to each family, so I suppose it's multi… it's multi ….there's multi. I think some of the ideas about trauma and thinking about trauma and focus helps us or, sorry, trauma informed. It can be helpful because it shines a light on how people, children who've had, or adults who've had experiences where the ACE's, or you know, it's recognising that these have an impact and giving them a name and a label sometimes can help. But it also, I feel can be a bit constraining sometimes if we're seeing that as it maybe doesn't then attend to the wider context and the relational pieces and how they might influence you know, families, relationships, communities. How they potentially might also have varying on a person's life. And I suppose sometimes trauma can be viewed as something that's internal to the person. Yes….and that you know that it's part of them and it's going to be part of them for the rest of their lives and its…. they have to…. You know…. rather than thinking about something that could be…. Um…I suppose adopted or by their relationships… or could be changed in some way or that better context might have an influence.

Appendix H: Reflexive and Conceptual Memos

Memo A.

Co-creation, Co-construction, or Power? A stance of not knowing, a bended knee.

Philosophical Challenge Conversation with Consultant Child and Adolescent Psychiatrist. January 2023.

I internally observed myself during this conversation. A good friend, I've known him and his family personally for years and yet something of our differences truly emerged.

I've been reflecting on this idea of Co creation and Co construction. Realising how I sit with this concept comes from an understanding of how I relate in my field and as a person. Yet something happened in this conversation. The power dynamic emerged, with me as not knowing and him as knowing, came strongly to the fore.

This conversation has impacted my research journey, the language I used, my concept of being strong in my field. Yet, I knew in the midst of this, what was a friendly conversation shifted to something different. As I submitted my understandings of child trauma, my questions about disorder diagnosis, I was met with a very strong knowing from my friend. He is after all a national expert in the field of child and adolescent psychiatry. But what of the integration of co-learning, of shared ways of knowing, not either/or, but, both/and?

I came away with the ideal of a shared partnership in a shared exploration being but an ideal. I need to assume a state of unknowing and abandon me. Positioning that I don't know, and you do. This was an important learning for me as I approach the interviews. The power dynamic, the academic field, the 'Big Other' of the psychiatric medical profession….it was rising in the conversation. I could sense an embodied lowering of self…this was not equal territory. This is going to be a challenge of positioning myself going forward. And yet how do I remain congruent to who I am and to the research that I am invested in. Where is the co…?

So, there is a sense of surrender, submit.

I am loaded with experiential knowing of these professions, loaded with bias. I am very far from value neutral. Am I too far over that line? Perhaps being younger to the research field would be easier? Less influences, less experiences of life, less assumed knowing. CSRA, Critical Self- Reflection on Assumptions. My supervision training is awakened. I am challenged.

Memo B.

***Clumsy*. Beginning the Analysis 15/4/23.**

Being visual, I tried this analysis on paper first, gathering the data from the range of interviews, developing line by line analysis, coding, and correlating concepts. I had a visual picture of how I would map the codes out on paper, gathering, and adding, comparing, and contrasting. Yet, as I engaged with the data, it appeared a 'clumsy' method and I was surprised by my unease, as though I was envisaging that I would have to repeat the process in print again. I returned to print on the computer, correlated the information from the interviews under the main question areas, which were based on the

objectives originally set out. Cutting and pasting, adding, and removing, reshaping, and forming. Identifying importance. I need to be careful that I don't 'prune' too early. It is a tendency I am aware of. This CGT methodology requires me to acknowledge that I might need this data later as other concepts emerge with further interviews. Patience, induction rather than deduction….and so at this stage I just need to collect…sort, observe… question.

I need to allow the data form… and shape, the structure.

Memo C.

Balancing the Methodology Phase. **Memo Sequence. May 2023**

10/5/23 Blocked by the need to create a template sheet to code a neat display of the coding process…. Excel perhaps?...text boxes… columns…. I lost hours defining my boxes rather than the codes. Perhaps typing and trying to 'order the disordered' was inhibiting movement. I needed to sit with the physical messiness of this process.

11/5/23 I return again to the hard copy, colour coding again and handwriting line by line, action codes in the left side margin…. even the operational aspect of this coding process is iterative…a back and forth working out what functionally works best. Even amidst my strive to place order on this process.

12/5/23 I sense progress. This feels like movement, tactile visual progress. Reminding myself to stay close to the wording of the data in the transcript. Extracting enough of the direct words to create an active code, rather describing the data in thematic codes. I had made this mistake initially. I am now hopeful of progress. 'Trust the process' I often say as a supervisor…it is the affirming knowing I give myself amidst the chaos of some family therapy sessions. Trust is emerging.

Memo D.

The Accountancy of Pharmacy. **Forcing in Practice. 30/4/23**

I am alerted. As I reread and edit the transcription of Rick's interview."The medication of children is calculated accountancy" (Rick 13/4/23). In response to Ricks comment, I noted how quickly I interpreted a response, "it's very profound what you're saying there about the accountancy of pharmacy". I am alerted early in the data collection, to the real engagement with the concept of forcing the data. It was not until I went back to analyse Rick's transcript did I notice the shift I had made in the language and underpinning that, the shift in perspective and my own construction. My own lens was blurring the data, I had gone ahead of Ricks language.

Memo E.

The Granite Quarry. **Analysis: Construction and Saturation. 8/10/2023**

He asks inquisitively how 'it's' going? I describe the likeness to a quarry. I see it. A hardstone granite quarry. I recognise it. The inquisitive trails of my childhood come into view. It is dark and I am in deep. This time, cutting the stone and manging to remove large boulders. I keep cutting and feel the enormity of stone here. The echoes of the cut stone quarry. But I'm tired. Of not knowing when or what I'm to make from this. When I use

these stones outside the quarry walls to form 'something'. A theory? Construct a theory. I'm not a geologist but I learnt to recognise granite years ago. Its strength, its' pillar positioning at the entrance of farmyard gates. I can see the granite sparkle. I don't know how many I'll need, or how large they need to be. I feel an offering of 5 loaves and two fishes too meagre. This is hardstone, granite construction, not loaves and fishes. I want to see the clusters of boulders, forming. A construction offering. When do I leave the quarry, or will I keep that lingering pull of entering and re-entering?

Memo F.

***Emersed in Methodology*. Theoretical Saturation/ Sufficiency 18/9/23**

Document reading, journal entries, recommended books, lecture notes, PhD thesis… "all is data" as Glaser said. ALL, the continuous supply of data to inform me of What is Grounded theory?... and then what is GT according to Charmaz. "Oh, that writer explains the philosophy clearly, and yes this theorist expands that contention, and I resonate with that concept". Information overload and a hunger to understand, to discern. Perhaps that writer describes CGT philosophy more critically? I keep going until a copious collection of information demands a halt. And yet the internal questioning continues, "Have I read sufficiently"? Many are saying the same thing, differently. I read over my collection and am alerted to many repetitive concepts. Even some quotes are similar. Theoretical saturation in practice…. no new concepts emerging. I sort, place them under headings, remove and shape the paragraphs. Discarding, refining, and defining as I go.

A growing awareness arises in me…. This process in of itself, is grounded theory methodology in practice.