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Trauma Therapy: Exploring the Views of Young People in Care

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ABSTRACT

Young people living in residential care are more likely to have experienced past abuse, neglect, and adversity that result in the experience of trauma. Their subsequent behavior can present challenges to care-givers and hinder their engagement in services designed to help them understand and manage such experiences. This research aimed to explore young people's views on what traumatized youth need from therapists to help them understand and respond to their experiences. Six young people aged 14 to 17 years old, residing in residential and secure care in the United Kingdom, were interviewed. Thematic analysis found three global themes related to the need for therapists to; involve young people in decision-making, take time to build trusting relationships, and create the right environment for treatment. Additionally, the findings indicated that alternatives to trauma therapy could be useful, which did not necessarily involve trauma exposure, and that this could be facilitated by primary care-givers as well as therapists, implying a need for more structured and integrated approaches between multi-disciplines involved in the residential care of young people. Young people's views can assist in the development and design of future trauma-informed and trauma-focused treatment services within residential care settings.

KEYWORDS

Trauma; looked after; young people views; therapy; residential care

Introduction

Young people in local authority care, specifically those living in residential settings such as children's homes, residential schools or secure care (Connelly & Milligan, 2012), have often experienced high rates of adversity including physical, emotional and sexual abuse, neglect, domestic violence and removal from the birth family itself (Rahilly & Hendry, 2014; Simkiss, 2012). For example, a study of 52 looked after young people found that 69% had experienced neglect, 48% physical abuse, 37% emotional abuse, and 23% sexual abuse (Chambers, Saunders, New, Williams, & Stachurska, 2010). Similarly, Johnson (2017) found that of a sample of 96 young people (74 males and 22 females), in Scottish residential and secure care, 51% and 68% had experienced emotional abuse, and 58% and 68% had been exposed to

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domestic violence respectively. More representative studies indicate that over 67% of young people had experienced at least four or more different types of adverse childhood experiences as defined by Felitti et al. (1998), and Briggs et al. (2012) found that young people in residential settings, when compared with those in non-residential settings, reported both higher rates of trauma exposure and higher rates of impairments. In addition to this, Salazar, Keller, Gowen, and Courtney (2013) found that 80% of young people studied reported at least one traumatic event in their lifetime, albeit this study involved young people in foster care as opposed to residential care.

These experiences have the potential to be extremely distressing and fulfil numerous definitions of psychological trauma. This includes the criterion specified for a diagnosis for posttraumatic stress disorder (PTSD) in that causal events must include; death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence (American Psychiatric Association, 2013) and also wider definitions based on the nature of the experience, for example trauma as experiences that are 'out of the ordinary' and overwhelm the person's mind, body, and capacity to cope (van der Kolk, 2003).

These experiences can have a lasting effect on young people in a number of ways. Ford, Vostanis, Meltzer, and Goodman (2007) found that looked after young people were 19 times more likely to be diagnosed with PTSD compared with young people living at home. Morris, Salkovskis, Adams, Lister, and Meiser-Stedman (2015) found PTSD symptoms to be high in a sample of 27 looked after young people, with 75% scoring greater than or equal to the threshold suggestive of PTSD, higher than estimates from samples of non-looked after young people. There may be longer term effects too; Poole and Greaves (2012) suggest that such early complex traumatic experiences have an overwhelming and lasting impact across a range of functioning. This fits with studies on the wider population that suggests adversity experienced in childhood increases the likelihood of mental and physical ill health (Felitti et al., 1998; Newbury et al., 2018; van der Kolk, 2005).

The rates of exposure to traumatic stress both prior to and during care and its association with later difficulties highlight this group's particular need for effective support. Many approaches aim to achieve this including those specifically designed for young people in residential care. These focus on different levels, from the macro organizational ethos (Bath, 2008) to the individual trauma-focused therapy level (e.g. Cohen et al., 2010).

There is growing consensus that psychological therapy for complex trauma takes a phased based approach (UKPTS Guidelines, 2017). This includes a primary focus on stabilization followed by phases that explore and approach the traumatic experiences and then focus on consolidation of progress and planning for the future. Many approaches or treatments largely subscribe to these stages including Trauma-Focused Cognitive Behavioral Therapy (e.g. TF-CBT; Cohen, Mannarino,

& Deblinger, 2006), Eye-Movement Desensitization and Reprocessing protocols (EMDR; Shapiro, 2001), and Progressive Counting (Greenwald, 2008).

TF-CBT (Cohen et al., 2006) is an evidence-based treatment approach designed for traumatized young people and their families, to help break down difficult trauma memories and develop resiliency in managing negative emotional and behavioral responses resulting from their experiences. This brief method (8–25 sessions) has been shown to provide effective results across several randomized controlled trials (Cohen, Deblinger, & Mannarino, 2016). However, the residential population can be considered unique and complex, so directly applying the results of these studies poses some difficulties (Knoverek, Briggs, Underwood, & Hartman, 2013). EMDR (Shapiro, 2001) and Progressive Counting (Greenwald, 2008) are both brief trauma resolution methods where the individual is asked to recall a traumatic memory whilst the therapist uses a bilateral sensory input; in EMDR this is side-to-side eye movements or hand tapping, and in Progressive Counting this is counting from one to 100. Both these methods have been shown to be effective in reducing the impact of traumatic memories, but research on the use of these methods within residential settings remains limited and based on small sample sizes (Lovelley, 2008; Zelechowski et al., 2013).

Each of these modalities emphasizes a focus on approaching and exploring the experiences of trauma in some way. Modalities differ on whether this exploration uses writing, narration, imaginal exposure and more but most if not all include the individual young person facing their experiences, rather than avoiding them (Cohen, Mannarino, Deblinger, & Berliner, 2009). This can be a significant endeavor and raises important complex ethical and technical issues within therapy.

Few studies have explored whether exposing young people to past trauma is necessary; however, Deblinger, Mannarino, Cohen, Runyon, and Steer (2011) studied four TF-CBT conditions with adolescents to compare treatment outcomes; two treatment conditions included the trauma narrative component and two omitted it. Positive outcomes followed all four treatment conditions, indicating that there can be positive outcomes without exposure to past traumatic experiences.

Dittmann and Jenson (2014) have been the first to study young people's perceptions of engaging in trauma treatment. They interviewed thirty 11 to 17 year olds following TF-CBT. The majority of young people found that trauma exposure work was helpful, despite their initial fears. This was aided by positive therapeutic alliances and being taught distress-management skills. However, seven young people found the therapy unhelpful, with the trauma exposure work being particularly unhelpful; some felt pressured to talk about their trauma and in doing so felt worse; and four dropped out of treatment. In a similar study, Salloum, Dorsey, Swaidan, and Storch (2015) explored parents' and young people's perceptions of parent-led, therapy-assisted

trauma therapy. 17 parents and 16 young people aged between eight and 12 years old were interviewed. 62.5% of young people found the relaxation exercises to be most helpful, followed by trauma exposure work (56.3%). They found that 18.8% of young people wanted to avoid the trauma narrative component as they disliked it or found it unhelpful. Five parents and six young people did not provide feedback on the treatment. Whilst both these studies provide important insights into the views of traumatized young people, the relatively small sample sizes and qualitative methods make wider generalization more difficult. A further limitation of both studies concerns the lack of information gathered about why some dropped out of treatment and why the trauma narrative component was considered unhelpful. Additionally, the study samples did not include looked after young people who are arguably well placed to contribute to this discussion.

There is a strong argument for seeking young people's views on this area; however, gaining service users' views remains a neglected area of research, with studies tending to focus on the perspectives of therapists when trying to understand how to improve therapy (Lowe & Murray, 2014). Service users have unique perspectives, highlighting views that are not necessarily considered by professionals (Auerbach & Silverstein, 2003; Gilbert, Rose, & Slade, 2008). Studies that have sought young people's views on mental health and residential services show that they have valid and reliable opinions about how such services can be improved (Copley & Johnson, 2016; Plaistow et al., 2014). Much research has suggested that even when young people are considered vulnerable, they can still make important contributions (Johnson, Ferguson, & Copley, 2017; Dance & Rushton, 2005; Mudaly & Goddard, 2006), as well as having a right to participate in service design (The United Nations, 1989); and they can provide the most reliable source of information regarding their own lives (Morrow & Richards, 1996). Despite this there is evidence that they are not always consulted on decisions regarding their care (Aubrey & Dahl, 2006), and that service evaluations are conducted without their views (Cavet & Sloper, 2004).

Seeking the views of young people who have experienced traumatic events seems particularly important given the values of collaboration and empowerment underpinning many trauma supports. For example, Hanson and Lang (2016) developed a framework to achieve more responsive and effective services for people who have experienced trauma. Gaining input from young people in the planning and development of trauma-informed systems is one of the core components of this framework. This is consistent with other trauma-informed core principles such as the Three Pillars Framework (Bath, 2015), The Sanctuary Model (Bloom & Yanosy-Sreedhar, 2008), and Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol (Fallot & Harris, 2009). However, Audit Scotland (2010) note there has been a general lack of consultation with young people in the development of new services.

Beyond the trauma-informed model, there are additional arguments for the involvement of young people. There is evidence that service design is failing young people; and those who have the greatest need are often those least likely to seek support (Plaistow et al., 2014) or who are more likely to respond poorly to the services available (Zelechowski et al., 2013).

Qualitative methods are able to provide in-depth accounts that allow for greater understanding of therapy as experienced by the service-user (Klein & Elliott, 2006). Such methods have been used successfully when examining service-users perspectives following therapy for many conditions, such as psychosis (McGowan, Lavender, & Garety, 2005; Messari & Hallam, 2003), depression (Clarke, Rees, & Hardy, 2004) and with individuals suffering from eating disorders (Laberg, Törnkvist, & Andersson, 2010). As noted above, similar research has explored trauma therapy, although only limited to TF-CBT (Dittmann & Jenson, 2014; Salloum et al., 2015) and not related to young people in care.

It is evident that when developing trauma services for young people in residential care that increased consultation with the young people themselves is needed. This study aims to bridge that gap by seeking young people's views on what they need from therapists, and how treatment in residential care settings could be delivered for traumatized young people. It is considered that this exploratory research is needed prior to more detailed analysis of trauma services for young people.

This exploratory study aimed to answer the following research question: What do young people in residential care think traumatized young people need from therapists to help them understand and respond to their experiences?

Methodology

Participants

This study used a purposive sampling method to recruit participants. Posters were displayed in 14 residential units; made up of two day service units (where young people come to attend education only and do not reside on campus), nine open residential units (where young people live in the unit, attend school and are able to move freely around, and leave, the campus), and three closed secure residential units (where young people live and attend education in a locked unit which restricts their movements for safety reasons). Each unit accommodates between two and eight young people, aged between 12 and 18 years old. The researcher attended each unit and spoke with the young people as a group to promote the study. Leaflets were distributed to provide additional information.

A total of six young people participated in semi-structured interviews with the researcher. The interviews were guided by a semi-structured interview template of ten questions relating to how the young people felt services

should be delivered to traumatized young people, what would be helpful and unhelpful qualities in therapists, what therapeutic work should involve and how it should be delivered. The average length of the individual interviews was 23 minutes and 11 seconds.

The sample included five males and one female, aged between 14 and 17 years old. All the participants were White British and were current residents of the education and care center based in the United Kingdom, with five of the young people residing in open residential units and one male young person residing in closed secure accommodation. All the young people were either currently involved in, or had previously been involved in, work with the Specialist Intervention Services team. For ethical reasons the young people's own personal traumatic experiences were not explored, nor were their individual experiences of trauma therapy, due to the potential harm discussing this could have caused. Instead the young people were asked general questions related to what they thought would be helpful or unhelpful for traumatized young people engaging in therapeutic work.

The Care Center

The education and care center was set up to provide education and accommodation to young people aged 12–18 years old, who have experienced a range of adversity and behavioral difficulties that has placed them at risk of harm to themselves or others. Opportunities for learning, working and purposeful activities are offered at the center, alongside psychological interventions.

Procedure

An internal ethics committee granted ethical approval for the study. Ethical consideration was given to the power of coercion that could result from the researcher being a staff member at the care center, and in particular a member of the Specialist Intervention Services (The British Psychological Society, 2010). This was somewhat mitigated by the researcher not having prior contact with any of the young people involved in the study.

All young people who expressed an interest in taking part in the study met with the researcher to discuss what this would involve, along with issues around consent and confidentiality. They were all asked to provide informed consent meaning that they understood they could withdraw at any time without negative consequences, and that confidentiality would only be breached if there were any concerns about harm. Allocated social workers and personal key-workers were asked to provide consent, and where appropriate parents or caregivers were identified, they were informed of the young person's interest in taking part in the study, given further information and the option to opt the young person out of the study.

During the introduction to each individual interview, the researcher defined trauma by using examples of experiences that could be considered traumatic to someone and have a lasting negative impact, for example, being involved in a serious car accident, seeing or experiencing violence, abuse or neglect, or being removed from their home environment. These examples were used to operationalize the concept of trauma and to explore the differences between their understanding of traumatic experiences and every day difficulties, such as having a scheduled activity cancelled. For the purpose of the interview, and to ensure that the language used was accessible and appropriate for the young people, trauma was explained as, and then subsequently referred to as, 'difficult things' throughout the study.

Once consent was provided the interviews were arranged with the young person and their key-worker. The interviews took place in a private therapy room within the center, either within the young person's residential unit or in the Specialist Intervention Services unit, and at a suitable time so as not to impede on any educational studies. One young person completed their interview across two separate days to account for other activities that they wanted to be involved in. A further young person's interview was completed in two parts to allow for a more suitable location to be found following a disruption in the residential unit where the interview began. All interviews were tape-recorded and completed by one researcher. Following the interviews they were transcribed verbatim.

The study was promoted until six young people took part, whereby initial coding of the data indicated repeated themes and subsequently no further participants were sought.

Analysis

The data was examined using Thematic Analysis (Braun & Clarke, 2006). The researcher used a recursive process and generated initial codes using a line-by-line coding approach. Data that appeared to deal with the same matters was then grouped together, and the next step involved reviewing these groupings of data to determine organizing and global themes that were then named and described. The data was then reviewed again to ensure that each organizing and global theme was sufficiently supported by the data, and specific quotes were selected to demonstrate each theme. This interpretative analysis used an inductive approach so that the young person's views could be understood within their broader social context.

Results

Three global themes were found which have been represented in the context of what therapists should do in relation to delivering trauma treatment. The

three themes relate to the need for therapists to; involve young people in decision-making, take time to build trusting relationships, and create the right environment for treatment. Within these themes the timing of treatment, the behaviours of therapists, and the consideration of exposing young people to past traumatic experiences were highlighted.

Involve Young People in Decision-making

All those interviewed were clear they should be involved in decision-making about their own care and that they should be able to make decisions related to how and indeed whether or not, they explore and process their own traumatic experiences.

“I think the young people should have the main, like, point on it, cause it is to do with them, they are the main person in it ... ”

“It’s up to them if they want to talk about it, not anyone else.”

Sub themes within this global theme included the recognition that discussing traumatic experiences can be beneficial when the time is right, but that therapists should also consider the positive and potential negative impacts of exposing young people to past trauma; and therefore therapists should consider and promote alternatives to this as a treatment option.

Ensure Treatment Timing Is Right

Individual choice appeared to be linked closely to ensuring that the time is right when engaging young people in trauma treatment. Not being pressured into treatment and allowing them time to settle into their residential placements were noted to be important.

“I think maybe if you just moved into a placement you wouldn’t really want to talk about it but maybe if you have been there for quite a while and you are starting to know everybody in it then maybe sort of ease your way into finding things out.”

“You want to feel like you’ve got control, you could stop at any moment and leave or say if that’s enough for the day.”

Consider the Positive and Negative Impact of Trauma Exposure

Young people highlighted some of the benefits of discussing their traumatic experiences.

“It’s good to talk about the situation, ya [you] can talk through it cos they can help ya, cos it helps ya understand.”

“Cause it lets it all out, lets a weight, takes a weight aff [off] their shoulders.”

However, they also noted the potential negative impact, so having a choice whether to engage in this or not appeared important to them.

“Like sometimes it could bring back bad memories or something when you are talking ... or it could just trigger something inside and it could make them, I don’t know, cause self-harming, you could do a lot of things, it could be getting angry, upset, sometimes you could just be having a bad day and you just can’t deal with it.”

Promote Alternatives to Trauma Exposure

The young people gave many alternative ideas for helping them to deal with their past trauma, suggesting that therapists should consider and promote alternative treatment options. In particular, it was noted that being able to speak to alternative staff, such as residential carers, could be more helpful than talking to a therapist.

“I just went back to the house [residential unit] and I spoke to the people [residential care staff] there, I felt it was a lot easier to speak to the people there cos I’ve known them a lot longer [than the therapist].”

Alternatives were also suggested that did not involve the young person actually discussing their traumatic experiences. These included providing physical comfort, allowing them to spend time with their friends, and developing creative ways for the young people to consider their experiences.

“Cause sometimes it is difficult, it’s easier to write it down or draw a picture even.”

“Sometimes you don’t even need to talk, sometimes you just need a hug and that’s it, just like a big hug.”

“Animals ... I think if folk hang about with animals it’s therapeutic.”

Take Time to Build Trusting Relationships

The second global theme related to therapists taking time to build trusting relationships with the young people. A positive, trusting relationship was considered by all the young people as being the initial starting point to facilitate effective trauma treatment, with an acknowledgment that this can take time to develop.

“... sometimes it is easier to get to know someone first, like build a relationship with them before you can speak to them about things like that, like bad things.”

Within this global theme, sub themes related to the positive and negative behaviours and qualities of therapists, which were noted to either damage or promote the development of positive relationships.

Engage in Behaviours that Promote Positive Relationships

Positive behaviours included therapists being kind and caring, listening to the young person's needs, being experienced in working with trauma, and showing empathy and understanding towards them and the issues they were facing.

“Staff [therapists] to listen ... cos, they need tae [to] know what ya want, they need tae know how to help.”

“They have got to show a kind and caring side to them ... like make you feel comfortable saying what you want to say.”

Refrain from Behaviours that Damage Relationships

The young people highlighted negative behaviours that could have a detrimental effect on building trusting relationships and which could prevent them from effectively working through their trauma experiences. They noted the difficulties of working with inexperienced therapists or with therapists that had not shared similar experiences to them, as well as therapists putting pressure on them to discuss their past experiences, withdrawing activities if they did not attend sessions, or not continuing with care once treatment had been completed.

“I don't want like a newcomer starting work on this really traumatic child, and they try to use all these techniques and they don't know what they're doing and it just gets them stressed out ... so an experienced person.”

“ ... judging me, my family and that ... ‘You used to stay with them, oh wow, how did you manage that?’ ‘That's my family pal.’ So people that pull faces and judge you ... ”

Create the Right Environment

The third global theme related to the therapists creating the right physical environment for trauma treatment to take place in, which young people felt could help them engage. They discussed the importance of considering issues, for example, privacy, comfort, and sensory factors such as temperature, lighting and sounds. The young people felt creating the right environment for their needs was facilitated by being involved in the decision-making process and by building positive relationships with their therapists.

Ensure Privacy

In relation to where trauma treatment should take place, the young people highlighted the need for these locations to be private, away from possible stigma particularly from their peers.

“You don’t wanna be, you don’t want to walk through big offices and that, with loads of people all staring at you and they all know why you are going in there.”

Consider Sensory Factors

With regards to where and how services are delivered, the young people considered factors referring to all their senses; what they could see, hear, touch, taste and smell. They noted both positive and negative factors, such as how the room was decorated, or how well plants were cared for as this related to how well they felt they would be taken care of, the level of comfort felt in a particular room, having the ability to touch or play with comforting objects, and having snacks available.

“ ... big, brightly colored walls and that, really modern and nice colorful couches and they are comfy ... relaxes them instantly ... instead of you sitting in a really small cramped room with white walls and feeling really tense.”

“It’s got to be in a certain room ... at a certain temperature ... it’s got to be at the right temperature ... it varies for different people, I like it freezing.”

It was identified through the young people’s responses that these three global themes (involving young people in decision-making, taking time to build relationships, and creating the right environment) interconnect; whereby through building positive, trusting relationships with therapists young people feel more able to make informed decisions for themselves, largely about whether or not to engage in trauma treatment, and should they do so, then who they want to undertake that work with, alongside where, and how such treatment is delivered.

Discussion

This exploratory study aimed to consider the views of young people in residential care on how therapists could help young people understand and respond to their traumatic experiences.

Three global themes were identified from thematic analysis of the data relating to the need for therapists to; involve the young people in decision-making, take time to build trusting relationships, and create the right environment for treatment to take place. Being able to make decisions for themselves underpinned all the responses from the young people and this ranged from who they wanted to build relationships with, whether or not they engaged in trauma treatment at all and in what environment trauma treatment should be delivered. They identified behaviours and qualities of therapists that either facilitated or hindered the relationship building process. Interestingly, suggestions were made regarding the several ways young people could be helped to manage and respond to traumatic experiences without the need to expose them directly to their past experiences.

The young people did not discriminate on who could help them to work through their traumatic experiences and they spoke of primary caregivers, which included residential carers, as being equally, if not more, important than therapists in providing a safe place for them to live and build trusting relationships. These findings support theories and models that advocate an integrated approach when working with traumatized young people, and which recognize the importance of the therapeutic alliance between young people and their primary caregivers (Golding, 2012; Hughes, 2004; Saxe, Ellis, & Kaplow, 2007). Feeling safe and meaningfully connected to others is an important part of helping traumatized young people overcome their difficulties (van der Kolk, 2014), which the young people in this study expressed as a fundamental need.

The notion of choice and having control was pervasive throughout the responses. All those interviewed were between the ages of 14 and 17 years old and previous studies have noted that this is an important time in an adolescent's development where independence and greater autonomy is desired (Eccles et al., 1991). Finding the right balance between providing protection and care and allowing adolescents to make informed choices for themselves is critical (Dozier et al., 2014), and this seems particularly relevant in care settings where fixed procedures might not provide the flexibility for young people to develop a healthy sense of autonomy.

Those interviewed suggested several helpful factors that could provide a comfortable environment in which trauma treatment could be delivered. There is some emerging research available that specifically explores the functional aspects of sensory processing issues for traumatized youth, and Robinson and Brown (2016) argue that the environment surrounding a traumatized young person is a critical but neglected area of research. Of note in this study, the temperature of the room where treatment takes place was raised, specifically, the need for the room to be cold. If exposure to past trauma leads to similar physiological responses as when the original trauma was experienced, for example heart palpitations, tense muscles and increased perspiration, then this could lead to significant barriers in treatment engagement. Future research might therefore usefully explore the role and impact of temperature during the delivery of trauma treatments.

This research provides several implications for practice. Firstly it adds to the literature that young people's views can assist in developing suitable services when working with trauma related issues (Auerbach & Silverstein, 2003; Gilbert et al., 2008; Plaistow et al., 2014). Young people are more likely to engage in such services and treatment if they feel their needs are being heard and met (van der Kolk, 2014) and where they have felt involved in the service design (Hanson & Lang, 2016).

Additionally, this research suggests the role of primary caregivers is important in trauma treatment for young people, and makes the case for

providing more support, training and supervision for residential care workers in this area, particularly for new and inexperienced workers. Whilst therapy is a useful and important aspect of resolving the difficulties resulting from trauma, this study highlights that the contribution primary caregivers can have to this should not be over-looked. This may mean that therapists and professionals working with traumatized youth should also be working in a more structured way with primary caregivers, including residential carers, to sufficiently support them to make a difference. This could include training in intervention models, and providing integrated supervision and development opportunities (Moses, 2000). Increased multi-disciplinary working could widen young people's support networks and lead to the implementation of trauma treatment alternatives, highlighted as being as important to the young people as therapy itself; for example providing comfort through physical touch, different sensory objects and comforting surroundings.

Due to the exploratory nature of this study the sample size was small; and as the results came from one specific residential unit they may not be representative of other residential services across other locations. Future research could build on these findings and should include young people from a range of residential settings. Additionally, due to ethical reasons the young people in this study were not asked to discuss their own traumatic experiences and therefore it was difficult to know which experiences the young people had in mind, if any, when they were exploring helpful and unhelpful aspects of trauma service design. Research that is able to explore the different experiences of young people and their subsequent views of available services could provide further insight into how such services can be designed more effectively to meet their needs. A further limitation came from the researcher being part of the wider service that delivered therapy to the young people in this care setting, which may have led to potential biases from both the young people's awareness of this and the researcher's own interpretation of the findings, although supervision was used in an attempt to avoid this.

This research aimed to explore young people's views on what traumatized youth need from therapists and what could be helpful or unhelpful in the design of trauma services. Those interviewed highlighted the importance of therapists taking the time to build trusting relationships with them, and provided insightful suggestions about the behaviours and qualities that make this possible. They shared their views on helpful and unhelpful environmental factors when delivering treatment, as well as an understanding of their need for autonomy and choice regarding the services and professionals they engage with.

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