Experiences of psychoanalytic psychotherapy for young people with a major mental Illness, and their psychotherapists within Child and Adolescent Mental Health Services

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ABSTRACT

Amidst the onset of major biopsychosocial changes, the developmental stage of adolescence poses the possibility for both great vulnerability and potential. It is critical to know what treatments best help adolescents suffering extreme psychological disturbance, who are at risk of suicide or further deterioration. The adolescents in this study had suffered from earlier traumas and losses, and their developmental trajectory had been derailed by mental illness and developmental breakdown. Psychoanalytic psychotherapy as a treatment for adolescents has diminished in public mental health services, despite growing evidence of its effectiveness. Participants in this qualitative study were drawn from a group of young adults who participated in the Time For a Future (TFFP) longitudinal research during adolescence, in Victoria, Australia. They participated in additional psychoanalytic psychotherapy (between 2002 to 2012) as patients of public child and adolescent mental health services (CAMHS). Twice weekly, open-ended psychotherapy was available, but most adolescents preferred weekly, and completed treatment in almost 2 years. The TFFP had demonstrated effectiveness of the treatment in quantitative terms. The present qualitative study aimed to explore retrospectively (a) the lived experience of the psychotherapy of both the adolescents and their psychotherapists, and (b) the views of the directors of Victorian CAMHS during the decade of the TFFP, concerning the place of psychoanalytic psychotherapy for adolescents in the public arena. In- depth semi-structured interviews were conducted with the three groups of participants and transcripts from 24 interviews across all participants were thematically analysed. It was found that CAMHS over this decade struggled to match resources with increasing demands for treatment. Regional and outer-metropolitan areas struggled to recruit and then retain clinicians in isolated situations. Long-term psychoanalytic psychotherapy

was not seen as feasible for resource reasons, although some directors acknowledged its usefulness for disturbed adolescents with complex needs, as psychoanalytic theory was considered appropriate for understanding complex dynamics. Interviews with the adolescents and the psychotherapists revealed that the psychoanalytic psychotherapy was experienced as effective: some adolescents stated that it had kept them alive. Functional improvement occurred in behavioural, emotional, cognitive and relationship spheres, including the development of a sense of identity, increased self-confidence and self-worth. The therapeutic relationship was identified as central. An ongoing relationship over time, where trust could be built with an independent adult who provided consistent, dependable care facilitated the process. The psychotherapists capacity to listen deeply to conscious and unconscious communications, to sit with the intense emotions and sensitively attune to rapid fluctuations in the adolescent's mood and hypothesise what the psychotherapist represented to the adolescent at any given moment were all found to be challenging but rewarding. The psychotherapists felt 'contained' by their theoretical framework, and their clinical supervision. Such complex and intense work also requires support within the service system. Premature ending of psychoanalytic psychotherapy was difficult for adolescents, an area requiring further study. The findings are discussed in the light of the small body of published research in this field, and the thesis concludes with implications of the findings related to theory, clinical practice and further research.

Declaration

This thesis is an original work of my research and contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

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CHAPTER 1

UNDERSTANDING MENTAL ILLNESS IN ADOLESCENCE: A PSYCHOANALYTIC THEORETICAL PERSPECTIVE AND FINDING A PLACE IN PSYCHIATRIC SERVICES

This is a study of complexity and change within a particular developmental stage of human life, and under specific conditions. The focus was adolescents who had experienced high levels of distress and disturbance in their mental health which resulted in them becoming patients of government funded, tertiary mental health services. Thus, another important condition came into focus, namely, the public system of child and adolescent mental health services (CAMHS), to which psychoanalytic psychotherapy treatment had been made available to cater for more severely disturbed adolescents.

The reflections on the experience of psychoanalytic psychotherapy from the perspective of both the young adult and that of the psychotherapist were gathered to glean an understanding of what made this experience matter. The challenge was how to explore the essence of the phenomenon of change without sacrificing the meaning, preserving the personal characteristics, history, and culture of the adolescent in each adolescent psychotherapist pair, and searching for what might be common across all dyads in their separate psychotherapy journeys, as to what assisted or encumbered each adolescent's experience of therapeutic progress whilst maintaining their confidentiality.

The reflections of the Directors of CAMHS at the time were also able to provide a fulsome account of the service delivery context within which these adolescents received psychoanalytic psychotherapy treatment in addition to treatment as usual (TAU).

Adolescent psychological development, mental health risks in adolescence, and the historical development of adolescent psychiatry are first briefly reviewed.

Adolescence is a critical period of change, holding great portent for the adult who will eventually emerge from a neurological, biological, psychological, cognitive, and emotional chrysalis. It is also a time of vulnerability, and potential can be lost when the natural trajectory of development becomes impaired through mental illness, overwhelmed by trauma or developmental breakdown, (Laufer and Laufer,1989). Mental illness is not only a private tragedy for the adolescent and their family, but also a public loss with ramifications for the wider community and society as a whole, as young people symbolize life, hope, the future, and the costs associated with mental illness are considerable. Epidemiological studies, trends and surveys furnish important evidence for the need for services and supports at the time of adolescence and such studies are discussed in Chapter 2.

Justification for this study emerges from a review of the research field in Chapter 2, and the rationale for conducting this qualitative study is set out in Chapter 3, as it flowed from a previous study, the Time For A Future Project (TFFP).

Outlined in this chapter are the history of adolescent psychiatry, psychoanalytic theories on adolescent development and concepts informing the practice of psychoanalytic psychotherapy in adolescence.

1.1 The development of adolescent psychiatry

The historical and sociological changes regarding childhood have been written about extensively (Aries, 1996; de Mause, 1980). There is a literature covering the specialized history of "growing up," and, as described by the historian Graff (1999), each age group has its own history.

Mental illness in children started to be documented when the medical speciality of paediatrics began to emerge in the middle of the nineteenth century and puberty and its impact in adolescent mental illness became more regularly mentioned in the second half of the nineteenth century (Parry-Jones,1992).

Parry-Jones (1989) wrote of the significance of Piaget's work on intellectual development in the 1920s, its influence upon child psychology, and the establishment of the Child Guidance movement initially in the U.S.A and the development of a collaborative multi-disciplinary team model. The development of the Child Guidance movement was influenced by the psychiatrist Adolf Meyer observing the interaction of environmental, psychological, and physiological factors produced disturbance, and these clinics were then established in England (Steinberg, 1987) and Australia (Damousi, 2005; Robson, 2015). According to Kanner (1957) the term child psychiatry was first introduced in 1933.

Developmental factors in understanding adolescents' emotional distress were considered important. Hall (1904) argued for the place of an adolescent psychiatry and helped create the view that adolescence was a time of emotional turmoil. The significance of emotional turmoil during adolescence has since been questioned as having psychiatric importance,

although the frequency of inner turmoil has been confirmed in the Isle of Wight study of mid-adolescents, by Rutter, Graham, Chadwick, and Yule (1976).

In a critique of Hall's work on adolescence, Arnett (2006) found that although some areas of Hall's thesis had not stood the test of time, other areas such as biological changes, patterns of depressed mood, increase in crime, heightened sensation seeking, orientation towards peers and relational aggression during adolescence were in accord with modern day research findings on adolescence.

Steinberg (1987) identified that whilst some adolescents were seen in the guidance clinics in England, that there had also been special hospital units for severely intellectually disabled adolescents and children, and that mentally ill young people were admitted to general psychiatric hospitals from the nineteenth century, and from the 1930s voluntary patients started to be admitted to two particular hospitals. The demand for adolescent inpatient places increased and the first adolescent psychiatric unit was established in St Ebba's Hospital, Surrey, in 1948.

As the field of child and adolescent psychiatry emerged so did that of psychoanalysis and child psychotherapy. Urwin (1991) described the impact of the first and second world wars, social, medical and welfare changes and the shifting focus upon the child and the study of child development beginning with Darwin's study of his own son. Urwin further identified the pioneering work of Lowenfeld, a paediatrician and child psychiatrist, and her pioneering influence on child psychoanalysis in the United Kingdom, and at the Royal Children's Hospital (RCH) in Melbourne, Victoria, Australia (Ericksen, 1998).

In Melbourne, Kindergarten teacher Ruth Drake established the Child Guidance Nursery in 1936 at the RCH, where children with behaviour problems were assisted using play techniques. Robson (2015) described the transition from kindergarten teachers to child psychotherapists and child psychiatry from the 1930s to the 1970s at the RCH (2015). There was no child psychotherapy training in Melbourne in the 1960s, and Margaret Ericksen first went to the Hampstead Clinic and then the Tavistock to further her training before returning to the RCH, bringing a more Kleinian object relations approach.

There was an interest in psychoanalysis in Australia in fields such as psychiatry, anthropology, university psychology departments, and the kindergarten movement in the 1920s, 1930s and 1940s, and the learnings regarding war neurosis. As in the United States, Australia was a place of refuge for immigrant analysts, and Lazar-Geroe who trained as an analyst in Hungary, not only began training analysts but also developed the area of child analysis in the Children's Court Clinic in Melbourne in the early 1940s (Damousi, 2005).

Rutter and Stevenson (2008) argued that the academic standing of child and adolescent psychiatry was enhanced by increased research and cited Bowlby's 1951 report on maternal deprivation having a reformative influence on the field and its operation. They emphasised how clinical observations were critical for the identification of new syndromes, notions of causality, clinical practice, and integration with empirical research.

In summary, twentieth century child and adolescent services originated in the nineteenth century, and developed from four key areas, educational psychology, child guidance, psychoanalysis, and hospital child psychiatry departments. Key clinical research findings on attachment, the impact of separation, particular diagnostic groups, and longitudinal

development have been described as influential in establishing this specialist area (Rutter, 2010; Wardle, 1991).

Moving from the late 20th century to the 21st century Child and Adolescent Mental Health Services (CAMHS), similar trends occurred in the UK and Australia. CAMHS were undergoing massive changes within a framework of finer auditing of needs and resources, increased accountability of CAMHS staff to government policies and direction, and increased demand to use evidence-based interventions. These changes occurred within the context of increasing consumer demand and complexity, alongside the need to respond to the developmental needs of different stages and family relationships, and rationalise scarce resources (Birlenson, Stripp, & Wilder, 1995; Cottrell & Kraam, 2005; Newman & Birleson, 2012, DH&CS, 1996).

Charman (2004) provided an overview of CAMHS in England and Wales becoming more aware of the rights of the child and developing a four-tier model with the most specialised services treating the most severe disorders and difficulties at Tier 4 level, and the need for inter-agency collaborative work, and a National Service Framework. However, child and adolescent psychiatry as a separate specialisation is not universal worldwide (Rutter, 2008). In most English-speaking countries the development of child psychiatry and CAMHS was synonymous with the development of child psychoanalytic psychotherapy and the different theories of Anna Freud and Melanie Klein (Rous, 2009; Rutter 2008). It is noted that in many of these countries, adolescent treatment was subsumed within child and adolescent community psychiatric services, but separate adolescent inpatient units and therapeutic communities attached to public hospitals developed in the 1970s and 1980s where there was a

focus on group therapies and family work (Bruggen, Byng-Hall, & Pitt-Aikens, 1973; Evans, 1982; Martin, 1965; Osman, 1990; Steinberg, Merry, & Collins, 1978).

In Victoria, where this study was conducted, there had been a history of catering for older adolescents within CAMHS at the State-wide Parkville Adolescent Services in the late 1980s where adolescents (15-20 years) participated in a joint inpatient/day programme during the week in a therapeutic community which provided a psychotherapy and social skills group work programme and family therapy, and, according to the need of the individual, additional psychoanalytic psychotherapy. Wellington House, which later became Wellington Youth Mental Health Services when it merged with the South Eastern CAMHS also catered for adolescents (15 to 25 years) until they were required to reduce the age group to 18. The decade between 2002 and 2012 when the adolescents in this study received psychoanalytic psychotherapy, CAMHS only serviced adolescents to 18 years of age. Further, acutely mentally unwell adolescents were still being admitted to adult inpatient settings in regional areas as there were only adolescent inpatient units in Melbourne and beds and transport were not always available.

1.2 Psychoanalytic theories of adolescent development

Psychoanalytic views on adolescent development were shaped by biological, cognitive, neurobiological, hormonal, sociological and historical theories regarding the developmental stage of adolescence, as well as psychoanalytic theory itself. Psychoanalytic views on adolescent development will be discussed briefly.

Just as adolescent psychiatry is often subsumed in child psychiatry, a similar process has occurred in psychoanalytic literature. Adolescence has been referred to as the "step-child of psychoanalysis" a description first coined by Anna Freud but reiterated by others as there was incomplete knowledge theoretically and practically about adolescents, and they could be difficult to engage in treatment (Freud, 1958; Kaplan, 1996; Lampl-De Groot,1960). As a result, adolescence has been described as a more neglected area of psychoanalysis (Perret-Catipovic & Ladame, 1998).

In 1925, Aichhorn, wrote about his pioneering psychoanalytic work with delinquent youth (1955) identifying anti-social behaviour or rebellious behaviour in this stage of development, often repeated in current day research (Arnett, 2006). The use of the term delinquency was renamed as the anti-social tendency to reflect its intrinsic part in regular emotional development of adolescents (Winnicott, 1987). Traditional views on adolescent development are sketched below, but as with all psychoanalytic theories they are constantly being revisited and reworked in the light of practice, research, and socio-cultural changes.

1.2.1 Ego development in adolescence

Although Sigmund Freud made little comment on what are considered core aspects of adolescence, such as adolescent states of mind, emotional growth, and the restructuring of the personality (Flynn, 2000), his essay on the transformations of puberty and the processes required to establish the primacy of the genital zones in 1905 was considered as the beginning of psychoanalytic study of adolescence by Anna Freud (1958).

In her 1958 paper, Freud described the conflict between the ego and the id as reignited with puberty and the resultant mourning and sometimes narcissistic withdrawal that can occur in the space between loosening parental ties and developing new attachments to external objects. Anna Freud's conceptualisation around the development of the ego, and the use of defenses to protect it from becoming overwhelmed by anxiety, has been particularly pertinent to understanding what happens in adolescence when the ego is in a weakened state. The loneliness in the gap between loosening bonds with the parents and establishing an adult-type relationship is described by Barrett (2008) as having the potential to be misdiagnosed as depression in adolescence.

1.2.2 Object relations in adolescence

Klein (1946) in her classic paper on schizoid mechanisms described her object relations theory. She proposed shifts between the paranoid-schizoid position, which used defenses such as splitting and that of the more mature depressive position. Changes in these positions are considered by many in the psychoanalytic field to be highly relevant in working therapeutically with adolescents, particularly those who have suffered early trauma and extended the concepts of such defenses (Blass, 2015; Tustin 1990)

Alvarez (2012) proposed a further separation of more extreme paranoid states from those representing deficit or chronic dissociation. Flynn (2000) described how the consequence of heightened aggressive desire and feelings in adolescence could lead to anxiety and guilt, which in turn heighten feelings of aggression. He also proposed that acute internal reactions against those feelings can result in a tendency to split perceptions of people and things into good and bad.

1.2.3 Holistic view of psychosexual identity development

Erikson (1977) linked the psychosexual stages of Sigmund Freud's theory with aggressive and sexual drives, with physical and cognitive schedules of development, cultural and social factors. Each stage in his theory was viewed as a developmental crisis and Erikson identified accompanying psychosocial tasks to be achieved before progression to the next stage. Whilst there was a sequential expectation to the stages, it was acknowledged that elements of each stage may exist in some form prior to each critical period. Adolescence was regarded as the stage of developing a sense of personal identity through establishing a meaningful self-concept, sexual identity and ego identity, accompanied by a risk of role confusion, at this time as the adolescent struggled with internal physiological changes and integrating all identifications. Much has been written about the importance of identity development in adolescence and changes in theoretical understanding of this concept (Briggs, 2008; Ferrer-Wreder & Kroger, 2019; Gerson, 2014; Tyminski, 2019; Waddell, 2018). Noam (2001) attributed the discovery of adolescence by psychoanalysis as an entrée to the study of development across the life cycle, such that tasks identified in adolescence have led to the study of similar significant shifts throughout life.

Bohleber (2010) has re-examined Erikson's concept of identity in adolescence with respect to feminist and gender research, intersubjectivity theories, and attachment research, and has suggested the experience of identity is an internal process built on a capacity for self-reflection and mentalization, based on the subjective exchange between mother and infant of pre-verbal affect regulation through mirroring (Fonagy, Gergely, Jurist, & Target, 2002). Bohleber considered the concept of identity as diffuse, intersubjective and emphasised that autonomy was not at the cost of attachment to others or a concrete mental representation.

Bohleber further observed the impact of major social, technological changes and world globalisation on late adolescents, who may remain at home longer and have a more protracted financial dependence, which is a topic of discourse for many writers (Adelman, 2018; Briggs and Hingley-Jones, 2013; Lemma, 2017).

1.2.4 Development of individuation in adolescence

Blos (1978, 1967) proposed that the totality of adolescence be viewed as the second individuation phase, with the first individuation phase described by Mahler (1963) as having occurred at the toddler stage of development. Blos likened both periods as a time of heightened vulnerability, given the demand for psychic structure to mature and the risk to forward development should individuation not be achieved. Briggs and Hingley-Jones discussed the expansion of this traditional view in relation to developing an adult sexual body, with the ensuing power(s), adaptation, ownership and associated anxieties in achieving an "*adult-embodied sense of self*" (p.4, 2011). They further developed a view of adolescent development within a social context with the use of subjective theory (Briggs, and Hingley-Jones, 2013).

Blos (1966) viewed the phases of adolescence as preadolescence, early adolescence, adolescence proper (mid adolescence), late adolescence and post adolescence. He described the processes of each phase and the role of the ego in each, including its functions, stabilizing mechanisms, and the ego ideal. The development of neuropsychoanalysis and research into the brain adds evidence for discriminating between different ages in adolescence, particularly with the knowledge that the brain is not fully developed until 25 years of age. The integration of this emerging knowledge of neurodevelopment has produced a more

sophisticated understanding of adolescence and therapeutic interventions (Bendicsen, 2019; Luyten & Fonagy, 2015; Music, 2019; Siegel, 2014; Taubner, Kachele, Rudyk, Buchheim, & Bruns, 2012; Yovell, Solms & Fotopoulou, 2015).

1.2.5 Attachment and psychoanalytic psychotherapy

The similarities and difference in relation to psychoanalysis and attachment theories have been discussed at length (Bretherton, 1999; Fonagy & Campbell, 2015; Fonagy &Target, 2007; Fonagy, 1999; Shapiro, 2007; Watchell, 2010). Bowlby's attachment theory based on observations of infant-carer relationships where differences due to the impact of loss or less than optimal caring situations helped to identify differences in attachment styles and personality development and resulted in a vast field of research, which is not the focus of this thesis (Main, 1996; Bowlby, 1969; 1988).

Bowlby (1978) talked about the role of attachment in terms of the therapeutic relationship. Research and thinking with respect to adult and now adolescent attachment and its implications for personality development, peer relationships, behaviour, emotional regulation, therapeutic alliance, and psychoanalytic psychotherapy has grown (Allen & Miga, 2010; Blatt & Levy, 2004; Eagle, 2006; Fonagy, Gergely, Jurist & Target, 2002; Fonagy, 2001; Harris, 2003; Holmes & Slade 2018; Holmes, 2001, 2010; Obegi, 2008; O'Connor, Woolgar, Humayun, Briskman, & Scott, 2018).

1.3 Psychoanalytic concepts for working with primitive states of mind and serious mental disturbance

Despite the parallel development of CAMHS and child and adolescent psychoanalytic psychotherapy, there has been a disappearance of psychoanalytic psychotherapy as a treatment within CAMHS. However, a number of key concepts central to the practice of psychoanalytic psychotherapy are used regularly in CAMHS, which is not surprising particularly when working with more severely disturbed patients, notably, those in inpatient treatment where unconscious and parallel processes can become extremely intense (Giovacchini, 1994). These concepts derive from the elucidation of unconscious processes and involve the relationship of the individual to their social world.

Internalisation and introjection relate to processes whereby external object relationships become represented in the internal world. This development of an inner world of internal objects is akin to Bowlby's description of the internal working model construct (Bretherton, 1999; La Planche & Pontalis,1988). Such complex processes lead to identification of aspects of the self with aspects of internalised others, particularly in adolescence where a re-working of earlier internal relationships and the re-construction of self-identity is prominent as described earlier.

Fonagy, Gergely, Jurist and Target (2002) associate the concept of reflective functioning or mentalization to early attachment processes and argue its primary role in affect regulation and self-organization. Making sense of mental states in oneself and other(s)" is the process of mentalizing according to Allen (2003, p.91). The concept of mentalization has been used in social cognitive, neurobiological, developmental, theory of mind and psychoanalytic

literature (Sharp, Williams, Ha, Baumgardner, Michonski, Seals, Patel, Bleiberg and Fonagy, 2009).

Mentalization is identified in early attachment processes with a primary role in affect regulation and self-organization. The process blends interpersonal and self-reflective elements which assist in the differentiation of inner from outer reality, and interpersonal communications from internal affect and mental processes. It is part of the development of self and a central aspect of social functioning with early primary-care relationships considered more than just a template for later relationships. (Fonagy, Gergely, Jurist and Target (2002).

Slade (2005) emphasised the impact on clinical work and development theory of the construct of reflective functioning which operationalised the process of mentalization and was proposed by Fonagy, Steele, Steele, Moran, and Higgitt (1991). They differentiated the pre-reflective self from the reflective self which reflects upon conscious and unconscious mental experience within the self and the other (Fonagy et al., 1991; Karlsson & Kermott, 2006).

The central concept of transference was initiated by Freud as an unconscious communication of earlier relationships within the psychoanalytic psychotherapy space. Transference, countertransference, projective identification, holding and container-contained are key concepts that are used in psychoanalytic psychotherapy and in prominent parlance in CAMHS. The meanings of psychoanalytic concepts evolve over time as psychoanalytic thinking and theorising does not remain stagnant, and there are different schools of thought.

The concept of transference emerged from the case study of Anna O written from Breuer's case note observations and Breuer's experience of the intensity of the feelings the patient developed for him within that relationship (Breuer & Freud, 1955[1893-5]and the concept of transference within the therapeutic setting was further defined, and its dynamics refined over time (Freud, 1905, 1912).

Klein (1952) developed her understanding of transference with reference to Freud's statements and her own conception of transference as deeply unconscious and belonging to the earliest stage of development in the context of different types of anxiety. Malan (1979) described transference as crucial in psychodynamic psychotherapy acknowledging that it is not always interpreted but that the psychotherapist needs to recognise it has occurred.

The concept of countertransference has been seen as the psychotherapist's response to the patient and was first introduced by Freud who recognised its occurrence and need to be examined closely. Ultimately he acknowledged that the personal characteristics of the analyst had an influence on the treatment (Stefana,2015). Kachele, Erhardt, Seybert and Buchholz (2015) describe the concept as elastic and that intersubjectivity theories assist with understanding the countertransference, whilst noting that Gabbard, (1995) has described the concepts of projective identification and countertransference enactment as assisting with different theoretical views finding commonality. They have then reported on various attempts using microprocess research to use the concept as an object of empirical research (Kachele et al., 2015).

The concept of projective Identification was first clearly demarcated by Klein (1946) and Bion highlighted the concept in his development of the container-contained model (Bion,

2013, 1959, 1957). Bollas (2006) discussed a number of problems with the concept and proposed a further concept of "*perceptive identification."* Spillius and O'Shaughnessy in their edited book on the concept conclude that it is a universal form of human communication (2012).

Brady (2015) discussed the importance of psychic isolation in adolescent development and its potential risks and the use of Bion's concept of containment. It is noted that Hinshelwood (2018) has historically traced the development of the concept of 'holding' (Winnicott, 1955) and that of 'containing' by Bion (1957) with reference to their various allegiances to mentors and analysts over time which adds another dimension to influences on the development of concepts. Hence, the need for conceptual research as is discussed further in Chapter 2.

The concept of interpretation linked to unconscious communication through the transference, countertransference and projective identification between patient and therapist has evolved, as have thoughts about timeliness of making interpretations, trauma; defensive structures, phantasy and consideration of the developmental factors when working with adolescents (Bion, 1962, 1957; Blass, 2018, 2017; Bollas, 2011; Mondrzak, 2012; Ogden, 2011; Sirios, 2012; Sugarman, 2009).

1.4 Conceptualisation of psychoanalytic psychotherapy

Psychotherapy is a generic term that covers a vast myriad of treatment approaches for working psychologically with people. In practice the term psychotherapy may refer to behavioural, cognitive, humanistic, psychodynamic, interpersonal, strategic, approaches, to

name a few, along with alternative approaches that may have minimal or no training standards.

Cummings and Cummings (2000) wrote of the various rivalries between theoretical orientations of psychotherapy and the need to recognize that no-one particular approach has a monopoly on the truth. They advocate for an amalgam of approaches so that the most effective treatment is applied to specific problems, as too often the approach the patient receives is not based on their need, but rather, the orientation of the therapist. The focus of interest in this review is psychoanalytic or psychodynamic psychotherapy, terms which are generally used interchangeably in the literature.

According to Perret-Catipovic and Ladame, the Swiss Psychoanalytic Society use a compact definition for Psychoanalysis; "*a procedure for the investigation of the unconscious area of psychic life, a therapeutic method based on this investigation, and a theory of the functioning of the human psyche*" (p.2, 1998). Dewald (1978) described psychoanalytic psychotherapy as a form of applied psychoanalysis rather than a completely separate discipline, as it is a treatment based on psychoanalytic theory of mental functioning, with many of its techniques derived from and originally developed in the psychoanalytic situation.

Both psychoanalysis and psychoanalytic psychotherapy share a psychoanalytic theoretical base, and the differences are perhaps more about training requirements and clinical focus, which may also have a degree of overlap. Whilst in the past, greater frequency of sessions was more common in psychoanalysis as was the use of the couch, however these differences are now not so vast with some psychoanalytic psychotherapist's using the couch and some psychoanalysts not, and perhaps these are somewhat superficial differentiations. Instead,

Kernberg, (1999) proposed psychoanalytic modalities be separated into psychoanalysis, psychoanalytic psychotherapy and psychoanalytically informed supportive psychotherapy as indicated by research and clinical experience. Waska (2007, 2006) further developed the commonalities of psychoanalytic approaches in describing a clinical stance of engagement with the patient to make analytic contact and mutually explore and interpret unconscious phantasies, transference, object relations and defences with the goals of ego integration and psychic conflict resolution. However, the patient's stance along with the clinician's observations ultimately determined what psychoanalytic modality suited the needs of the patient in the moment.

Psychoanalytic psychotherapy is distinguished from other types of psychotherapy in that it includes the interpretation of the transference, countertransference, and unconscious wishes and resistances. Transference occurs when the patient experiences the therapist as being like early significant attachment figures, and when difficult relationship patterns emerge within the therapeutic relationship there is an opportunity to understand and change these patterns.

Shedler (2006) argued that psychoanalytic psychotherapy has common skill requirements with other methods of psychotherapy namely, building rapport, creating a working alliance, making attuned inferences about indirect communications, and understanding fantasies and resistances. He takes account of mental processes of memory, perception, judgment, affect and motivation that are not readily accessible to conscious thinking; and of some things we do not want to know, which have led to the development of resistance and defenses. Shedler further observed that empirical research has found the most effective therapists are those that recognize transference and work with it therapeutically, regardless of what therapeutic orientation they use.

On their website the Child Psychoanalytic Psychotherapy Association of Australia (CPPAA, 2021) paraphrasing an earlier document (VCPA, 1993) describe how child and adolescent psychoanalytic psychotherapists help with difficulties with emotions, behaviour, and functioning in relationships through an understanding of the child or adolescent "*within their families, environment, school and community and how this is connected to their inner world. Linking past experiences with present, and interaction between the child's inner experience and outer world leads to insight, understanding and reorganisation of internal dynamics. This dissipates internal conflicts, creating fulfilment of potential within children and adolescents.*"

1.4.1 The challenges of psychoanalytic psychotherapy with adolescents

Initial engagement, diagnosis and assessment, remaining in treatment and enactment are frequently referred to as challenges in adolescent psychotherapy and that they need to be understood within the frame of social context and adolescent development (Alfille-Cook, 2009; Baruch, 2001; Baruch, Gerber & Fearon, 1998; Briggs, 2008; Horne, 2009; Horne, 2006; Waddell, 2018; Waddell, 1998).

When working with adolescents it is common to experience intense countertransference and the therapist needs to be thoughtful about whether to interpret and at what level, given the adolescent's likely fear of shame or regression (Edgcumbe, 1988 cited by Horne, 2006). Horne discusses at length the dilemma for the adolescent of individual psychotherapy, which is a relationship requiring intimacy, and while the adolescent can experience relief in being understood, arousal of primitive fear of not being separate or merging with the therapist

object can be experienced. The therapist has also to be mindful of the experience of pauses and silences in the sessions and whether these might be experienced by the adolescent as an absence of the object, particularly if this reflects their early life experience (Lanyado & Horne, 2006).

Resistance is considered a form of defense against an unwelcome affect, thought, impulse or action by the self or another, and is commonly reported in work with adolescents. Thus, acting out can be a way of holding unwelcome or threatening feelings at a distance (Graafsma, and Anbeek, 1984).

1.4.2 Psychoanalytic psychotherapy and adolescence with mental illness

The notion of individual psychoanalytic psychotherapy from a clinical perspective at the time of adolescence would perhaps seem counter intuitive when the adolescent is needing to separate and individuate (Erikson, 1977, 1971; Blos,1978). However, for those adolescents where the developmental trajectory has been compromised, it is seen as a way of helping them rework these issues and help them get back on track developmentally. An example of this is a clinical case study described by Novak (2004), involving 7 years of analysis with a traumatised adopted Russian orphan with disrupted attachment, in which her analysis allowed her to fully develop her mentalization capacity and move into a healthy adolescent position.

Laufer and Laufer (1989) in a clinical study of nine adolescents who were treated at the Brent Consultation Centre applied a psychoanalytic developmental model of the mind to make sense of their psychological illness. Their thesis was that during adolescence what might appear to be a psychosis may represent a mental disorder of adolescence which can respond

to intensive treatment. It was their contention that breakdown in development at the time of puberty, at the time of sexual maturity (for some adolescents) manifested in the adolescent's relationship to their own body. They found that by the time the adolescent came for help the capacity to incorporate the sexual body into their new body image had been severely derailed. Others have focussed on the emotional impact of puberty in adolescence upon psychosexual development and the body ego (Brady, 2018; Briggs, 2008; Diem-Wille, 2021).

1.4.2.1 The therapeutic frame

There has been considerable thinking about the therapeutic frame since Milner (1952) first made the analogy with a painting frame delineating a boundary which enhances the development of transference and provides containment in terms of regularity, time, and space. Discussion around the need for flexibility versus rigidity, that the frame benefits the therapist as well as the patient, external consultation is needed particularly for counter-transference blind spots, and the adaptation to outreach psychotherapy (Anagnostaki, et al. 2017; Busch, 1995; Bass, 2007, 2008; Bromberg, 2007; Cherry & Gold, 1989; Gabbard, 2007; Gold & Cherry, 1997; Gregson & Lane, 2000; Hartocollis, 2003; Laor,20 07: Rogers, 2014; Scharff, 2008; Spero, 2010)

1.4.2.2 The adolescent needing mental health intervention

Winnicott linked the position of isolation of the infant as repeated in young adolescents, and then connection develops (1965). When there is mental illness, there can be uncertainty as to what is due to the developmental phase of adolescence and what might be a serious deterioration in mental health. Organisations such as schools and treatment services play a

role in supporting the adolescent and their family or carers and their importance in mediating psychiatric crisis is mentioned in Chapter 2, Section 2.1.5. Indeed, the parents of adolescents who find themselves seeking help from Child and Adolescent Mental Health Services (CAMHS) can potentially feel lost and traumatised. CAMHS plays a role in providing containment for the adolescent and their family/carers.

Rous and Clark (2009) conducted a review of child psychoanalytic psychotherapy amidst concerns from clinicians that it was under threat as a treatment in CAMHS in the UK and they found there was no significant or consistent decline. A further study interviewing child psychotherapists in the UK found the profession recognised an evidence-base was needed to improve child psychoanalytic psychotherapy and maintain it as a treatment within CAMHS. However, there were questions about the validity of what constituted evidence, as Randomized Control Trials (RCT) were favoured by CAMHS commissioners and these were difficult for child psychoanalytic psychotherapists to conduct (Rous & Clark, 2013). An overview of the development of adolescent psychotherapy research will be discussed in the next chapter.

CHAPTER 2:

RESEARCH ON PSYCHOTHERAPY WITH ADOLESCENTS WHO HAVE A MENTAL ILLNESS

This chapter concerns research on psychoanalytic psychotherapy with adolescents experiencing mental health difficulties. As noted in Chapter 1, adolescence is seen as a distinct developmental stage with distinct phases. However, in the research field there is considerable blurring of developmental stages, so that younger adolescents may be included in child studies and older adolescents subsumed in adult studies. As a consequence, some mention is made of adult and child studies where this has occurred.

Firstly, the need to establish appropriate treatments for adolescents with severe mental illness is demonstrated with initial reference to epidemiological studies. Philosophical, conceptual, historical, and methodological complexities in the field of psychotherapy research in general are then discussed briefly, followed by an outline of psychoanalytic psychotherapy research in particular. Acknowledgement of the early pioneering studies on psychoanalytic psychotherapy research with adults is made, given that the adolescent research studies in psychoanalytic psychotherapy initially lagged behind the adult field, and in recognition of the inclusion of adolescents in some adult studies.

The substantive evidence-base in adolescent psychotherapy research is acknowledged, with the different areas of outcome and process research in the field of serious mental illness in adolescence highlighted. Of particular note are studies that have occurred within public child and adolescent mental health services (CAMHS) which cater to adolescents who are the most severely mentally unwell and are the focus of this study.

Finally, psychoanalytic psychotherapy research with adolescents is presented, leading to a finer focus on qualitative research on adolescents' and psychotherapists' experience of psychoanalytic psychotherapy.

As noted in Chapter 1, the terms psychoanalytic psychotherapy or psychodynamic psychotherapy are used interchangeably for the purpose of this review.

2.1 Epidemiology concerning mental illness in adolescence

Extensive epidemiological research has shown increased proclivity for the onset of mental health difficulties during adolescence. Whether or not these difficulties were previously present in childhood and became exacerbated or more noticed in adolescence, the research has clearly shown that they can extend into adulthood.

2.1.1 Prevalence and severity

Epidemiological studies indicate the onset of mental illness during adolescence is serious in terms of mortality, and the potential for life-long mental illness (Costello, Egger, & Angold, 2005; Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005; Patton, Coffey, Posterino, Carlin, & Wolfe, 2000; Sawyer, Miller-Lewis, & Clark, 2007). Kessler et al. (2005) reported that nearly 50% of Americans would meet the criteria for a DSM 1V diagnosis at some point in their lifetime, with the first onset most likely in childhood or adolescence.

In England, adolescent psychiatric disorders were identified by researchers as a serious public health issue with the demand for hospitalization increasing dramatically during adolescence; a death rate nearly six times the rate of the normal population one year after an adolescent inpatient admission has been found (James, Clacey, Seagroat, & Goldacre, 2010).

Another English study investigated whether the perception that adolescent mental health had deteriorated over the decades was accurate by comparing two national cohorts (1986 and 2006) using symptom scales, finding evidence of substantial deterioration over a twenty-year period, particularly for girls (Collishaw, Maughan, Natarajan, & Pickles, 2010).

2.1.2 Impact of early adversity

Many large population studies reinforce the evidence that childhood adversity has lasting effects on mental health difficulties into adulthood (Bayer, Hiscock, Ukoumunne, Price, & Wake, 2008; Edwards, Holden, Felitti, & Anda, 2003; Green, Greif, McLaughlin, Berglund, Gruber, Sampson, Zaslavsky et al. 2010; McLaughlin, Green, Greif, Gruber, Sampson, Zaslavsky, & Kessler, 2010; Schilling, Merikangas, He, Burstein, Swanson, Avenevoli, Cui et al. 2010; Aseltine & Gore, 2008).

In addition, multiple studies indicate the detrimental impact on later mental health of early childhood adversity and high correlations between child and adolescent difficulties are suggestive of a continuation of difficulties from childhood into adolescence (Skarbo, Rosenvinge, & Holte, 2004). Early exposure to stress significantly related to adolescent anxiety, while depression had more proximal stressors in data collected from pregnancy over

different time-points from mothers of 816, 15-year-old adolescents (Phillips, Hammen, Brennan, Najman, & Bor, 2005)

2.1.3 Gender

Gender differences regarding depression in adolescence have been found. In one Dutch community based, longitudinal multiple-cohort aged 4-18, differences were found in developmental trajectories of depressive symptoms from early childhood to late adolescence, with a chronic trajectory of early childhood-onset depression only in girls (Dekker, Ferdinand, van Lang, Bongers, van der Ende, & Verhulst, 2007). Individuals with elevated trajectories during their whole childhood or commencing in adolescence were found to have significantly more mental health concerns in young adulthood. Although about half recover from an adolescent depression, a later reoccurrence was more common in females, (Curry, Silva, Rohde, Ginsburg, Kratochvil, Simons et al. 2010)

2.1.4 Comorbidity of diagnoses

Comorbidity of diagnoses is considerable, and an American population survey of 10,123 adolescents 13-18 years, found one in four or five young people met the criteria for a mental disorder over their lifetime, with 40% comorbidity. They found anxiety disorders were the most common condition (31.9%), with a median onset at only 6 years of age, whilst mood disorders (14.3%) had a median onset at 13 years. Overall, 22.2% of this population were severely impaired and/or experienced extreme distress (Merikangas, He, Burstein, Swanson, Avenevoli, Cui, Benjet, Georgiades, & Swendsen, 2010).

Based on four population studies across separate community samples of early and middle adolescents, it was found that younger adolescents had a higher prevalence of psychotic symptoms compared to older adolescents and, in both age groups, most who reported psychotic symptoms met the criteria for at least one diagnosable non-psychotic disorder and were at high risk of comorbid diagnoses (Kelleher, Keeley, Corcoran, Lynch, Fitzpatrick, Devlin, Molloy, Roddy, Clarke, Harley, Arseneault, Carli, Archiapone, Hoven, Wasserman, & Cannon, 2012).

2.1.5 Factors mediating mental illness

Collishaw, Pickles, Messer, Rutter, Shearer, and Maughan, (2007) investigated a community sample where 10% reported childhood maltreatment and while prospective measures showed higher rates of psychiatric disorder in adolescence and in adulthood, they found a substantial minority of abused children had no mental health problems. Mediating factors identified were perceived parental care, adolescent peer relationships, the quality of adult love relationships and personality style. This signified that it is important, on the one hand, to provide the best and most useful care to adolescents and their families at the time of illness, but on the other hand to investigate factors that protect or mediate psychiatric crises during adolescence. It is noted that such findings are consistent with adolescent development, psychoanalytic and attachment theories as discussed in Chapter 1.

2.1.6 Service engagement and dropout

Lack of service access and high dropout rates were common findings, and La Greca, Silverman, and Lochman (2009) cited the US Surgeon General's report (1999) estimation

that of the 10 to 20% of children and adolescents suffering with psychological distress, 75% to 80% did not receive a service. Furthermore, if treatment was sought, the drop-out rates ranged between 40% to 60% (Kazdin, Holland, & Crowley, 1997; U.S. Department of Health and Human Services (1999) cited by La Greca et al. 2009).

In the United Kingdom in a survey of children (from 5 to 15 years), those with anxiety disorders were less likely to seek help compared to children with other psychiatric disorders (Ford, Hamilton, Meltzer, & Goodman, 2007).

In the Australian context similar findings were identified from epidemiological studies and census collections.

2.1.7 The Australian experience

Australian findings appear consistent with findings found in the rest of the world regarding prevalence of mental disorders in children and adolescents, and utilisation of services, and that it is a time of great risk.

In the first Australian National Survey of Mental Health and Well-being, Sawyer, Arney, Baghurst, Clark, Graetz, Kosky et al. (2001) found 14% of children and adolescents were identified as having mental health problems by their parents. In a further Australian population study of adolescents (13-17 years), the need for clinical health interventions were highlighted as a strong relationship was found between mental health difficulties and health-risk behaviours, low utilisation of health services by adolescents, and discrepant perspectives between parents and adolescents regarding the presence of mental health difficulties (Sawyer,

Miller-Lewis, & Clark, 2007, p.193). Consultation responses to this major survey included a call to acknowledge the different developmental needs across the lifespan and plan for these needs in developing services (AICFMHA, 2003). AICFMHA wrote an additional position paper based on research, highlighting adolescents at risk of developing mental health problems who have had parents with a mental illness, experienced early abuse, misused substances and alcohol and experienced intergenerational trauma such as indigenous and refugee groups. They further highlighted the discrepancy in services between rural and metropolitan regions (2011).

In the second Australian National Survey of Mental Health and Well-being of children and adolescents, the prevalence of mental disorders was similar to the first (Lawrence, Johnson, Hafekost, Boterhoven de Haan, Sawyer, Ainley, & Zubrick, 2015). However, the prevalence of major depressive disorder for adolescents aged between 12-17 years, had increased to 5% by 2013-14. The prevalence of major depressive disorder based on adolescent self-reports was 7.7% for 11-17 years and remained higher than that reported by their parents. Nearly a third of 4-17-year-olds diagnosed with a mental disorder had comorbid diagnoses within the year prior to the study, with over half diagnosed with both major depressive disorder and an anxiety disorder. Major depression was more prevalent for young people in stepfamilies, one-parent families, and families with low levels of income, education, and employment.

While Lawrence et al. (2015) found comparison between the two surveys regarding use of services problematic, their data indicated a significant increase in use by 2013-14. They found that female adolescents use of services had nearly doubled that of male adolescents, those diagnosed with depression often saw talking therapy as the type of help they most needed, and the prevalence of major depression was higher in females. Female adolescents

and older adolescents were found to have a higher prevalence of depression, with 14% (16–17-year-old) compared to 5% (11-15-year-old), and 19.65% of females (16-17-year-old) were diagnosed with major depression.

The Australian Institute of Health and Welfare analysed suicide and hospitalised self-harm and found female adolescents between the ages of 15-19 years were the highest group hospitalised for deliberate self-harm between 2010 and 2011 (Harrison & Henley, 2014). Higher rates of hospitalisation corresponded to lower socio-economic status and remoteness of residence. Hospitalisation rates related to self-harm for males and females from 1999-2000 to 2011-2012 were highest for the younger age groups with the 15-19-year-old age group increasing the most over this time.

Deliberate self-harm and injury was more frequent in female adolescents, with one in ten adolescents aged 12-17 years admitting they deliberately self-harmed (Lawrence, Johnson, Hafekost, Boterhoven de Haan, Sawyer, Ainley, & Zubrick, 2015).

A study of 2721 young people aged between 14 and 24 years examined help-seeking behaviours and particular factors emerged that were for or against help-seeking. Suicidal thoughts, anti-help-seeking attitudes, and fears of stigma restricted seeking help, whereas a previous positive experience assisted the endeavour (Rickwood, Deane, Wilson, & Ciarrochi, 2005).

In conclusion, based on a multitude of international studies, the incidence of adolescent mental illness is substantial, comorbidity of diagnoses is common, the majority of young people in need are not accessing services, and those who do seek treatment have a high drop-

out rate. In childhood and adolescence, anxiety disorders appear to have the earliest onset, are the most prevalent, and this cohort rarely seeks treatment. Female adolescents are more likely to have a chronic depressive trajectory with higher incidents of hospitalisation for self-harm or injury. Furthermore, the deterioration in the mental health of adolescents appears to have increased over the decades with increased risk of self-harm, suicide, and the potential to establish a trajectory of persistent mental health issues which continue into adulthood.

2.2 Psychotherapy research and differences in definition, method, and philosophy

2.2.1 Different types of psychotherapy

A multitude of theories form the foundation of modern psychotherapies and address varying aspects of human problems, including behavioural, biological, psychological, cognitive, developmental, social, and spiritual difficulties. Kazdin pointed out that there was no standardized definition of psychotherapy and proffered that it was "*an intervention designed to decrease distress, psychological symptoms, and maladaptive behavior or to improve adaptive and prosocial functioning*." (p.785, 1991). Kazdin further described the multiple modalities of psychotherapy such as family, group, and individual settings, using different methods, including, behavioural, insight oriented, and cognitive approaches, and focus on behaviours, affects, or thinking of the patient/client varied according to the approach.

Karasu (1996), noted in addition to the plethora of different psychotherapies, the gap between theory and practice. He identified the overarching paradigms of psychotherapy as psychodynamic, behavioural, and experiential, and observed that although there is competition between different approaches, they can also be complementary. Across the

myriad of different psychotherapies, general definitions usually include a notion of change as an aim of treatment.

2.2.2 Change

To think about the changes associated with the treatment of psychotherapy, one has to examine the variables that contribute to change, how changes occur, what changes happen, and how change is measured. This results in a complexity of multiple variables. The challenge then becomes how to isolate such variables without becoming so reductive that the essence and meaning of the process of psychotherapy are lost.

Theoretical and philosophical underpinnings of psychotherapeutic approaches play a role in thinking about what sort of change is being sought and the mechanisms for such change which naturally lead to different methods of investigation.

2.2.2.1 Determining mechanisms of change

A history of methodological debates has ensued between behavioural and cognitive-based therapies (CBT), initially more goal directed and thus outcome-focussed, compared to psychodynamic therapies which are more process-oriented and less goal directed. Krantz (1995) saw the debates from 1980 were complicated by factors such as conflicting philosophical, political, and theoretical positions, which influenced methods of investigation.

Karasu (1996), using Jacques Derrida's deconstructive analytic approach, asked what produces change in psychotherapy and then argued a dualistic dilemma between the specific

and the non-specific. This was further deconstructed into three different dualisms: the use of one method for all problems versus a multimodal orientation; one theory or strategy being good for a particular problem versus common core ingredients as central to therapeutic cure; and recognising the secondary versus primary role of strategies or technique versus therapeutic relationship.

2.2.3 Outcome research, relief of symptoms and specific therapies for particular diagnoses

Outcome has been measured in terms of reduction in symptoms and functioning on social and psychological measures. One division of outcome studies in psychotherapy research has been to divide them into either efficacy or effectiveness studies. Efficacy studies use a randomised control method in a more controlled clinical trial and maintain internal validity at the expense of external validity, whereas effectiveness studies have more external validity being conducted in the usual clinical setting. The first type of study does not always translate to the clinical setting and because of the need to control variables, a more homogenous diagnostic group is required. This provides a potential source of the gap between research and clinical practice where, as previously discussed, there is high comorbidity in adolescent diagnoses.

2.2.4 Process research and the psychotherapeutic relationship

Strupp observed that identification of the independent variable responsible for therapeutic change is difficult (1963), while Lambert (2001) commented on the elusiveness in identifying the mechanism of change in psychotherapy. Strupp highlighted variances just in the

personality, skills, and attitudes of the psychotherapist, and postulated that satisfactory outcome research required a better understanding of the therapist's contributions. Thus, the interpersonal influence of the therapist was seen as another contribution to therapeutic change. Strupp, Wallach, and Wogan, (1964) began to study variables related to patients using a retrospective survey of former adult patients.

Rosenzweig (1936) initially talked about common factors across diverse methods of psychotherapy, which was further promulgated by Frank (1971, 1974, 1982). Focussed on the psychotherapy relationship, qualities of both psychotherapist and client, six necessary and sufficient requirements for personality change were postulated by Rogers (1957). Butler and Strupp (1986) urged a shift away from common and non-specific factors as a research focus and to shift towards a greater understanding of the interpersonal characteristics between and within patient and therapist. Luborsky, Singer, and Luborsky (1975) in a comparative review of different types of psychotherapies and different conditions, found no significant difference in outcome.

Wampold (2011) has summarised findings that psychotherapy is effective, that there are small differences between therapies, and there is now more known about the role and characteristics of effective psychotherapists. Wampold identified six key interpersonal skill areas of therapists, namely empathy, warmth and acceptance, verbal fluency, affect modulation and expression, interpersonal perception and focus on the other.

A more recent review of key papers, meta-analyses, and systemic reviews on the specific versus common factors debate in psychotherapy research found more agreement on better outcomes being achieved through common factors such as engagement, collaboration, and optimism (Mulder, Murray, & Rucklidge, 2017).

Draeger, (1983, p.371) proposed that the nature of psychotherapy needed to be explored alongside its relationship to truth and pointed out the complexity and difficulty of proving efficacy using scientific methods, and the impediments in understanding the effectiveness and meaning of psychotherapy as a treatment. Taking a more extreme position, Draeger advocated replacing scientific method with phenomenology, contending that psychotherapy is not just the activity of the psychotherapist, but a telling of the patient's story, and the process of psychotherapy is thus one of personal experience and awareness. A phenomenological method of research can be argued to access more than the experience but the meanings and complexities as described by the participant in psychoanalytic psychotherapy (Giorgi, 2012; Giorgi, 2012).

Karasu (1996) highlighted the need for precise, accurate definitions and descriptions of psychotherapy given that patient and therapist characteristics and the type of therapy used all contribute to the process of therapy, and that these variables cannot be completely separated from each other. In this reconstructed system, Karasu identified three universal healing processes – affective experiencing, cognitive mastery and behavioural regulation.

2.2.5 New and less polarised positions on psychotherapy research

Seligman (1995) advocated that combining the features from large scale surveys such as the Consumer Reports with features of efficacy studies would provide the best empirical evidence for the effectiveness of psychotherapy. It has been further suggested that effectiveness studies can complement efficacy studies in providing ecological validity (Lambert, 2001).

Midgley (2004) argued that the use of qualitative research might be a way to bridge the research and clinical gap, particularly with regard to understanding therapeutic processes. He also traced an historical account of the gap that developed between child and adolescent clinicians and academic researchers (as mentioned in Section 2.2.3), alongside the growing recognition that clinicians need to engage in empirical research with particular regard to accountability and outcome (Midgley, 2009).

Leichsenring (2004) argued that given RCTs and naturalistic studies have applied to different domains of the laboratory and clinical setting there is a need for different and separate criteria of evidence. Thus, emphasising the importance of all research approaches and the requirement of high standards that fit the type of research conducted. Goldfried & Davila (2005) argued that therapeutic change can be achieved through the relationship and technique and an integration of both which removes the debate around different theoretical assumptions.

Neurobiological measures have been introduced to measure outcome changes in psychological processes such as brain structure imaging compared to changes in psychological processes (Karlsson, 2011). A shift that has been embraced by psychotherapy researchers whereby these findings can be integrated with psychodynamic understandings, attachment and trauma (Newman, 2017; Nunn, 2006; Solms, 2018).

2.3 Psychoanalytic psychotherapy research

2.3.1 Historical overview

There has been a long history of debate regarding the nature of psychoanalytic psychotherapy as being a combination of art and science. Although there is a naturalistic, observational approach based on theories of development and the mind, there is also what is referred to as the art of psychotherapy, the intuitive, unconscious dimension that arises in the course of a developing relationship between the patient and therapist and may involve interpretations in the transference and counter transference in the case of psychoanalytic psychotherapies.

As with most public and private mental health services world-wide, the provision of efficient, economic, and effective treatments and services is required, and demand for services exceeds the resources that are available. Hand in hand with the rise of a multitude of psychotherapies, there has been parallel research into their effectiveness and efficacy. Vigorous debates have ensued around methodology as mentioned previously, often pitting one form of psychotherapy against another with classic splits being psychoanalytic psychotherapy versus cognitive-behavioural therapy (CBT), RCTs versus naturalistic studies and quantitative methods versus qualitative methods (Hinshelwood, 2002; Seligman, 1995; Tarrier, 2002). Whilst psychoanalytic theory and practice has been around for more than a century and it has had a long history of questioning and reflecting on its practice and place in public mental health, its position as a treatment in public mental health has diminished (Fonagy & Lemma, 2012; Gabbard, Gunderson, & Fonagy, 2002; Goldbeck-Wood & Fonagy, 2004; Greaves, 1952; Salkovskis & Wolpert, 2012; Nand, 1958; Spencer, 1939; Steiner, 1985; Tuckett, 2001, 2012; Wallerstein, 2002, 2006).

The International Psychoanalytic Association (IPA) recognised the imperative for psychoanalysis to embrace research in the context of economic rationalism and managerial changes in the public sector and the demand for therapies to have an evidence base. Decades of psychoanalytic and psychoanalytic psychotherapy outcome research was gathered together in the first 'Open Door' review edited by Fonagy (2001), mostly involving psychotherapy with adults.

In 2001 when planning for the TFFP began, a review of the literature revealed studies of process and outcome of psychodynamic or psychoanalytic psychotherapy with adolescents as scant. The 'Open Door' review which incorporated studies in psychoanalysis and psychoanalytic psychotherapy from Europe and North America, provided an overview of the field. It pointed to major studies like the Menninger psychotherapy project which commenced in 1956 and followed up 42 patients (Wallerstein, 2000), the Boston Institute studies (Kantrowitz, Katz, Paolitto, Sashin, & Solomon, 1987) which followed 22 patients with a focus on the match of therapist and patient and dyad interactions, the Heidelberg and Berlin studies, and the Stockholm Institute Studies of 405 public patients in long-term psychotherapy and psychoanalysis (Blomberg, Lazar, & Sandell, 2001; Sandell, Blomberg, Lazar, Carlsson, Broberg, & Schubert, 2000; Sandell, Blomberg, & Lazar, 1997).
Key figures in the psychoanalytic field have attempted to encourage and develop a culture for embracing research (Emde & Fonagy, 1997; Fonagy 2000). In the third edition of the 'Open Door' review, where Fonagy outlined the history of psychoanalytic research, he also pointed out areas where psychoanalytic research was failing. Fonagy identified the fragmentation of the knowledge base, lack of shared assumptions, lack of deductive thinking, ambiguity in terms, its diverse development in different countries depending on its professional and mental health services affiliations giving it varying degrees of contextual power and its isolationism

from other areas of knowledge, such as genetics, neurobiology, psychology, and socio/cultural contextual theories (Fonagy, in Leuzinger-Bohleber & Kachele, 2015).

Nevertheless, the field has contributed to the research and evidence base of psychoanalysis and psychodynamic psychotherapy in terms of RCT outcome studies comparing two or more treatments for a particular condition or comparing short-term and long-term treatment.

Additionally, there is a range of process research examining mechanisms of change and the therapeutic relationship, use of qualitative and mixed methods research and conceptual research. Conceptual research is starting to address inconsistent and ambiguous definitions of terms over time. Many of the concepts of psychoanalysis are in common parlance in public mental health services and the community, but their operationalisation and measurement for psychoanalytic research whilst difficult, is slowly developing with the additional development of micro-process research (Bohleber , Fonagy, Jimenez, Scarfone, Varvin & Zysman, 2013; Leuzinger-Bohleber & Fischmann, 2006; Leuzinger-Bohleber, 2004).

2.3.2 Conceptual research

Freud's description of psychoanalysis as an investigation, treatment, and theory complicates its study as a natural science according to Ricoeur (2012). In addition to the many types of psychotherapies, the domain of psychoanalysis also has a plethora of underlying theories requiring testing, validation, and operationalisation. Research in the psychoanalytic field originally took the form of the single case history as described by Freud and Breuer (1893), and contemporary empirical research has systematically aggregated such data (Dreher,

2000). Kachele, Albani, and Pokorny (2015) described the development of this area of research with the inclusion of taped recordings of sessions and computer technology enabling repeated observations on a single case and the formation of different systematic methods to examine the micro-processes, shifting from rich descriptions of clinical case material to exact quantitative data resulting in identification of phases and foci in psychotherapy.

Kachele et al. (2015) described in particular, the development of the Psychotherapy Process Q-Set (PQS) published as a manual by Enrico Jones 35 years ago, (Ablon, Levy and Hansen, 2011) and Luborsky's 1970s invention of the Core Conflictual Relation Theme (CCRT) with identification and coding of three types of relationship elements with most frequent elements determining a core theme. Luborsky (2000) reviewed his original 1976 therapeutic alliance paper where he described the CCRT as a new personality measure produced from the narrative data of 20 psychotherapy cases.

Dreher (2000) identified Kachele's analysis of psychodynamic psychotherapy as having three phases - outcome, process, and micro-process. Dreher described the systematic clarification of psychoanalytic concepts such as transference and resistance and tracing historical origins and changes in meaning and use over time as conceptual research. In addition, psychoanalytic theory had added value in being applicable to normal and pathological development in individuals and could be generalised to groups and cultural institutions.
It is noted that there is a growing trend to explore psychoanalytic concepts, link across fields of research, look at similarities between theories of attachment, personality development, psychoanalytic theories, and psychopathology, operationalising such concepts and attempting to forge empirical models to explore within psychoanalytic research (Bohleber, Fonagy, Jiménez, Scarfone, Varvin, & Zysman, 2013; Eagle, 2000; Fonagy & Bateman, 2016;

Fonagy, Luyten, Moulton-Perkins, Lee, Warren, Howard, Ghinai, Fearon, & Lowyck, 2016; Fonagy & Campbell, 2015; Fonagy, Gergely, & Target, 2010; Fonagy & Luyten, 2009; Luborsky & Barrett, 2006).

Luyten, Vliegen, Van Houdenhove, & Blatt (2008) argued the exploration of commonalities provides a richer understanding of change in psychoanalytic research rather than psychiatric diagnostic disorders which are atheoretical.

2.4 Adult meta-analysis and reviews

A large number of meta-analyses and systematic reviews of quantitative studies of psychoanalytic psychotherapy, including naturalised treatments, have been conducted. Shedler (2010) commented that effect sizes for efficacy for adult psychodynamic psychotherapy were comparable to other psychotherapies considered efficacious and this was on the basis of high-quality meta-analyses over a number of diagnostic groups. A meta-analysis on the treatment of adults with depression by Barth, Munder, Gerger, Nuesch, Trelle, and Znoj (2013) showed improvement. A systematic search on RCTs of psychodynamic psychotherapy with adults found psychoanalytic psychotherapy met the Task Force on Promotion and Dissemination of Psychological Procedures criteria for efficacious and possibly efficacious treatment across a number of diagnostic groups (Leichsenring, Leweke, Klein, & Steinert, 2015; Leichsenring, Luyten, Hilsenroth, Abbass, Barber, Keefe, Leweke, Rabung, & Steinert, 2015; Steinert, Munder, Rabung, Hoyer, & Leichsenring, 2017).

2.4.1 Adult efficacy studies with psychoanalytic psychotherapy

Psychoanalytic psychotherapy has been shown to be effective in a growing number of short-term and long-term adult studies (Leichsenring & Rabung, 2008; Leichsenring, Salzer, Jaeger, Kachele, Kreische, Leweke, Ruger, Winkelbach, & Leibing, 2009).

In a group of adults with treatment-resistant depression, who were provided long-term psychoanalytic psychotherapy (LTPP) as an adjunct to treatment as usual (TAU) and followed up at 6-month intervals during their 18-month treatment, found self-report and observer-report depression scores showed greater decline for LTPP and more improvement on social adjustment (Fonagy, Rost, Carlyle, McPherson, Thomas, Fearon, Goldberg, &Taylor, 2015)

2.4.2 Adult process studies of the psychotherapy relationship and therapeutic alliance

The concept of the working alliance in psychoanalytic theory was examined by Bordin (1979) and he predicted the strength of the alliance and fit between therapist and patient would be the most influential on change and that it could be examined across different therapies. In 2004, Sandell interpreted 40-65% of psychotherapy research outcomes were related to common psychotherapist-related factors and only 7% to the chosen method, (cited in Lindgren, Folkesson, & Almqvist, 2010, p. 225). The therapeutic alliance has consistently predicted outcome in psychotherapy outcome research, but after 15 years of research in the area there was still much to be understood and learned according to Horvath and Luborsky (1993).

Blatt & Shahar (2004) revisited and further analysed data from the Menninger Psychotherapy Research Project (Wallerstein, 1987), and found subtle differences between psychoanalytic and supportive expressive psychotherapy in their mechanisms of change when assessing attachment style. They emphasised the contribution of interpersonal differences of psychotherapist and patient needed to be explored.

In a meta-analysis covering 14,000 treatments across different psychotherapies by Horvath, Del Re, Fluckiger, and Symonds (2011), the correlation of the alliance and outcome was robust and some findings of note were that the therapist's response to the alliance was critical, the alliance could not be separated out from the rest of the therapy experience, developing a good alliance early in therapy countered dropout and fostered collaboration, and the alliance fluctuated within and between sessions.

Hoglend (2014) reviewed the role of transference across different psychotherapies and found in almost all cases there were associations with transference and psychodynamic change, and that transference was important to women in particular who had difficult interpersonal relationships and severe personality pathology. He hypothesised that gain in insight was a potential mechanism for change, but that it had only been used in one study so needed further exploration.

2.4.3 Young adult long-term outcome and qualitative studies: Stockholm

Over a number of years, studies regarding the patient's experience of treatment and that of their psychotherapists have been conducted in the young adult (18 plus) range by members of

the Stockholm psychotherapy research group. They have focussed on expectations of therapy, working alliance, psychotherapy in retrospect, patients' views of psychoanalytic psychotherapy, and the therapists' view of psychoanalytic psychotherapy with young adults (Levander & Cullberg, 1994; Lilliengren & Werbart, 2005; Lilliengren & Werbart, 2010). It was found for young adults who overcame depression, the changes were not just about symptom relief but also about developing self-identity (von Below, Werbart, & Rehnberg, 2010).

In a qualitative study of young adults' experience of successful psychoanalytic psychotherapy, they found therapists experienced the work in a similar way, and the centrality of the relationship was confirmed as a secure base from which to explore and grow (Palmstierna & Werbart, 2013). A further mixed-method design study looked at the therapists' experience of successful psychotherapy with young adults and whilst it was seen as hard work, there was a positive charge to the relationship early on, and that the therapists' relaxed, flexible, and collaborative stance allowed for the young adult's autonomy. Three core themes were found: 'therapist motivation;' 'a safe and attentive therapeutic stance;' and 'a thorough, diligent approach.' Measures of outcome such as symptom reduction were used, but therapists also indicated dimensions of improvement in other areas (Werbart, Missios, Waldenström, & Lilliengren 2017).

2.5 The field of research in adolescent psychotherapy

Adolescent research has developed in the wake of research on adult psychotherapy. Some wide-ranging reviews in the field of research in adolescent psychotherapy have been

published, with less research into the relationship and process issues in adolescent psychotherapy. Often such studies have tended to straddle the developmental stages of both childhood and adolescence.

Different methods have been used to implement research into the effectiveness of psychotherapy with adolescents, and into the processes by which effectiveness is achieved. In the review below, the major methods of empirical research in this area are described, with reference to some of the more outstanding examples in each instance.

Fonagy (2003) proposed the need for a research agenda for child psychoanalytic psychotherapy with three major foci: first, to gather evidence related to specific patient groups; second, to develop measures sensitive enough to identify subtle changes beyond symptom alleviation, that can reflect the parents and child/adolescents' values of the benefits and may carry a predictive role to assist in prevention; and third, to adapt, extend and improve psychoanalytic psychotherapy, so that it is more generalizable over clinical groups and has a greater impact on symptom relief or prevention.

Types of published research include epidemiological, population or cohort studies as noted at the beginning of this chapter regarding the incidence of mental illness, diagnostic groupings, identification of mental health problems; defining mental health problems; exploration of causes of mental health problems; and mediating or protective factors associated with improvement.

Further, there are descriptive studies involving close observation, such as case studies, naturalistic follow up groups, diagnostic groupings, comorbidity studies of more than one diagnosis, retrospective studies, and audits.

Beyond the descriptive, the research has usually focused on outcome or process aspects of treatment including efficacy of treatment, with comparison between treatments in randomized controlled trials for different psychiatric diagnoses and effectiveness of treatment within clinical services.

The term psychotherapy is used in the field in a general way, and there remains a dearth of specific adolescent psychoanalytic studies without shifting into young adulthood or into child studies. Toward the end of this chapter, the few studies focussed on the experience of psychoanalytic psychotherapy in adolescence using a phenomenological qualitative analysis will be discussed in more detail, along with studies related to the psychotherapist's experience.

2.5.1 Meta-analyses and review of general child and adolescent psychotherapy

Through the late 1980s and 1990s, a small number of meta-analyses were reported concerning combined child and adolescent studies, mostly under research conditions with predominantly behavioural treatments.

Weisz, Weiss, Alicke, and Klotz, (1987), in a meta- analysis of 108 outcome studies of 4-to 18-year-old using various outcome measures, found 21% were better adjusted than those with no treatment and that therapy was more effective for children than adolescents. Weisz, Weiss, Han, Granger, and Morton (1995) presented a meta-analysis of 150 outcome studies

and referred to the two prior child and adolescent outcome studies meta-analyses by (Casey & Berman, 1985 and Weisz et al. 1987) which covered diverse treatment methods and clinical problems. In 1995, Weisz et al. found the overall mean effect of therapy was positive and highly significant, and they looked at types of problem, level of training, type of therapy but they found the overall effect of therapy was less than in their 1987 study. Behavioural treatment methods tended to have stronger effects than non-behavioural with particularly positive outcomes for adolescent girls. Treatment was seen to have stronger effects when specific clinical problems were targeted.

Weisz and Jensen (2001) reviewed over 500 studies conducted under laboratory conditions that showed probable efficacy for some therapy treatments for internalising disorders, but only 14 effectiveness studies of child and adolescent clinic studies, provided limited empirical evidence for treatment.

The first major critical review of 50 years of psychotherapy research was written by Roth and Fonagy (2006), and one chapter was devoted to the treatment of child and adolescent psychological disturbance which looked at meta-analytic studies of child therapy treatment outcomes. This showed that ¾ of children were better off after treatment compared with controls with no treatment. Treatments of particular disorders and evidence of their efficacy were also reviewed, and it was observed that there were considerably less studies of therapies for children than adults, and even less related to adolescents. There were more systematic studies of behavioural and cognitive-behavioural treatment (CBT) than family therapy or individual psychoanalytic psychotherapy.

Of the major meta-analyses Roth and Fonagy (2006) reviewed, they noted that non behavioural treatments and normal clinical populations were not represented, except for the work of Weisz and Weiss in 1989, which was the first attempt to study clinic-based treatment. At the time of their review whilst there was some evidence for the effectiveness of cognitive-behavioural programs with depressed children and adolescents, there was only one study involving clinical levels of depression and over half of the children treated were still depressed at termination. Midgley, Anderson, Grainger, Nesic-Vuckovic, & Urwin (2009) edited a further book on quantitative and qualitative international research in psychoanalytic child psychotherapy covered research history, philosophy and studies in the field.

2.5.1.1 Meta-analyses with psychoanalytic psychotherapy

Lis, Zennaro, and Mazzeschi (2001) focussed on CBT and psychoanalytic psychotherapies in their review of definitions of psychotherapy, and research into outcome and process in child and adolescent psychotherapy, noting there were quite broad definitions of what constituted psychotherapy which represented many types of intervention. Behavioural treatments were the most researched and evaluated, whilst psychodynamic therapies were the most practised in the United States and in European child and adolescent clinical services.

Kennedy (2004) wrote a report of a systematic review focussed on the effectiveness of psychoanalytic approaches in 37 studies using child and adolescent psychotherapy, most of which included clinically referred participants. A high level of disturbance was present for many, and a range of diagnoses and problems. Psychoanalytic psychotherapy was effective for a range of disorders, and those with more severe difficulties needed longer treatment and could be helped when this was provided.

In a systematic review of 34 studies of psychoanalytic psychotherapy in children and adolescents, which included nine randomised controlled trials (RCT), outcome studies indicated a growing evidence-base for the efficacy and effectiveness of psychoanalytic psychotherapy (Midgley & Kennedy, 2011).

Abbass, Rabung, Leichsenring, Refseth, and Midgley (2013) conducted a meta-analysis on 11 child and adolescent studies of short-term psychodynamic therapy (STPP) for a range of diagnoses including anxiety, depression, eating disorder and personality disorder and found this may be an effective treatment.

Zhou, Hetrick, Cuijpers, Qin, Barth, Whittington, Cohen, Del Giobane, Liu, Michael, Zhang, Weisz, and Xie (2015) conducted a systematic review and network meta-analysis of 52 RCTs with children and adolescents with depression and found CBT (N=1149) and interpersonal therapy (IPT) (N=344) to be the most effective, while psychodynamic psychotherapy (N=35) was found to have no effect.

Fonagy, Cottrell, Phillips, Bevington, Glaser, and Allison (2015) published the second edition of their book critically reviewing child and adolescent research of treatments pertaining to specific diagnostic groups. This provided an evidence-base for the use of particular treatments with specific mental health problems with only a handful of studies specific to manualised psychoanalytic treatments. There has been controversy around the use of treatment manuals in psychotherapies, with research reviews indicating that they can impede the effectiveness of the best therapists (Silverman, 1996; Wampold & Hanna, 2003), whilst for others a manualised treatment has tighter controls for efficacy research.

Briggs, Netuveli, Gould, Gkaravella, Gluckman, Kangogyere, Farr, Goldblatt & Lindner (2019), conducted a systemic review and meta-analysis on the effectiveness of psychoanalytic psychotherapy in the decrease of suicidal behaviour and self-harm, stating this was the first in this area. They looked at twelve trials of psychoanalytic psychotherapy RCTS and these included adolescents as well as children and adults. It was found that psychoanalytic psychotherapy was effective in reducing suicidal behaviour and self-harm, but the latter effect was short-term, as reduction was not maintained at the 12-month follow up.

2.5.1.2 Meta-analyses and reviews of therapeutic relationship research

Meta-analyses of therapeutic alliance related to adolescents and treatment studies show research in this area is increasing DiGiuseppe, Linscott, & Jilton, 1996; Karver, Fields, & Bickman, 2006; Shirk and Karver, 2011).

In 2004, Bickman, Vides de Andrade, Lambert, Doucette, Sapyta, Boyd, Rumberger, Moore-Kurnot, McDonough, and Rauktis estimated that less than 3 % of child treatment studies had analysed treatment processes such as therapeutic alliance, despite how predictive it had become in terms of psychotherapy outcome in adult research. They proposed that therapeutic alliance might be an even more significant component of treatment for youth and children, given they do not usually seek treatment on their own accord. They further speculated that research by Armbruster and Kazdin (1994) found 30% to 60% of youths terminated prematurely which might indicate the need to explore the therapy relationship.

Oetzel & Scherer (2003) in a review of therapeutic alliance found initial engagement was necessary for a successful psychotherapy intervention. Engaging adolescents was found to be difficult and adult therapeutic models were not suitable in working with them. They reported that expression of empathy, genuineness assisted engagement and the therapeutic alliance. Karver, Handelsman, Fields, and Bickman (2006) noted that the empirically supported therapy movement through its focus on evidence-based outcomes, has ignored common therapy process factors which have a greater impact on outcomes. In their meta-analysis of 49 youth studies, they examined therapeutic relationship variables and the extent they contributed to outcomes. A number of treatment approaches were included, but only four with psychoanalytic psychotherapy and one with play therapy. They reported on a wide variety of therapy relationship constructs with "process to outcome" and "process to process relationship" for each construct.

Zack, Castonguay, and Boswell (2007) reviewed the adult literature and youth alliance studies and the general findings that the relationship does matter and that a weak alliance is associated with premature termination. They commented on the lack of a single definition of youth alliance and concern that adult alliance definitions continue to be used even though this may well be inappropriate.

2.5.2 Efficacy studies of psychotherapy

There is a tendency to review studies in the literature according to diagnostic group. This approach provides a higher degree of homogeneity in the population of interest, which helps to reduce multiple variables. However, the power of such studies can be compromised in generalising to clinical populations of serious mentally ill patients, where there is high

complexity particularly in relation to co-morbidity of diagnoses, socio-economic, abuse and cultural differences.

Birmaher, Brent, Kolko, Baugher, Bridge, Holder, Iyengar, and Ulloa (2000), enrolled 107 patients with a DSM-111-R diagnosis of major depression, aged between 13 and 17 years of age, excluding those with ongoing sexual and physical abuse, psychosis, bipolar, obsessive-compulsive, eating or substance disorder and randomised them into three psychotherapy treatment groups and found that in the short term CBT was more efficacious than the alternative therapies of family therapy and supportive psychotherapy. However, they were followed up for 2 years after the 12-to-16 week trial and no differential effects was found for the three therapies in the long term.

The Treatment for Adolescents with Depression Study (TADS) which was an RCT of 439 patients aged between 12 and 17 years diagnosed with major depression found the combination of Fluoxetine and CBT showed the greatest reduction in suicide attempts (March, 2004).

Research within adolescent psychiatry in relation to treatment efficacy and effectiveness has considerably more empirical studies with RCTs looking at the use of CBT, medication, or a combination, than with psychoanalytic psychotherapy. These studies have shown that psychotherapy is effective in the treatment of adolescents with depression, and this diagnostic group appears to have been more extensively studied in the last few years (Goodyer, 2007; Melvin, Tonge, King, Heyne, Gordon, & Klimkeit, 2006; Weisz, Southam-Gerow, Gordis, Connor-Smith, Chu, Langer, McLeod, Jensen-Doss, Updegraff, & Weiss, 2009).

2.5.3 Efficacy studies of psychoanalytic psychotherapy

An Australian randomised control trial of 54 children diagnosed with anxiety disorders where the age range did extend into adolescence (14 years) compared cognitive behavioural treatments with treatment as usual (TAU) (comprising child psychotherapy, family therapy and eclectic treatments), and found that there was no significant difference between the treatments but that the children did improve significantly on all anxiety measures over time. (Barrington, Prior, Richardson, & Allen, 2005).

Trowell, Joffe, Campbell, Clemente, Almqvist, Soininen, Koskenranta-Aalto, Weintraub, Kolaitis, Tomaras, Anastasopoulos, Grayson, Barnes, and Tsiantis, (2007) used an RCT for N= 72 patients aged between 9-15 years, who were diagnosed as moderately to severely depressed. They randomly allocated participants to two treatment groups of either psychoanalytic psychotherapy or family therapy (FT), to test the clinical effectiveness of these treatments for depression. They found significant reductions in clinical depression for both treatments (74.3% off psychoanalytic psychotherapy group and 75.1% of the FT group were no longer clinically depressed) and these included cases of double depression (that is dysthymia and major depression). At the six-month follow-up, after the completion of treatment, 100% of the individual psychoanalytic psychotherapy patients and 81% of the FT patients no longer had depression. It is noted that, similar to a number of studies in the field it included a mixed age-group which straddled childhood and adolescence, and it would be

useful to see the effectiveness of treatment and diagnosis for the separate developmental stages or age groups.

It is noted that the IMPACT study developed an RCT protocol to examine CBT and short-term psychoanalytic psychotherapy (STPP) for adolescents with uni-polar depression in terms of reduction of relapse (Goodyer, Tsancheva, Byford, Dubicka, Hill, Kelvin, Reynolds, Roberts, Senior, Suckling, Wilkinson, Target, & Fonagy, 2011). They further reported on the use of this protocol in a multicentre, observer blind RCT across 15 CAMHS sites in England with 470 adolescents (11-17 years) diagnosed with a major depressive disorder. They compared the outcome of 3 different treatment interventions 12 months after treatment. Adolescents were randomly assigned to CBT, short-term psychoanalytic psychotherapy or a brief psychological intervention and followed up at several time points. At 36 weeks post treatment there was no significant difference between CBT and short-term psychoanalytic psychotherapy groups on self-reported depression symptoms and neither treatment was superior to brief psychological intervention, with no significant difference in treatment costs between the groups (Goodyer et al. 2017).

Salzer, Stefini, Kronmüller, Leibing, Leichsenring, Henningsen, Peseschkian, Reich, Rosner, Ruhl, Schopf, Steinert, Vonderlin, and Steil (2018) in an RCT comparing CBT, psychodynamic psychotherapy, and waitlist for 107 adolescents 14-20 years-of-age diagnosed with social anxiety disorder. Assessment occurred at baseline, termination, at 6 months and 12 months post-termination. Both treatment groups were found to produce better outcomes than the waitlist.

2.5.4 Outcome clinic studies in adolescent psychoanalytic psychotherapy

In their Time For A Future Project (TFFP), Tonge, Hughes, Pullen, Beaufoy, and Gold (2008) recruited 88 adolescents seen in CAMHS, to a naturalistic study with a range of comorbid diagnoses. At the 12-month follow up, 55 participants responded, and those in psychoanalytic psychotherapy had a greater reduction on measures of depression, social and attention problems than did those in treatment as usual (TAU) alone (Tonge, Pullen, Hughes, & Beaufoy, 2009). Being a naturalistic study of real-life psychoanalytic psychotherapy, this outcome study is considered an effectiveness rather than an efficacy study.

Baruch and Vrouva (2010) reported on a 15-year service audit in a clinic study, which began in 1993 at a voluntary community psychotherapy service for 1608 young people aged between 12- 21 years of age with multiple difficulties . The clinic provided open-ended psychodynamic psychotherapy and repeated measures such as the Youth Self Report. The dropout rate was high, particularly for younger adolescents with externalising behaviours, suggesting externalising behaviours are more difficult to treat with psychodynamic psychotherapy. Participation at baseline was 94% and it dropped to a 38% response rate at the 12-month follow up. Their discussion concerned the difficulties of collecting data post treatment and the value in collecting routine audit data whilst patients remained in treatment as a way of maximising data collection.

2.5.4.1 Adolescent inpatient assessment and discharge follow up studies

Gossett, Barnhart, Lewis, and Phillips (1977) followed up 60 adolescent patients from 26 months to 4 years post discharge with a clinical interview and looked at six variables, namely severity of psychopathology, onset of symptomatology, type of hospital treatment

termination: continuation of psychotherapy post discharge, physically destructive behaviour prehospitalisation and energy level. They also sought evaluation from the spouse and/or parent of the adolescent at follow up. Their findings suggested that those patients diagnosed as neurotic had an extremely high probability of functioning well several years after discharge. Those with process or chronic psychosis in adolescence had a lower probability of being able to function well, although a few did seem to recover, and this may have been connected to the continuation of psychotherapy post discharge. Results from this study agreed with earlier studies that initial psychopathology and the type of onset of symptomatology were the most useful predictors of long-term outcome.

Pyne, Morrison, and Ainsworth (1985) followed up the first 70 patients 12 months after discharge, from an adolescent inpatient unit, assessing their outcome using a semi-structured interview on three areas of global functioning which were sexual, work, and social adjustment and change of their main symptom was rated at discharge using a 4-point scale. They found that the optimal stay was 5-25 weeks was the optimum level of stay and those who completed treatment did better than those discharged prematurely. The focus of this research, however, was as an evaluation of the service delivery of an adolescent inpatient unit and they did not appear to have a repeat follow-up design based on base-line data.

Allen, Hauser and Borman-Spurrel (1996) explored the long-term sequalae of psychopathology in adolescents hospitalised at 14 years old, compared to a similar socio-demographic school group at the time of hospitalisation and eleven years later retaining 142 of the original 146 participants. An attachment perspective of the internal working model was used, and they found severe adolescent psychopathology was more likely to become a

long-term psychopathology with those insecurely attached in the hospitalised group but could possibly be mediated by attachment organisation.

Rosenstein and Horowitz (1996) conducted attachment assessments on 27 mother-adolescent pairs amongst a group of 60 adolescent inpatients all found to have adolescent and maternal insecure attachments, particular attachment organisations were linked to specific personality traits, and their findings supported a model incorporating relational experiences with parents.

Skarbo, Rosenvinge, and Holte (2004) provided an example of a long-term mental health outcome study of young adults who as children or adolescents were referred to outpatient psychiatry for mental health problems. One hundred patients referred to Nordland County, Norway during 1990-1994 were interviewed in-depth 5-9 years after referral. They used multiple measures (GHQ & GAF, SCL-90, Beck, BDI, BHS, SES) and there was a general effect of life events at a young age affecting several mental health variables. Childhood and adolescence difficulties were highly correlated, indicating a possible continuation of effects from childhood to adolescence.

A further direction in research in hospitalised adolescents and their follow up has been to incorporate understanding of attachment, and the impact of insecure attachment organisation on personality development, psychopathology, such as the capacity for reflective functioning or mentalization, self-regulation and other outcomes of functioning (Hart, Venta, & Sharp, 2017; Sharp, Venta, Vanwoerden, Schramm, Ha, Newlin, Reddy & Fonagy, 2016; Sharp, Ha, Carbone, Kim, Perry, Williams & Fonagy, 2013).

2.5.5 Case studies in adolescent psychoanalytic psychotherapy

The single case-study design has a strong tradition in psychoanalytic psychotherapy research and has been a research method of choice within psychoanalysis and psychoanalytic psychotherapy. This has been used to study particular themes, theoretical concepts, and techniques in working with different diagnostic groups in adolescence, such as eating disorders, depression, trauma, psychosis, working with the transference, countertransference resistance and common defense mechanisms (Anastasopoulos, 1997; Andreou, 1991; Barrett, 2008; Bromfeld, 2000; Hug & Lohne, 2009; Lombardi & Pola, 2010; Marriott, 2007; Novak, 2004; Seidel, 2006).

2.5.5.1 Adolescent multiple case studies in psychoanalytic psychotherapy

The Psychotherapy Research Project of the Menninger Foundation of 1954 to 1982 used a detailed multiple case-study and followed up 42 people for over 40 years. Despite their original intention to recruit only adults, due to the complexities related to growth and developmental processes occurring in adolescence, they did end up with an adolescent 'special group' of 8 young people between 17 and 23 years of age (4 were under 20) designated as such, due to their educational and psychological development (Wallerstein, 2000).

Regarding the treatment prognosis for 3 of the adolescent group there was an over-optimism which was attributed to the precocity and intellectual and emotional growth issues in two adolescents. Failure to account for the combination of longstanding emotional disturbance and the degree of personality disorganisation was seen as contributing to overestimating treatment prognosis, along with being disarmed by intellectual endowment and the

concealment of information. One of the adolescents completed suicide 11 years after her first psychoanalysis ended and one year into a new psychotherapy treatment, following the development of a psychotic illness. It was concluded that the initial analysis was insufficient to prevent her decompensating ten years later. Another finding was that premature cessation of treatment was linked to the ambivalence of the relative who paid for psychoanalytic treatment regarding its effectiveness, and he encouraged the young person to stop treatment prematurely when there appeared to be improvement (Wallerstein, 2000).

There were many limitations evident in this study. The researcher's perspective was dominant, and the therapists' notes and the voices of the adolescent and their parents were not present. The adolescents were assigned to a 'special group,' rather than the research and treatment needs developed for that particular age group and its developmental needs. It would not comply with ethical standards today, as informed consent was not obtained at the outset. It would be difficult to replicate the study due to a number of reasons, including cost (for a sample of 42 patients, there were at times 20 investigators gathering data for years); and there were no regular questionnaires or recordings. When the study began in the 1950's there were not the systematic processes employed to analyse multiple case studies as there are today (Yin, 2009).

Another long- term study, from 1989 to 1994, (Hauser, Allen, & Golden, 2006), looked at recovery from psychiatric illness of 150 adolescents who were hospitalised in their early teens and had annual assessments. Twelve years after hospitalisation, most of the then young adults were unhappy in their lives and struggling, but a small group of young adults were happy and doing well. The researchers selected nine young people who met their criteria for high resilience based on what would be expected of well-functioning young adults, and a

contrast group of seven young people who were of average resilience and conducted two extended interviews supplemented with psychological development assessment measures. They used the narratives of the sixteen participants to determine and compare themes between the two groups and examined content and structure. This method was a way to understand levels of resilience and how resilience might be influenced by experience. The researchers then described four detailed case studies from the resilient group based on 4 interviews held during the course of the original study and the follow up interviews from the second study.

There were common themes of early difficulties, including abuse for some, and themes about relationships in both groups. An important difference, however, was that the resilient group thought more about their participation in relationships, whilst the contrast group talked less about others, and the way relationships worked seemed of less interest. Both groups had an early vision of themselves and their place in the world, but a difference in their views emerged as young adults. The resilient group's vision of themselves changed as their lives changed, whilst the early vision was still dominant for the other group. Hauser et al. (2006) concluded that ideals and values being less rigid, and more open to elaboration and change, were suggestive of protective factors in operation in the development of resilience.

2.5.6 Mixed outcome, process, and micro-process research in psychoanalytic psychotherapy

Church (1993) conducted a study looking at the construct of "Transference" in adolescent psychotherapy (16 to 18 years of age) using transcripts of audiotaped sessions and compared the way 3 novice and 3 experienced therapists dealt with transference in the sessions. She

found experienced therapists were quite active in responding to transference allusions and made these a central focus of the therapy. Novice therapists on the other hand, rarely commented on them and appeared threatened by both overt and covert transference feelings; the patients frequently rejected their therapy-related interventions.

Atzil Slonim, Shefler, Dvir Gvirsman, and Tishby (2011) used the Core Conflictual Relationship Theme (CCRT) method on interview with 72 adolescents (15-18 years), who had been in psychodynamic psychotherapy for one year to explore rigidity in interpersonal patterns and found a reduction in symptoms and rigidity during the course of their psychotherapy.

Bychkova, Hillman, Midgley, and Schneider (2011) compared processes of 5 different types of therapy with adolescents using the Adolescent Psychotherapy Q- set. Eighteen experienced therapists rated their typical and actual practice. Preliminary findings revealed some cross-modality similarities and differences, and therapist-adolescent interactions.

2.5.7 Adolescent services research

Reference to this area of research was considered important as the present study explored the treatment context of the adolescents seen in psychoanalytic psychotherapy who were patients of public CAMHS.

Service research has become paramount in industrialised countries in order to describe types of clients who use services, whether their needs are being met by services, and the costs of providing services. In times of limited resources what are the best ways of working with

people to achieve the best mental health outcomes? Requirements to develop adolescent evidence-based treatments that are effective and efficient have become critical for service funders, managers, and government policymakers.

Basu and Isaacs (2019) profiled 101 case-records (from 2013-2017) for cultural diversity in a regional Victorian CAMHS in Australia and found just under 50% were Aboriginal in addition to nineteen other different cultural groups. The main diagnosis was disruptive mood regulation disorder (nearly 40%), and over a quarter were diagnosed with developmental trauma disorder. The most common psychosocial stressor was conflict and death in the family followed by domestic violence and emotional abuse. They pointed out the challenges for children adjusting to remote and rural areas and the need for clinicians to have cultural awareness in their assessments.

Audin, Mellor-Clark, Barkham, Margison, McGrath, Lewis, Cann, Duffy, and Parry (2001) proposed a model in the UK public mental health setting for developing practice research networks to provide the infrastructure to enable discrete services within a geographical region the opportunity to collaborate on audit and evaluation ventures.

There are examples of studies in services research in the UK where adolescents or their parents have been asked about their views of mental health services ((Paul, Berriman, and Evan, 2007, Worrall-Davies, 2008; Worrall-Davies, Kiernan, Anderton, & Cottrell, 2004; Worrall-Davies & Marino-Francis, 2008).

In an example of how research findings can have direct implications for better ways to improve service access, Ford, Hamilton, Meltzer, and Goodman (2008) conducted a general

population study of 2461 children aged 5 -15 years which explored service use in relation to mental health in the UK by examining a number of potential predictors gathered in a 1999 cohort study, and the use of services over the next three years. They found three factors predicted contact with most services, namely the impact of psychopathology, contact with teachers or primary health care, and the perceptions of the parents and teachers of the degree of the child's difficulties. They thus concluded that education of teachers and parents might improve the chances of children with significant psychiatric difficulties being referred to appropriate services.

Singh, Paul, Ford, Kramer, Weaver, McLaren, Hovish, Islam, Belling, and White (2010), studied the transition from CAMHS to adult mental health services across six mental health trusts in England over one year. In evaluating the process and outcomes of users, carers, and clinicians they conducted some additional qualitative interviews. They found for the majority of the 154 adolescents, that transitioned to adult services their transition in terms of process and outcomes was poor.

Watsford, Rickwood, and Vanags (2013) used a qualitative method for analysing themes regarding interviews with 20 participants aged between 12 and 24 years, about their expectations of attending an Australian youth mental health service prior to their first appointment. They found that, overall, the young people were unsure of what to expect, and that unrealistic and unmet expectations contributed to a less positive engagement and outcome.

Following this Watsford & Rickwood (2014) used a quantitative prospective research method consisting of a survey prior to treatment and two months later, of participants aged 12 to 25 who attended a youth mental health service. They found the participants' experience of

therapy and their commitment to therapy were associated with positive outcome variables and their findings suggested that initial expectations are less important than motivation and early actual experience of therapy.

In a third study Bradford and Rickwood (2014) surveyed the preferred models of delivery for mental health services of a non-clinical sample of participants aged between 15 and 19. For those with depressive symptoms, two-thirds preferred a face-to-face interaction, and only 16% said they would prefer an online treatment, and they were more likely to be male. However, the highest intention expressed was to not seek help.

2.5.8 In-depth qualitative studies of adolescent's experience of psychotherapy

2.5.8.1 In-depth qualitative studies of adolescent's experience of psychoanalytic psychotherapy

There are few studies on adolescents' and psychotherapists' experience of adolescent psychoanalytic psychotherapy. Given the view of psychoanalytic psychotherapy as a co-evolving relationship between the adolescent and the therapist whereby both influence the other consciously and unconsciously, it makes sense to explore the psychoanalytic psychotherapy process from the perspective of each participant's experience.

Very few studies have been reported which explored the experience of psychoanalytic psychotherapy either from the adolescent's or the psychotherapist's perspective, and both are the focus of the present study.

Eight main studies of adolescent and psychotherapist perspectives that have been found are discussed below. Each used an interpretative phenomenological analysis (Smith, Flowers, & Larkin, 2009) to reach some understanding of the participants' experiences and highlight different aspects of the meaning of psychoanalytic psychotherapy for either adolescents or psychotherapists.

2.5.8.2 Binder, Moltu, Hummelsund, Sagen, and Holgersen (2011)

In a Norwegian study, 14 adolescent participants (16 -19 years), who had been in ongoing psychotherapy for at least 3 sessions, were interviewed using a semi-structured interview. Their aim was to develop descriptive knowledge from the adolescents' perspective on their therapists and the therapeutic relationship. Findings included an overarching theme of the therapist's establishment of a collaborative relationship that helped foster the autonomy and individuality of the adolescent. Other themes found were ambivalence and vulnerability at the beginning of therapy, the need to see that the therapist as comfortable in their role, the therapist's ability to help the adolescent with therapy boundary awareness when they were in a regressed state and to recognise and respect the adolescent's boundaries, and finally to help the adolescent make meaning and sense of their intense experiences (Binder, Moltu, Hummelsund, Sagen, & Holgersen, 2011).

There was no consistent treatment approach used, so different styles of psychotherapy included CBT, psychodynamic and systemic approaches. Further limitations of the study were the variation in range of the length of psychotherapy (from 3 sessions to several years), with some having had more than one therapist. Treatment was concurrent with the research and was part of the CAMHS TAU. The study concentrated on older adolescents and some of

the findings in the research reflected their developmental preoccupations in terms of identity, independence, and autonomy. A strength of the study was that five researchers were involved in identification, development and auditing of themes that emerged from the patients' data.

2.5.8.3 Bury, Raval, and Lyon (2007).

A second qualitative study in the UK used a semi-structured, narrative based interview with 6 young people (16- 21 years). All had finished psychoanalytic psychotherapy for at least 3 months in the public CAMHS treatment system and letters inviting participation in the study were sent out to 36 patients of the community clinic.

They also used an interpretative phenomenological analysis which generated 3 main themes. The first main theme that emerged was seeking help and engagement, and it had three subthemes of being in difficulty, stigma, and prior expectations. The second main theme was about beginning therapy and ambivalence and the therapist's response emerged as subthemes. The third theme was the therapeutic process of therapy and included sub themes of learning what therapy required of them, what was helpful, and the power differential where participants found it hard to challenge the therapist. The final theme was finishing therapy, which included sub themes of ambivalence, separation and loss and moving on. The theme of ambivalence and heightened anxiety state of participants at the beginning was discussed in relation to seeking help and in terms of the tension between developmental needs of adolescence to separate and individuate versus being in serious psychological difficulty. The affective relationship with the therapist was also found to be of importance. The researchers recommended that if patient's views were listened to, this may improve their initial

engagement and assist in the development of more appropriate service processes (Bury, Raval, & Lyon, 2007).

Strengths of the study were that treatment was completed and there was a specific treatment of psychoanalytic psychotherapy (trained at Brandon Centre by Baruch whose research has been mentioned in this review). The longest period of treatment was just over 18 months. The study makes an important beginning contribution to the evidence base of psychoanalytic psychotherapy in relation to presenting the adolescents' voices and meanings around psychoanalytic psychotherapy. Rich data emerged from a systematic analysis that could be used for outcome factors based on their significance to participants in psychoanalytic psychotherapy. A further strength of the study was that it is specifically looking at adolescents, and there is no merging of data covering both child and adolescent psychoanalytic psychotherapy.

Limitations of the study are around potential biases in recruitment of only 6 of 36 potential participants and the reasons the majority did not participate remain unknown. Another limitation is that the study does not seek the views of relevant others such as therapists and parents/carers.

2.5.8.4 Midgley, Target, and Smith (2006) & Midgley & Target (2005)

Midgley, Target, and Smith (2006) used a 'memories of therapy' interview to look at the outcome of child psychoanalysis (4 to 5 sessions per week) from the patient's point of view. In their group of 27, there were 6 who were referred as adolescents. A number of important themes emerged in response to the way therapy had helped. These included the act of talking

to someone in and of itself, the aspect of unburdening themselves to a person who listened, for some the emphasis was on the attention of the therapist changing how they felt about themselves, and how talking to the therapist led to seeing things differently. The authors were concerned that over a third of their group had found analysis had not helped or was a waste of time. They described their study as unique and concluded that whatever distortions there were in a retrospective study it still had value in adding to the understanding of child psychoanalysis, in a field where the patient's voice has been remarkably under-investigated, (Midgley, Target, & Smith, 2006).

A limitation of the study is that the follow up was done between 18 to 42 years after initial referral. Forty-two % responded to a written invitation sent to former child patients, and it was unknown what distinguished those who participated from those who did not. It was unclear whether any of the participants were still in treatment. Combining child and adolescent data when they are quite different developmental stages was problematic in this study. Information might be better examined more fully in the light of the separate stages of development. The study looked at child analysis which usually has more frequent sessions per week compared to psychoanalytic psychotherapy in a public setting. Whilst the analysts would have had a rigorous training, a lot would have changed in technique and approach over the course of the 42 years of this retrospective study.

2.5.8.5 Sagen, Hummelsund, and Binder, (2013)

The fourth study is part of a larger study that occurred within CAMHS in Norway and presented findings from the same group of patients studied in 2.5.8.2 above and evidenced evidencing similar strengths and limitations to that study, as previously mentioned on p. 65.

Here the focus was to explore relational qualities of the therapist that made it easier for the adolescent to talk openly. Using phenomenological thematic analysis, five themes emerged – receiving full, undivided attention, not having to look after the therapist, feeling accepted and valued, having the therapist sit with them and their distress, and therapist facilitation of openness through sharing (Sagen, Hummelsund, & Binder, 2013).

2.5.9 Psychotherapists' experience of adolescent psychoanalytic psychotherapy

2.5.9.1 Binder, Holgersen and Nielsen (2008a)

A qualitative study examining the perspectives of nine psychotherapists looked at the challenges they experienced trying to connect and form a bond in adolescent psychotherapy. The therapists worked across two Norwegian CAMHS. A phenomenological hermeneutic analysis was made of transcript material. Five themes emerged- understanding the problem so work progressed collaboratively, finding the therapist role, motivating adolescent engagement, developing a frame to co-create meaning making, and managing the adolescent's ambivalence. The writers concluded with emphasising the importance of exploring the psychotherapists' subjective experience of therapeutic dilemmas (Binder, Holgersen, &Nielsen, 2008a).

Strengths of the study included a narrow focus which enabled in-depth interpretive analysis of therapists' descriptive knowledge on the beginning phase of adolescent therapy. Everyday views on the importance of developing a therapeutic bond, and how the therapists connected with adolescents were elicited. The researchers also examined an intersubjective matrix with regard to the therapist's theoretical position, the stage of adolescent development and

contextual demands of public mental health services in Norway and expectations of empirically supported treatment. Common dilemmas in the work were identified, but therapists had different solutions, but agreed that the establishment of a therapeutic bond was hard work and more so when adolescent ambivalence was involved. It was concluded by the researchers that the importance of flexibility according to the relational needs of individuals, was at odds with public mental health treatment contextual demands (Binder et al., 2008a).

A limitation was the considerable variability in the therapist's clinical and theoretical orientation, age and experience, and lack of detail on their specific training, which made it difficult to determine what factors mostly influenced their approach and how they positioned themselves in their intersubjective relating with the adolescent. Binder et al. (2008a) recommended more research was required into the adolescent's experience of the therapeutic relationship.

2.5.9.2 Binder, Holgersen, and Nielsen (2008b)

A second qualitative study using the same group psychotherapists working in public CAMHS in Norway focused on ruptures in the working alliance in psychotherapy with adolescent clients. It found most participants explored the reasons for the rupture from the adolescent's perspective but differed on how much they would go into the therapeutic relationship or adolescent intrapsychic aspects. It was noted that there was a wide range of clinical experience and adolescent specific experience ranged from 1 to 15 years. The authors reported that to invite the adolescent's perspective on the relationship can be personally

challenging for the therapists but produced a more equal and collaborative relationship (Binder, Holgersen and Nielsen, 2008b).

The strengths identified in section 2.5.9.1 equally apply to 2.5.9.2 as the researchers have taken a large research study and then narrowed the focus for a more in-depth paper on a specific clinical area, addressing relevant adolescent developmental processes and how they impact on the therapist's thinking and approach, particularly around facilitating adolescent autonomy within the therapeutic relationship.

A limitation of this study was described in Section 2.5.9.1. was only one therapist claimed to be purely psychodynamic and the others practiced eclecticism which included psychodynamic, with one not having a psychodynamic perspective. Given that some psychotherapists described themselves as using more than one style of therapy, it is impossible to determine what differences in experience might surround their theoretical positions and ways of working..

2.5.9.3 Jones, Rabu, Rossberg, and Ulberg (2020)

Described as a separate qualitative study nested within an RCT with depressed teenagers (16-18) transference was investigated in psychoanalytic psychotherapy treatment. Out of nine therapists in the original study, six therapists (54-71 years), agreed to face to face in-depth interviews. All the participants were experienced mental health clinicians identified as having primarily a psychoanalytic/psychodynamic theoretical position with a minimum of 2 years of formal psychodynamic training, and a further 1-year training in psychodynamic psychotherapy with and without transference interpretation. The participants were

interviewed for the purpose of adding knowledge and understanding of transference interpretations (TI) from the therapist's experience. The therapists identified circumstances when (TI) was not advisable, such as times of emotional crisis, when there were mentalization difficulties, history of relational trauma, and time-limited therapy. TI was seen as a way of enhancing the therapeutic relationship, but that intervention must be relevant to the therapeutic material (Jones, Rabu, Rossberg, and Ulberg, 2020).

Strengths of the research were that a common training and type of psychotherapy was offered by the therapists which was psychoanalytic. The researchers also gave a transparent step by step description of their method of thematic analysis. Constraints of the study were that the therapists reflected back several years to the original therapies in the RCT, and the use of TI or non-TI was based on an original randomised allocation, and this was not a naturalistic treatment situation. The challenge of not being able to interpret was experienced when it was the allocated condition but contrary to the therapist's clinical intuition and interfered with the natural intersubjective process between therapist and adolescent. Another issue was the group of adolescents was diagnosed with MDD, but in clinical mental health settings, adolescents more commonly have co-existing diagnoses and contextual concerns, and it could be inferred from the psychotherapist's comments that the latter was indeed the case. The psychodynamic psychotherapy offered was also short-term and manualised.

2.6 An integrative study of psychoanalytic psychotherapy with adolescents

The above review of relevant research to adolescent psychoanalytic psychotherapy sets the background for the empirical study reported in this thesis. Eight in-depth qualitative studies of the experience of psychoanalytic psychotherapy during adolescence from the perspective

of adolescents in public mental health services and psychotherapists were highlighted. Four papers generated by a larger study in Norway looking at the perspective of adolescents and psychotherapists around engagement, and processes of engagement at the beginning of psychotherapy from the perspective of the adolescent and from the psychotherapist in terms of making and developing a therapeutic bond, and ways of understanding and repairing ruptures in the therapeutic alliance. (Binder et al., 2011; Binder, et al., 2008a; Binder et al., 2008b; Sagen et al., 2013). The Norwegian studies referenced attachment theory, therapeutic alliance research, psychoanalytic and adolescent developmental theory and processes and used a phenomenological interpretative analysis (IPA) of interview transcripts. Initial ambivalence and vulnerability were experienced by adolescents, and this was also a feature of findings of Bury et al., (2007), who looked at adolescents receiving psychodynamic psychotherapy within UK CAMHS, and they divided themes into broad domains of seeking help and expectations; engagement and beginning therapy; the processes of therapy and finishing therapy, with ambivalence being a feature at the beginning and the end of therapy.

Midgley et al., (2006, 2005) in a retrospective study of the experience of child analysis 18 to 42 years after referral, also had participants referred and treated during adolescence and used IPA on interview data. Common features of all studies were the importance of having someone to talk to who listened, and through the process adolescents developed a capacity to think about different perspectives and changed the way they felt about themselves. Sagen et al., (2013) also found the experience of receiving complete attention from the therapist helped adolescents feel accepted and valued. Binder et al., (2008b) further reinforced the importance of collaborative working relationships which enable open discussion around ruptures when they occurred. Jones et al., (2020) explored TI and non-TI within psychoanalytic psychotherapies and their use depended on the developmental stage of the

adolescent, their trauma history, capacity for mentalization and whether they were in crisis. Despite differences in location, culture, clinical services, and historical contexts, and the length of time since treatment, across studies, there were a number of commonalities in themes, but also differences around how the adolescent understood and felt about the referral and the helpfulness or not of the treatment.

Some studies had limited detail about clinical training, theoretical orientation, and psychodynamic supervision, of the psychotherapists, and the treatment was part of treatment as usual in CAMHS which may have included other functions for the therapists.. Some studies involved short-term and manualised treatment, and studies varied in the length of time in retrospect that psychotherapy had finished, and for some their therapy was current making diversity in length of treatment variable as well. Only one study touched on the impact of the treatment context of public mental health services. Previous qualitative studies above focussed more heavily on the engagement and beginning of therapy.. There is a gap in the research field related to in-depth qualitative studies on the phenomenological experience of adolescents in long-term psychoanalytic psychotherapy where the psychotherapy is non-manualised, the training of the psychotherapists is clear and multiple perspectives with rich information about the context of treatment, the adolescents and their therapists are considered.

This study was inspired by the TFFP which commenced in Victoria, Australia at the end of 2001. As noted in section 2.5.4 above. The TFFP was a follow up, naturalistic study of adolescents with serious mental illness who were engaged in psychoanalytic psychotherapy treatment provided within the public CAMHS system. The next chapter will give a description of the TFFP.

CHAPTER 3

THE TIME FOR A FUTURE PSYCHOANALYTIC PSYCHOTHERAPY PROJECT

The study reported in this thesis had its impetus in the findings of the four-year follow-up phase of The Time for a Future Psychoanalytic Psychotherapy Project (TFFP). This clinical research program was designed in the latter half of 2001, and data were collected over the decade between 2002 to 2012.

3.1 Background to the TFFP

The TFFP was a naturalistic assessment and re-assessment follow-up study of the recovery process of emotionally and behaviourally disturbed adolescents referred to Child and Adolescent Mental Health Services (CAMHS) in urban and metropolitan regions of the city of Melbourne and regional Victoria, Australia. CAMHS were run and funded under the auspice of the Victorian State Government and the CAMHS Directors were responsible to the mental health section of the Department of Human Services. The TFFP was funded to provide psychoanalytic psychotherapy in addition to (TAU) to seriously mentally ill adolescent patients of CAMHS across Victoria. The TFFP was a study of effectiveness rather than efficacy.

Victoria is the second smallest state of Australia in land mass and is roughly equivalent to the size of mainland Great Britain. Its total land mass, including mainland and islands is 227,416 square kilometres which amounts to 3% of the entire continent of Australia according to Geoscience Australia (2004). The capital city Melbourne has the second largest population

of Australia's cities, and its land size is 9,990.52 square kilometres, which is roughly six times the area size of Greater London but with less population density. By 2012 to travel from one side of Greater Melbourne to the other was approximately 130 kilometres from each compass point. In 2015, the population density of Victoria was 26 people per square kilometre, and the population density of Greater Melbourne was 450 people per square kilometre, but the highest density was in the inner-city where it was 14,100 people per square kilometre (ABS, 2015).

In 2002, when the TFFP started recruiting, the State of Victoria was divided into 9 health regions, with considerable diversity within and between regions, although the greater the distance from the capital the less ethnic diversity occurred. Greater Melbourne supplied three quarters of the population of Victoria, and Melbourne's outer suburbs accounted for 89% of the total population growth of the State between 2001 and 2011 (ABS, 2011). This trend has continued with Melbourne maintaining the fastest and largest growth of any of the greater capital cities in Australia by 2014-2015 according to the ABS (2016).

By the 2011 Census the population of Melbourne was just under four million. In 2011, 4.3% of the total population of Melbourne were migrants born in the United Kingdom, followed by migrants born in India (3% of total population), and that population trebled over the decade 2001 to 2011. The next biggest group were migrants born in China and that population doubled over the same decade.

According to the Australian Institute of Health and Welfare (2011) the proportion of 12-14-year-olds in Victoria in 2009 was 3.7% and that of 15-19-year-olds was 6.7%, with the

majority of adolescents in Australia living in the capital cities. The estimated resident population of Victoria in 30 June 2009 was 5.44 million people (ABS, 2009). Different locations in Melbourne have discrete culturally and linguistically diverse groups living in their areas thus each CAMHS had differing multi-cultural and socio-economic communities that it served. Child and Mental Health Services over the decade 2002 to 2012 covered the age group 0-18 years, but by 2012 some of the services were in the process of increasing the age range to 25 years. Four metropolitan CAMHS provided acute inpatient services to regional Victoria, although some rural services had access to one or two beds for adolescents co-located in adult or paediatric services, and in total there were thirteen CAMHS catchment areas (Department of Human and Community Services, 1996).

Eight CAMHS regions in Victoria were involved in the TFFP. The TFFP obtained ethics approval from five metropolitan CAMHS that included Southern, Northern, Eastern and Western Metropolitan areas: Alfred, Austin, Maroondah, Royal Children's Hospital and Southern Health, and ethics approval from three regional CAMHS, Ballarat Health Services, Barwon Health and Bendigo Health. It is noted that some of the Metropolitan CAMHS consulted and provided inpatient beds for rural regions. For instance, Gippsland had adolescents admitted to the 'Stepping Stones' Adolescent Inpatient Unit at Southern Health at the time. However, the TFFP did not extend to community CAMHS in Gippsland or Hume. Not all CAMHS required separate ethics application and were prepared to accept the Monash University and Southern Health Ethics approvals for their service. The Monash University ethics project number was 2002/645MC (see Appendix I).

The TFFP was initially funded by the Pratt Foundation philanthropic trust which paid for the psychoanalytic psychotherapy and its supervision (at a reduced rate), and the project

researchers were employed through Monash University Centre for Developmental Psychiatry and Psychology (CDDP) located in Melbourne. Ongoing funding was provided for up to twice weekly psychotherapy for each adolescent, and weekly clinical supervision for the psychotherapist per adolescent psychotherapy. The Pratt Foundation continued to pay for the psychoanalytic psychotherapy and supervision for as long as the adolescent remained in psychoanalytic psychotherapy, but the funding for the research ceased after four years. A second Philanthropic Trust, The Dara Foundation, supported further research re-assessments to continue for an additional two years. Each of the philanthropic trusts required an annual report on research progress.

The psychotherapists that provided the psychoanalytic psychotherapy in the TFFP were either graduates of, or undertaking the same advanced psychoanalytic psychotherapy training Master degree course. Therefore, apart from the CAMHS, and the philanthropic trusts, the other key stakeholder in the TFFP research was the Master of Child Psychoanalytic Psychotherapy course based at Monash University. This was a clinical and academic training programme which provided seminars, infant observation and weekly individual supervision on child, adolescent, and parent psychoanalytic psychotherapy over a three-year period. To be eligible for membership of the Child Psychoanalytic Psychotherapists Association of Australia (CPPAA) and the Psychoanalytic Psychotherapy Association of Australasia (PPAA), graduates were also expected to have had their own psychoanalytic psychotherapy concurrent with the training. Supervisors in the TFFP were also associated with the course, and all were eligible for membership of the CCPPA and PPAA.

3.2 Rationale and aims of the TFFP

The rationale for the TFFP assessment and follow-up study was that the long-term outcome of adolescents who presented with features of early psychosis or other severe mental illness was not well understood, and to determine if the provision of psychoanalytic psychotherapy in addition to usual treatment provided extra mental health benefit. The high degree of emotional distress experienced by such adolescents potentially compromised their ability to attend school, to form relationships with peers, teachers, and family members, and to keep themselves and/or others safe (Tonge, Hughes, Pullen, Beaufoy, & Gold, 2008).

The TFFP aims were to monitor and evaluate the recovery process of adolescents with severe psychological illness to gain an understanding of what may have assisted or been helpful in their recovery process, and to evaluate the outcome of long-term psychoanalytic psychotherapy for the those who received this form of treatment in addition to TAU (Tonge et al., 2008).

3.3 Design

The TFFP was a naturalistic study beginning with an original assessment, followed by TAU, or if a psychotherapist was available, the addition of psychoanalytic psychotherapy. Participants from both groups were followed up at one-year, then at two-yearly intervals amounting to four re-assessment points. Multiple informants included the adolescents, their parents/carers, psychoanalytic psychotherapists, and CAMHS case managers. Comparisons were made across time between the outcomes of psychoanalytic psychotherapy and TAU (only) within a naturalistic clinical setting, rather than a randomized control trial. This was

because it was not possible to randomise intervention allocation given that a psychotherapist might not always be available at the time of admission of the young person to the clinical service. The TFFP provided training cases for the MCPP trainees, and thus provided the opportunity to explore the effectiveness of psychoanalytic psychotherapy in a clinical population of adolescents.

3.4 Method and materials of the TFFP

3.4.1 The nature of the psychoanalytic psychotherapy provided in the TFFP

A psychoanalytic psychotherapy assessment followed the TFFP assessment, and during that process the adolescent decided whether they wished to proceed with psychoanalytic psychotherapy or not. Funding for up to twice weekly psychoanalytic psychotherapy was available for each adolescent seen, and there was no time limit on the duration of treatment. All the psychoanalytic psychotherapists were experienced clinicians and shared the same Master training in child and adolescent psychoanalytic psychotherapy.

3.4.2 The nature of the treatment as usual provided in the TFFP

Adolescents referred to the TFFP all received the usual treatment provided by CAMHS as determined by their case managers, treatment team, adolescents and their families. Such treatment sometimes involved a combination of group work, inpatient, day programme, community outreach, family work, and individual case management and medication. Case Managers were asked to indicate the type of treatments provided and their duration.

3.4.3 Procedure of the TFFP

The Directors of CAMHS were initially approached for permission to conduct the TFFP within their particular service. Following ethics approval at each site, a series of talks were given to clinical staff at the different CAMHS in metropolitan Melbourne and regional Victoria, as well as to supervisors and trainees in the MCPP training course. Referral criteria and pathways, assessments, and the parameters of psychoanalytic psychotherapy treatment were described. A copy of the inclusion and exclusion criteria for referral can be found in Appendix II. Those adolescents referred for psychoanalytic psychotherapy were still expected to receive active case management and TAU from CAMHS.

The TFFP researchers collaborated with the (MCPP) coordinator, teaching and supervisory staff, the directors and clinicians of CAMHS, and the psychoanalytic psychotherapists in developing the project. The researchers liaised with psychotherapists, families, adolescents and CAMHS clinicians regarding follow up re-assessments for adolescents in the project.

Adolescents who were patients of CAMHS were referred to the TFFP for either psychoanalytic psychotherapy or TAU mainly by their case managers. A base-line assessment was conducted by the TFFP researchers, involving standardised techniques. Four re-assessments for both groups occurred at one year, two years, four years and six years post the baseline assessment. Adolescents and parents/carers were interviewed separately at each assessment, and case managers completed a questionnaire at each assessment if they were still involved. Adolescents in psychoanalytic psychotherapy also consented to the psychotherapist completing a questionnaire at each re-assessment for the duration of the psychoanalytic psychotherapy treatment.

3.4.4 Participants in the TFFP

Adolescents referred to CAMHS were seriously mentally unwell, many had been inpatients at some point, and often they were on medication. Parents/carers of the adolescents also consented to participate in the TFFP research. Psychoanalytic psychotherapist graduates and trainees from the Master of Child Psychoanalytic Psychotherapy course (MCPP), Monash University, providing psychotherapy to the adolescents also consented to participate.

3.4.5 Measures used with the TFFP adolescents

At base-line separate clinical interviews with the adolescent and his or her parent(s) or carer(s) were conducted to assess diagnostic status using the K-SADS (Kaufman, Birmaher, Brent, Rao, & Ryan, 1996), a standardised reliable and valid clinical diagnostic assessment providing DSM-IV diagnoses. Clinical severity and functioning were also gathered using clinician ratings of the standardised Global Assessment of Functioning (GAF) (APA, 1994, p.32), and Global Assessment of Relational Functioning (GARF) (APA, 1994, pp.758-759). Diagnostic information from the Case Managers and parents who completed questionnaires was also available from assessment questionnaires and case files. A complete list of measures used at each re-assessment in the TFFP is shown in Appendix IV.

The adolescent and parents completed self-report measures in separate clinical interviews, with the adolescent completing measures for depression, anxiety, coping, and dissociation. Parents completed additional measures of negative life events and temperament of the adolescent, and measures regarding their own depression, anxiety, and dissociation.

3.5 Summary of findings of the TFFP

3.5.1 Initial descriptive findings

Tonge, Hughes, Pullen, Beaufoy, and Gold (2008) described the first stage of the TFFP where 88 adolescents between the ages of 12 and 18, referred to CAMHS were assessed at baseline using separate clinical interviews with parents/carers and adolescents, and information from CAMHS clinicians. It was found that the mean age of entry into the project was 15.4 years, that there was a high rate of comorbid DSM IV diagnoses, with the most common DSM IV Axis 1 disorder being Depression, and that two-thirds of the adolescents had clinical levels of Internalising problems. Further, a high level of family dysfunction was reported by multiple informants.

3.5.2 Twelve-month re-assessment findings

Tonge, Pullen, Hughes, and Beaufoy (2009) reported on the twelve-month follow up of the TFFP where the number of participants was 55, and within that group 22 had received individual psychoanalytic psychotherapy in addition to CAMHS TAU. Findings were that the psychoanalytic psychotherapy group had a significantly greater reduction in depressive, social and attention problems than TAU alone, if these problems were initially in the clinical range.

3.5.3 Four-year re-assessment findings

Pullen, Tonge and Beaufoy, (2011) compared outcomes at the four-year re-assessment on 68 participants in the TFFP for 22 adolescents who received psychoanalytic psychotherapy and 46 adolescents who received treatment as usual (TAU). Both groups improved on measures of depression and anxiety over the 4 years.

Using regression analysis which controlled for gender and age, it was found that the average increase in GAF score per year was 2.1 for the 'treatment-as-usual' group and 4.6 for the 'psychotherapy' treatment group. The rate of difference between the two groups was not significant (P>0.26), but the difference between the groups at the four-year re-assessment was significant (P>0.004). Whilst both groups improved over time, the psychoanalytic psychotherapy group improved at a faster rate having started from a more severe initial rating. At baseline, the mean GAF for TAU was 51.2 (sd 8.8) and the mean GAF for the psychoanalytic psychotherapy group was 44.7 (sd 9.8). At the 4 year re-assessment the mean GAF for TAU was 60.2 (sd 14.8) and the mean GAF for the psychoanalytic psychotherapy group was 64.4 (sd 14.5). Thus, it was revealed that the psychoanalytic psychotherapy group improved at a greater rate over time and was doing significantly better than the treatment as usual group on the GAF rating from the DSM IV (Pullen et al., 2011).

Overall, at the 4 year follow up, the GAF scores were in the 61-70 range, which were still indicative of some ongoing issues such as depressed mood, mild insomnia, or some difficulties in social, occupational, or educational functioning. Considering that most of the adolescents had been hospitalised or had a hospital admission at the time of pre-assessment, this was a very encouraging improvement.

3.5.4 Qualitative findings concerning psychotherapy of adolescents in TFFP

The significant difference between the groups on the GAF prompted a systematic thematic qualitative analysis of data obtained from psychoanalytic psychotherapy participants' responses to structured questions repeatedly asked at re-assessment intervals in the TFFP. The method of data analysis used was that described by Miles and Hubermann (1994). Complementing the quantitative outcome research, this qualitative approach highlighted the complexity of exploring the course of severe psychological disturbance in adolescents over time, in relation to the role psychoanalytic psychotherapy as distinct from other factors, might play in that process.

Responses to three questions asked of the psychoanalytic psychotherapy group in the TFFP at up until the 4-year re-assessments were systematically analysed:

1. *Was psychoanalytic psychotherapy what you thought it would be like?*
2. *Has there been anything about psychoanalytic psychotherapy that has been helpful for you?*
3. *Has there been anything about psychoanalytic psychotherapy that has been unhelpful for you?* (Pullen et al., 2011).

Overall, it was found that adolescents had a limited understanding of what psychotherapy would be like, but more were hopeful that it could help them than were not. In the domain of helpfulness, four higher order themes emerged, the first was related to process, and the most frequent sub-theme was "*Talking*", then "*Emotional Expression*" followed by "*Thinking or analysis*" and the final sub-theme pertained to "The psychotherapy relationship."

A difference emerged between those adolescents in the psychoanalytic psychotherapy group who were more reflective and articulate about their experience, compared to those in TAU only, who were more concrete, and less reflective and coherent in their discourse. It appeared from the outset that some adolescents were better able to reflect or mentalize, but others improved in their ability to remember, reflect and talk about their experience over time. There were a small number that continued to struggle at the four year follow up and they fell into the grouping that could not articulate what they found helpful about psychotherapy.

In other words, at the four-year re-assessment of participants in this qualitative extension within the TFFP it was revealed not only that psychoanalytic psychotherapy patients tended to be more reflective than TAU patients, but also the psychoanalytic psychotherapy patients varied considerably in the depth of their reflectiveness, a feature of adolescents in psychoanalytic psychotherapy that had not been as highlighted in the other related qualitative research described in Chapter 2 above.

3.6 Conclusions drawn from TFFP findings

The TFFP represented a ten-year naturalistic, longitudinal study of adolescents in psychoanalytic psychotherapy, which is a rare achievement. The patients in this study had serious mental illness and heterogeneous diagnoses, often multiple co-morbid diagnoses, and were typical of the most unwell adolescents that enter the public mental health system. It is most difficult to continue to obtain participation in long-term follow up studies of this nature and particularly with the group being studied, given their difficulties and potential for moving away as they become older. Nevertheless, after more than 4 years, an overall follow-up

response rate of more than 50% was achieved in the TAU group, and an even higher response rate of around 90 % in the psychoanalytic psychotherapy group.

In conclusion, these quantitative and qualitative findings provide an understanding of the outcomes and experience of seriously mentally ill adolescents who received psychoanalytic psychotherapy. For example, the TFFP study found important variation in reflective capacity of those who received psychoanalytic psychotherapy. In thus expanding the scope of understanding adolescent psychoanalytic psychotherapy beyond that of the field reviewed in Chapter 2, the TFFP provided the impetus to further explore what the experience meant for the different participants involved. Thus, multiple perspectives on the experience of psychotherapy during adolescence along with a rich contextual description of the nature of the public health system at the time psychoanalytic psychotherapy occurred could be explored.

The TFFP psychoanalytic psychotherapy was open-ended, up to twice weekly in addition to CAMHS TAU, and non-manualised. A uniform treatment was offered in the sense that all therapists and their supervisors were trained in the same child and adolescent psychoanalytic psychotherapy programme. The TFFP had shown the two groups of adolescents TAU and Psychoanalytic Psychotherapy had improved on attentional, social, anxiety and depression measures. However, the superior functioning of the psychoanalytic psychotherapy group in their global functioning at the four-year re-assessment stage suggested the need to explore the meaning of this treatment and its significance to the participants in a qualitative sense. As a long-term treatment and clinical research programme embedded in a CAMHS treatment context, the TFFP afforded an extraordinary opportunity to explore more deeply the multiple perspectives and experience of this form of treatment. A further advantage was that the

researcher was already familiar to both adolescents and psychotherapists. .A qualitative study of the complexity, meaning and contexts of the experience of psychoanalytic psychotherapy provided in the TFFP formed the basis of this PhD research as explained in the next chapter.

CHAPTER 4

RATIONALE, AIMS AND EXPECTATIONS OF THE PRESENT STUDY

This chapter presents the rationale for the conduct of the present study, its aims, and the expectations generated based on theory pertaining to psychoanalytic psychotherapy and for previous research. It begins with a summary of the rationale.

4.1 Rationale of the present study

The present study was developed in the latter half of 2010. The study was stimulated by the TFFP findings that began to emerge with preliminary data analysis of the four-year re-assessment follow ups in 2010 and ensuing data collection for the six-year re-assessments. The TFFP provided access to both quantitative and qualitative outcome data and further opportunity to explore the meaning and experience of psychoanalytic psychotherapy treatment for both the patient and their psychotherapist participants. Arising from the TFFP research work, and from reviews of the related international literature at that time, were six broad critical issues:

1. the importance of research into clinical interventions during adolescence for a clinical group of highly disturbed adolescents;
2. clarification of the place of psychoanalytic psychotherapy in public child and adolescent services;
3. the need to strengthen the evidence base of psychoanalytic psychotherapy during adolescence for it to be regarded as a viable treatment in public mental health;

4. understanding the experience of psychoanalytic psychotherapy during adolescence from multiple perspectives;
5. questioning whether outcomes are the main focus, what type of outcomes are seen as important, and are they associated with psychoanalytic psychotherapy; and
6. what role does the process of psychoanalytic psychotherapy play in the lived experience of adolescents and psychotherapists.

From these issues, in turn, emerged the rationale for the present study. It was proposed to use a method of rigorous qualitative investigation to capture the essence of what the experience of psychoanalytic psychotherapy during adolescence can mean for the various participants. The present study would constitute a starting point for examining retrospective multiple perspectives on the experience of psychoanalytic psychotherapy during adolescence where the adolescent has been struggling with severe psychological difficulties. The present study would be unusual in soliciting the perspectives of multiple participants and examining the service context as well as the socio-cultural context prevailing at the time psychoanalytic psychotherapy was provided.

4.2 Research questions

The above considerations were distilled to generate the following research questions that are the focus of this study.

1. How did adolescents who have had serious mental health difficulties experience psychoanalytic psychotherapy?

2. What did participants perceive were important influences on their mental health during psychoanalytic psychotherapy?
3. What difference did the experience of psychoanalytic psychotherapy make?
4. What impact, if any, did the research have on the psychotherapy?
5. Can there be a place for psychoanalytic psychotherapy with adolescents within public child and adolescent mental health services (CAMHS)?

4.3 Aims and objectives of the present study

4.3.1 Aims

The present research was planned to explore these questions in a group of very disturbed adolescents who received psychoanalytic psychotherapy, within the context of public child and adolescent mental health services as part of the TFFP in Victoria, Australia.

This led to two aims:

1. to explore how these young people, and their psychotherapists perceived and experienced the psychoanalytic psychotherapy process and its outcomes.

2. to describe the overall context of care as perceived by the directors of CAMHS, by the now young adults, and by their psychotherapists.

4.3.2 Objectives

These aims were to be enabled by the following objectives:

1. to conduct in-depth interviews to explore with young adults their retrospective experience of the psychoanalytic psychotherapy they received as adolescents.

2. to conduct in-depth interviews with their psychotherapists to explore their retrospective experiences and thinking about the adolescents they treated in psychoanalytic psychotherapy as part of the TFFP; and

3. to conduct in-depth interviews with directors of services to explore their retrospective narratives concerning CAMHS during the period of the original research, commenting on the context within CAMHS at the time the psychoanalytic psychotherapy of the TFFP occurred.

4.4 Expectations of the study

The present qualitative study did not propose hypotheses as in quantitative research where deductive testing of hypotheses is required. This study was of an exploratory nature and involved the observation and collection of naturally occurring data for analysis.

Nevertheless, given that the researcher was trained in the MCPP understanding and knowledge connected to psychoanalytic theory, previous research, and clinical practice in this

area, it was clear that expectations of the study's findings could easily be identified. It was considered important to articulate these expectations at the outset before data collection procedures were developed. These expectations could then guide the design and make explicit potential researcher biases.

In the following three sections, the expectations relating to each of the three research objectives are set out. The chapter ends with an explanation of how these expectations led to the construction of the semi-structured interviews to be used with the three groups of participants.

4.4.1 Expectations of the interviews with the adolescents (now young adults) and the psychotherapists

4.4.1.1 There would be a therapeutic relationship between adolescent and psychotherapist

The experience of the relationship between the adolescent and the psychotherapist, concerning quality, engagement, and continuity, would emerge as important. This expectation drew upon research findings, particularly of therapeutic alliance studies (Binder, Holgersen, & Nielsen, 2008a; Binder, Moltu, Hummelsund, Sagen, & Holgersen, 2011; Karver, Handelsman, Fields, & Bickman, 2006; Karver, Shirk, Handelsman, Fields, Crisp, Gudmundsen, & McMakin, 2008; Lindgren, et al., 2010; Pullen, et al., 2011; Shirk & Karver, 2003; Strupp, Fox, & Lessler, 1969).

4.4.1.2 Engagement and attendance in psychoanalytic psychotherapy

Psychoanalytic psychotherapy would mostly be viewed as a positive experience considering the participants' relatively prolonged attendance in psychoanalytic psychotherapy. Their positive experience of psychoanalytic psychotherapy may in addition be reflected in their agreement to participate in the present study as well as being linked to their previous participation in the TFFP research. Whilst one person, had used TFFP research to express criticism of their psychotherapist, overall, more people had a positive experience than did not. (Oetzel and Scherer, 2003; Pullen, et al., 2011).

4.4.1.3 Supportive nature of psychotherapy

The psychoanalytic psychotherapy relationship was likely to have a central element in their lived experience as the adolescents had been so unwell and needed support in face of their severe psychological distress and psychopathology (Bowlby, 1988,1978; Shirk and Karver, 2011; Shirk, Karver & Brown, 2011).

4.4.1.4 There would be a need for an independent thinking space

The experience of the development of an independent thinking space would emerge as important. This expectation was based on comments made by certain adolescents in the qualitative dimension of the TFFP research where a common theme was not having to worry about the impact of what they were saying on the therapist as they would with family or friends whom they did not want to distress or burden, (Pullen, et al., 2011).

4.4.1.5 Changes in interpersonal relationships

The quality of family and peer relationships would be linked with the experience of the relationship with the therapist. This expectation comes from attachment theory and psychotherapy research and theory as well as clinical experience (Bowlby, 1988, 1978; Davila & Levy, 2006; Dykas, Woodhouse, Cassidy, & Waters, 2006; Eagle, 2006; Fonagy & Target, 2002; Perl, 2008).

4.4.1.6 Attachment experience in family, peer relationships and intimate relationships

Attachment capacity of the adolescents would improve. This expectation was also connected to clinical experience, attachment theory and psychotherapy research (Levy et al., 2006; Muscetta, Dazzi, DeCoro, Ortu, & Speranza, 1999).

4.4.1.7 Reflective functioning in relationships

The adolescents would improve in their capacity to mentalize and reflect on their own internal world and that of others. (Fonagy & Target, 1997; Hawley & Garland, 2008)

4.4.2 Expectations of interviews with psychotherapists

4.4.2.1 Participation in research

It was expected that psychotherapists from the TFFP would be willing to participate given they had an experience of participating in the previous research. A recent study indicated that

whilst psychoanalytic psychotherapists might be reluctant to be involved in research initially, that once they began to participate, they saw its value, (Henton & Midgley, 2012)

4.4.2.2 Psychotherapists would use psychoanalytic theories and concepts in their analysis of therapeutic processes

Given the psychotherapists psychoanalytic psychotherapy training within the MCPP it was expected that therapists would discuss processes and concepts from psychoanalytic theorists in reference to their therapeutic relationship with the adolescents.

4.4.3 Expectations of interviews with directors of CAMHS

4.4.3.1 Belief that there was no evidence-base for psychoanalytic psychotherapy

Some Directors might hold the fallacious perception that psychoanalytic psychotherapy lacks an evidence-base, which is a phenomenon that has been reported, despite the evidence to the contrary, and this lack of perceived evidence base would be seen as a barrier to the usefulness of psychoanalytic psychotherapy in CAMHS. This expectation was supported by the demand for evidence-base therapies and changes in service delivery throughout the world (Vostanis, 2007). The ramifications of this perceived lack of evidence-base are discussed in relation to psychoanalysis, and this could equally include psychoanalytic psychotherapy (Fonagy, 2003).

4.4.3.2 Consider that psychoanalytic psychotherapy had no place in CAMHS

Directors may hold the view psychoanalytic psychotherapy was not relevant to public adolescent mental health treatment today and this view was reflected in some letters of response to the debate about psychoanalysis in the British Medical Journal (Fonagy & Lemma, 2012; Salkovskis & Wolpert, 2012).

4.4.3.3 Fear that psychoanalytic psychotherapy could harm vulnerable adolescents

In the TFFP there was an experience in the early years, of some clinicians holding a very rigid and historical view of psychoanalytic psychotherapy, and it was feared that harm to psychologically fragile adolescents, would ensue if their defences were challenged and stripped away. This misconception about modern psychoanalytic psychotherapy practice led to the development of a handout (see Appendix III) which was distributed to clinicians in CAMHS outlining the myths and realities of psychoanalytic psychotherapy. It was expected that some directors might continue to hold these views.

4.5 Concluding remarks

In summary, this qualitative study would explore the meaning of psychoanalytic psychotherapy for participants in the context of CAMHS to enhance and enrich the quantitative findings from the TFFP, as well as elucidate the sociocultural contexts of the adolescents. Potentially uncovering deeper, complex processes of commonality and difference between participants, generating further hypothesis for research, facilitating theoretical understanding and contributing to research about effectiveness of interventions.

CHAPTER 5

METHOD

Philosophy of science, research methodology polemic and psychoanalytic theory each informed the method of this study. In this chapter the background to qualitative method is first discussed briefly, in terms of how the design used best fits with achieving the aims of the study. Secondly, potential participants are identified and described, and the proposed method of recruitment outlined. Thirdly, the development of questionnaire protocols for the present study, and how they were designed to advance the study's objectives, are discussed. Fourthly, the procedure for gathering data is detailed. Fifthly, the method of data analysis is described and finally, the ethics approval for this study is reported.

5.1 Background to methodology

As stated in the previous chapter, The Time For A Future Project (TFFP) was a naturalistic follow up longitudinal study collecting quantitative data and some limited qualitative data, the findings of which provided the impetus for the present study.

A qualitative study was planned in which in-depth interviews would explore the experience of participants in the TFFP psychoanalytic psychotherapy. Thus, the present qualitative study would complement and enhance the quantitative findings of the TFFP. It was expected that a large amount of descriptive data involving the complex phenomena of each individual participant's unique circumstances and experiences would be generated. The intent was to develop a greater understanding and knowledge of what the experience of psychoanalytic

psychotherapy meant to participants, and the research was thus qualitative and phenomenological in nature.

Pope and Mays (1995) clarified three ways in which qualitative research can be complementary to quantitative research. Firstly, to describe and better understand a phenomenon and suggest questions for further quantitative research investigation. Secondly, to supplement quantitative research with mixed methods to examine different levels of a phenomenon. Thirdly, to explore complex interactions, attitudes, and conscious and unconscious communications that quantitative research is less able to investigate.

The methodological orientation of the study adopted a hermeneutic phenomenological approach. The present study would be retrospective, whereby information would be filtered and processed some years after their psychoanalytic psychotherapy experience.

Denzin and Lincoln define hermeneutics "*as an approach to the analysis of texts that stresses how prior understandings and prejudices shape the interpretive process,*" (2011, p.16). It is noted that in the present research, the researcher had a role in following up the young people and their families since they were adolescents. Thus, there was a prior history, relationship and understanding of their situations and experience as well as the influences of the researcher's clinical training, experiences, and theoretical predisposition. Therefore, the researcher as participant would need to describe these influences as part of the research method.

Finlay (2011) argued that phenomenology was a way of joining the gap between clinical practice and research, identifying six different types of phenomenological research. The

method of the present study accords with Finlay's description of the interpretative phenomenological analysis (IPA) approach, based on the philosophical thinking of Husserl and Heidegger (Smith, 2007, 2004). Here, the experiences of participants were to be explored using semi-structured interviews, with a focus on individual meanings and patterns across participants being analysed.

Smith, Flowers, and Larkin (2009) have been at the forefront of adapting IPA to qualitative inquiry in psychology whereby the researcher promotes the reflection of participants' experiences of important events in their lives and how they make sense of them. The researcher is considered a participant, with an interpretative role in understanding the sense making of the participant. Smith et al., (2009) identified three major philosophical influences on their model which are phenomenological, hermeneutic and idiographic. Their study of the phenomenological included description of the perception and relevance of experience, but also the interpretive aspects that accompany the concept of intersubjectivity of our relatedness and engagement within the world involving for example, language, culture, and relationships. Attention to the particular is reflected in the commitment of the model to start with a detailed examination of each individual within their specific context and then to make sense of it with an awareness of the preconceptions of the researchers which required 'bracketing'. In this study the lens of the interpretation would be through the use of psychoanalytic theory and use of the concepts of transference and countertransference experienced by the researcher during the interviews.

As a practical piece of research, this study would explore the usefulness of psychoanalytic psychotherapy in improving the lives of young people during their adolescence with implications for lesser cost and demand upon the adult system. Imposition on the data as an

exercise of researcher projections was to be kept to a minimum with the practice of reflexivity. The researcher's reflexivity was to be enabled through making notes as described in section 5.4.1. Separate notes were also to be made prior and during the data analysis and the researcher had ongoing discussions with supervisors. Description of multiple perspectives using a systematic and rigorous method of data analysis was to be privileged to include each individual voice, and the data was also aggregated from individual cases to group data in order to protect the identities of participants.

There is vigorous discussion about the development of validity standards for qualitative research ((Rolfe, 2006). McVilly, Stancliffe, Parmenter, and Burton-Smith (2008) provided an in-depth overview of the literature on the trustworthiness or validity of the data in qualitative research and the need for different terms compared to those used in quantitative research. Maxwell (1992) was cited by them as arguing for the use of the alternative concepts of descriptive validity, interpretative validity, and theoretical validity. Qualitative research is considered to have a high degree of trustworthiness when there is a systematic approach to data collection, data analysis, data display, and a clear declaration of the theoretical influences upon interpretation (Guba, 1981, McVilly et al., 2008*)*. The present study would strive to utilise such a systematic approach.

5.2 Overall research design

A qualitative research design was adopted to accommodate the aims of this study, which were to explore the experience, perceptions and meaning of psychoanalytic psychotherapy during adolescence from multiple perspectives. In addition, the context of care was explored from multiple perspectives, including that of the clinical directors in public child and

adolescent mental health at the time the psychoanalytic psychotherapy occurred. The data collected were expected to be complex and multi-layered, depending on the perspective of the participant and their internal and external circumstances both at the time of the psychoanalytic psychotherapy and since.

Individual in-depth semi-structured interviews were conducted for each group of participants (adolescents, psychotherapists, and service directors) which evoked narratives of retrospective lived experience, freely expressed by the participants, guided by prompting and probing questions to ensure coverage of areas considered critical by the researcher. Data were gathered through audio-recordings and the researcher's observations and reactions written down during a break in the ex-patient interviews and following the other participant interviews. Transcripts of recorded interviews would be produced, and these data subjected to systematic interpretive thematic analysis.

5.3 Participants

5.3.1 Identification of participants

Three groups of participants were identified to be recruited. Twenty-two adolescent participants from the Time For A Future Project (TFFP) who received psychoanalytic psychotherapy (PP) for more than four months, in addition to (TAU). These 22 young people were identified as potential participants in the present study along with their psychotherapists, the second group of participants. The third group of participants were the directors of the relevant CAMHS at the time of the TFFP study.

The aim was to include as many adolescents as possible who participated in psychoanalytic psychotherapy in the TFFP to gather the broadest understanding of what the experience of psychoanalytic psychotherapy meant to them. Likewise, in the psychotherapist group the aim was to interview all psychotherapists who had been involved with the psychoanalytic psychotherapies of the adolescents who consented to be involved, and have their psychotherapist interviewed. The hope was to have an extensive range of perspectives and experience from the psychotherapist group. The aim was to interview all the CAMHS Directors over the decade the psychoanalytic psychotherapy was offered through the TFFP. The hope was that this would generate a broad-ranging understanding of the political, social and treatment context of public child and mental health services over that decade.

5.3.2 Description of potential participant groups

The participant psychotherapist and adolescent groups were involved with the TFFP from the outset, and the adolescents had all terminated their psychoanalytic psychotherapy. As part of the TFFP, they were accustomed to annual re-assessment interviews over a six-year period to complete measures and respond to short-answer questions. Thus, there was a wealth of data already accumulated about the young people and their families through the TFFP.

Descriptions of the participant groups at the time of the adolescents' entry into psychoanalytic psychotherapy treatment with the TFFP are found in Chapter 6.

5.3.3 Exclusion criteria

The following exclusion criteria were applied in respect of the potential adolescent participants:

1. when the adolescent had actually been in psychoanalytic psychotherapy with the current researcher
2. where the adolescent was still in psychoanalytic psychotherapy with the original psychotherapist, and it was deemed by their psychotherapist for participation to be inappropriate; and
3. when the psychotherapist had not completed their psychoanalytic psychotherapy training with the MCPP.

5.4 The interview protocols

Interview protocols were developed for the three categories of participants described above. These were flexibly semi-structured, adapting to the individual participant, and the goal was to facilitate the emergence of as much information and understanding as possible. They were designed to facilitate or enable the implementation of the objectives discussed in the previous chapter. It was anticipated that a large amount of descriptive data regarding the socio-cultural context would be gathered.

Whilst the study featured the expectations detailed in Section 4.5 of the previous chapter, the object of the interview was to remain open to the voice of the participant, through asking broad, open-ended questions.

5.4.1 Interview protocol for the young adults

The interview protocol (Appendix V) developed for the young adult participants began with a preamble which outlined the context of the research and explained that the focus of the interview was on the young adult's experience of psychoanalytic psychotherapy as an adolescent.

A preamble developed for the interview was read out, specifying the approximate length of the interview, which was predicted to range between 1 and 2 hours depending on the recall and loquacity of the participant and because of the break in the middle. The preamble proposed taking a break in the middle of the interview for 10-15 minutes with the length of the break dependant on what was needed by the young person participant.
Ten domains of enquiry were covered by the questions (Appendix VI). It was hoped the young adult interview protocol would elicit an understanding of the experience of participating in psychotherapy as an adolescent, what they thought the experience of the psychotherapist was and an understanding of the context in which it took place, in terms of the family, the adolescent's stage of development and the culture of adolescents in the area in which they lived at that point of time in history.

The decision to incorporate a break for the young adult interview was influenced by the findings of other researchers in interviewing adults about their experience of psychoanalysis.

Leuzinger-Bohleber (IPA training, 2011) in a personal communication, suggested using a second interview with an intervening supervision to process the countertransference; in previous research she had found that unlike the first interview, the participant was not regressed in the second. Leuzinger-Bohleber, Stuhr, Rugel & Beutel (2003) found a replication of the original transference conditions of psychoanalysis occurred in follow-up interviews, which had also been found in previous research that they cited.

Time did not permit the possibility for two interviews, or supervision between interviews in this study, in order to meet the timeline of the requirements framework of a PhD thesis. Out of the 23 interviews to be conducted, the estimated total distance across metropolitan and rural areas was 4,400 km with 2,500 km being in regional areas and 1,640 km across metropolitan Melbourne. Thus, it was proposed that a way to manage a possible regression would be to take a break in the middle of the young adult interviews.

During the break in the middle of the interviews it was planned for the researcher to write process notes on her observations, transference, and counter-transference responses, which would create a space to process these experiences before the second part of the interview.

In addition to the broad open-ended questions asked of each participant group in the research protocol, additional prompt, probing, clarifying, and paraphrasing questions were employed. The extent additional questions occurred were dependant, upon the participant's ability to fully articulate their experience, to reflect, and to remember. It was considered important to ensure what was meant by the participant was accurately understood by the researcher. Thus, someone who was less expansive in responses, or struggled to recall, may have required more prompts to elaborate upon comments. On the other hand, for those who were articulate and

able to recall and readily comment on recalled experience, the number of prompt questions were minimal.

After the interview with each participant, it was proposed for the researcher to write process notes on her observations, transference, and counter-transference responses.

5.4.2 Interview protocol for the psychotherapists

This psychotherapist interview protocol appears as Appendix VII. Eleven domains of enquiry were explored with the psychotherapists.

There were 12 broad questions included, corresponding to the young adult's protocol. For example, the first broad question was "*What can you tell me about the young person's experience of psychotherapy?"* The checklist of potential areas were: engagement; what was worked through; what was unresolved; transference; counter-transference; termination; how psychotherapy could be improved; structure or setting and turning points. This interview protocol was designed with the hope of gaining an understanding of the therapist's perception of the adolescent's experience of psychotherapy, her own experience as the therapist, and her theoretical understanding of what took place, and of the context in terms of the period of time and the culture of adolescence in the relevant geographical area.

5.4.3 Interview protocol for CAMHS directors

The primary goal of the interview was to understand the context in which psychoanalytic psychotherapy took place within the service. The interview protocol for the directors,

presented as Appendix VIII, was designed to explore their expectations of the TFFP research, their perceptions of the issues for adolescents in the wider community at that time in history; their perceptions of the context of the public system at the time of the original TFFP research, their thoughts about working with adolescents with serious mental illness, and their perceptions of the place of psychoanalytic psychotherapy in the public system.

Six broad open-ended questions explored directors' perceptions: of the CAMHS context, the geographical location of services and where adolescents lived, views about research, consent, and expectations of the TFFP within their service, views on best treatment for disturbed adolescents, and views about psychoanalytic psychotherapy and its place in CAMHS. See Section 4.6 regarding the study's expected responses from directors. The directors were not aware of the identity of specific adolescents in the present study and were asked about adolescents in general, within CAMHS between 2002 and 2012.

5.5 Procedures of the study

5.5.1 Recruitment of participants

Where a young person was still in psychoanalytic psychotherapy at the time of recruitment, his or her psychotherapist was telephoned and asked about possible inclusion in the study. If the psychotherapist considered inclusion inappropriate, then the potential participant was excluded. Those young people included would be contacted by telephone, to speak to them about the new research project and the paperwork involved. Contact details were available from the TFFP records for both young people and their parents.

Where contact details had changed or were unknown, online telephone directories, parental contact address, other social media such as 'Facebook' and the electoral roll for the State of Victoria were explored. Where there was no matching telephone number for the address on the electoral roll, a letter was sent, explaining this study, and inviting the young person to telephone or email the researcher.

In the first telephone conversation, the young adult was asked for verbal consent and postal details so that the relevant explanatory statements (Appendix IX) and consent forms (Appendix X) could be sent. About a week after the consent and information sheets were posted, the young person was telephoned again, and if they were still agreeable to participating following reading of the written information, an interview time was arranged.

Following the written consent of the young person, his or her psychotherapist was then telephoned, and the same process replicated. (See Appendix X1 and XII).
Directors of Child and Adolescent Mental Health Services were contacted by letter and then telephoned to arrange an appointment. See Appendix XIII.

5.5.2 Conduct of interviews

The location, time and day of the interviews were set according to what best suited the participant. A text message was sent the day before the scheduled interview, as a reminder to the participant.

Upon arrival at the interview and after initial greetings, the researcher asked for the signed consent form and asked if there were any further questions the participant may want to clarify before commencement of the interview.

The participant was reminded about the audio recording and asked again if they agreed to the interview being recorded.

5.6 Data analysis procedures

5.6.1 Transcription of interview data

The interviews were audio-recorded, and the interview date and I.D. number were labelled on the digital recording before it was transcribed in full.

Rules for transcription were established. Each transcript was typed and headed with the I.D. number of the participant. The interviews were transcribed verbatim, and utterance or pause was accurately transcribed. Grammar, errors in speech, out of order word sequence were recorded as uttered and not corrected. The punctuation was based on the way the person spoke, so if for example a person spoke rapidly and continued without a stop, then this was reflected in the punctuation.

A slight pause was denoted by dots and a longer pause was noted in parentheses. The precise time interval in the recording was regularly noted throughout the transcript for ease of returning to a particular section of the interview to clarify the length of a pause or some other aspect.

Brief comments on sounds, non-verbal sounds such as laughing or crying, or if the interview was interrupted due to a phone call or another person entering the room, were all noted in italics and placed in parentheses.

The main questions were in bold and underlined and numbered. All the main and subsidiary questions or comments articulated by the researcher were in bold. All speech utterances by the participant were in regular type. Thus, the researcher and participant's utterances were distinguished as bold type (for the researcher) and regular type for the participant. The inside and outside margins of the transcript were 2.5cm to allow for comments to be written in the left and right margins on observations, mental state and affect, transference and counter transference responses.

After the interview was fully transcribed, the recording was listened to again and the transcription edited by the researcher to pick up on any errors such as correction of grammar, or re-ordering of sentence structure, and the like.

5.6.2 Ethics

A major ethical issue in research is the preservation of confidentiality and anonymity.
An important ethical consideration related to data analysis procedures given the deeply personal nature of the information was how to protect the individual from recognition. The data analysis method described by Miles & Huberman (1994) had the advantage of entirely disguising the identity of participants when aggregated as group data. The allocation of subject numbers to participants contributing to the data meant quotations illustrating themes could be easily traced.

The data analysis described and implemented here allowed for maximum extraction and interpretation of meaning of the narratives of the participants experience of psychoanalytic psychotherapy and their mental health, whilst still permitting anonymous individuality to emerge in lesser mentioned themes and accompanying quotations.

5.7 Qualitative data analysis methodology

Miles and Huberman (1994) method of data analysis was chosen because it was respectful of the voices of the participants through the ability to trace back to their original quotations to illustrate themes whilst maintaining their anonymity through aggregating data. It also combined thematic and content data analysis capacity and was systematic and transparent in its procedure.

The transcripts for each group of participants were subjected to a systematic thematic content analysis. The method utilised was that of Miles and Huberman (1994). This stepwise method involved the comprehensive identification of discrete themes, which were arranged into a matrix or chart, then the production of successive matrices displayed the fine-grained data, pooled for each group of participants. The data were then pulled together or aggregated into layers of higher order themes, representing interpretation of layers of meaning in the reported experience of participants. At each point in the analysis, the positioning of typical individual quotations was indexed. In this way, in the final matrix for each group of participants, common themes across all participants were identified, and all individual themes were also noted.

Additional research notes on observations and experience of transference, counter-transference and parallel processes, may inform a deeper understanding of separate participant groups.

Auditing of the content analysis to establish validity (Smith et al., 2009) was conducted mainly by the primary doctoral research supervisor, and also by the secondary supervisor, both of whom have experience in thematic data analysis and qualitative methods, generally.

Appendix XIV sets out a step outline of the thematic content analysis as conducted for the young adults in each domain. Appendix XV shows some sample pages of the steps to create successive matrices for the young adult participant group up until the first matrix combining all the young adults' data is developed. In selecting the samples of raw data, care has been taken to avoid revealing identifying information, and the analysis of group data preserves the participants' confidentiality whilst providing rich information about their lived experience. The final combined matrices of condensed group data are displayed in the findings Chapters 7, 8 and 9.

5.8 Ethical approval of the study

The overall method and specific procedures of the study were approved by the Southern Health Directorate of Research Services, Research Project Application No. 01133B. Certification of this approval appears as Appendix XVI. This was an amendment to the original Southern Health TTFP ethics approval and a reciprocal arrangement between Southern Health and Monash University no longer required an additional research amendment application.

CHAPTER 6

FINDINGS 1: PARTICIPANT GROUPS

Three participant groups were interviewed, being the young adults who participated in psychoanalytic psychotherapy as adolescents in the Time For A Future Project (TFFP). The second group was the psychotherapists who provided psychoanalytic psychotherapy to them, and the third group was the directors of public child and adolescent mental health services (CAMHS) at the time the TFFP was commenced.

6.1 Recruitment

6.1.1 Recruiting the adolescents

Twenty-two adolescents had received psychoanalytic psychotherapy in the TFFP, and after the exclusion of five young people (as discussed in the exclusion criteria of the method chapter), the potential number of participants was therefore seventeen. Contact was achieved with 14 potential participants as three could not be located. Four young people were unable to participate for various reasons. One claimed to be too busy, one was clearly unwell when contacted, and shortly after was admitted to a psychiatric facility. Two initially agreed to participate, but then changed their minds; one of these had a psychiatric admission at the time but did consent to their psychotherapist's participation in the study. Ultimately ten young people consented to be interviewed.

6.1.2 Recruiting the psychotherapists

Twelve young adults agreed for their psychotherapist to be interviewed in relation to their psychoanalytic psychotherapy as adolescents. Only one psychotherapist (who saw two adolescents in the TFFP for psychoanalytic psychotherapy) declined to be interviewed for health reasons. Interviews relating to ten adolescents were conducted, but three of the psychotherapist interviews were subsequently not included in the data analysis.

There were a number of reasons for deciding not to analyse all of the psychotherapist interview data. One of the trainee psychotherapists had not made training progress beyond the second year of training, whereas all other trainee psychotherapists had completed their psychoanalytic psychotherapy training. Whilst one young person consented for the psychotherapist to be interviewed, the young person did not take part in an interview. Finally, the psychotherapist's responses appeared to have reached saturation after thematic analysis of the fifth interview , therefore it was decided to finish the analysis after analysis of the transcript of the seventh interview.

Consequently, the data of seven adolescent's psychotherapist interviews were analysed. As some psychotherapists saw more than one adolescent, one psychotherapist was interviewed on three separate occasions, another on two occasions, and the remaining two interviews involved two further psychotherapists, thus accounting for the seven adolescent psychotherapies.

6.1.3 CAMHS directors

The seven directors interviewed as described in Chapter 5, were directors of government funded and administered CAMHS across seven different regions, which included all metropolitan, semi-rural, and rural regions in the State of Victoria, Australia. The TFFP research and psychoanalytic psychotherapy treatment covered the decade between 2002 and 2012, and all directors who initially approved the project taking place within their services were approached to be interviewed about the context, culture, and the place of psychoanalytic psychotherapy within CAMHS during that decade. Feedback was also provided to the directors as to the TFFP outcomes and state of progress.

It is noted the directors did not know the specific identity of adolescent participants in this study, but some would have had some knowledge of individuals referred to the TFFP.

6.2 Description of potential and actual participant groups

6.2.1 Demographics of the potential participants who received TFFP psychoanalytic psychotherapy when adolescents.

6.2.1.1 Potential participants who received TFFP psychoanalytic psychotherapy

Of the 22 TFFP patients who had a minimum of 4 months of weekly sessions, 15 were female and 7 male. At the time of entering into psychoanalytic psychotherapy their mean age was 15.4 years (range was from 13 to 18 years).

Diagnostically they were heterogeneous. At baseline there were 46 diagnoses on Axis 1, for the DSM-IV (APA, 1994) with most having 2 or more diagnoses. The group thus uniformly had a high degree of comorbid diagnoses, and almost 60% were diagnosed with parent child relationship problems.

Diagnostic clusters on DSM IV Axis 1 at the TFFP baseline were that 13 of the 22 had diagnoses in the Major Depressive Disorder/Dysthymia/Depression cluster, 8 were diagnosed in the anxiety/PTSD cluster,4 had psychotic features or a diagnosis of Psychosis NOS, 3 had a diagnosis of Pervasive Developmental Disorder, 3 were diagnosed with an Eating Disorder, and 2 were diagnosed with reactive attachment disorder of childhood.

At the time of diagnosis, less than 30% were living at home with both their biological parents. Although 45% of the adolescents lived in a two-parent family, more than 65% of those were blended families. Just over 45% of adolescents lived in a single parent household and for 80%the parent was the biological mother. Six biological parents were known to be deceased, 2 being mothers. In the families where the biological parents had not been a couple, or were separated or divorced, and the non- residing parent was still alive, 80% either had no contact or minimal contact, and domestic violence and/or alcohol abuse were prevalent prior to the marital breakdown.

Almost 25% of parental couples were both born overseas and from a non-English speaking background (NESB). In 14% of families, one parent was from a NESB. The group had mixed culturally and Linguistically Diverse (CALD) backgrounds, comprising Asian, European, Middle Eastern, and South American backgrounds. Two parents were indigenous,

one had left the relationship prior to the birth of the adolescent, and the other had left when the adolescent was a child and had not returned.

6.2.1.2 Potential participants who received TFFP psychoanalytic psychotherapy after application of exclusion criteria

The 17 TFFP participants approached to participate in this study were referred for psychoanalytic psychotherapy when they were CAMHS patients. They were a similar group, in that most of them lived with their family, they had complex difficulties, and a high level of comorbid Axis 1 DSM IV diagnoses. The majority of these adolescents received treatment in the most restrictive psychiatric setting, an inpatient admission, due to extreme disturbance in their behaviour and mental health functioning. Twelve had been inpatients of CAMHS, of the 6 who were not inpatients at the time of referral for psychoanalytic psychotherapy, 3 had pervasive developmental disorder, 2 had reactive attachment disorders, and 1 had a trauma history from early childhood.

Sixteen of the participants, when adolescents, had more than one Axis 1 DSM IV diagnosis. These heterogeneous diagnoses included a major depressive episode, dysthymia, PTSD, conversion disorder, anxiety, and psychosis. Ten adolescents had serious parent-child relationship problems. Ten adolescents had self-harmed, experienced suicidal ideation or had made suicide attempts. Eight were confirmed as having experienced abuse, 4 had a confirmed history of physical and emotional abuse and 4 had disclosed sexual abuse. A further 3 adolescents were suspected by their CAMHS clinicians, of having been subjected to child sexual abuse.

Six of the young people came from 'Culturally and Linguistically Diverse Backgrounds' (CALD), both parents of 5 adolescents were from CALD backgrounds, 4 adolescents were born overseas, and 2 were already adolescents when they migrated to Australia.

There were 13 females and 5 males in the group, and the mean age that they commenced psychoanalytic psychotherapy was 15 years, 3 months, and the mean length of time they participated in psychoanalytic psychotherapy treatment was 1 ½ years (ranging from 4 months to 8 ½ years). Three were seen twice weekly and 15 in weekly psychoanalytic psychotherapy.

At the time they began psychoanalytic psychotherapy, 17 adolescents lived at home and 1 lived with a friend's family. Nine lived in a single parent household, 1 of which was a long-term foster care arrangement. Eight of the adolescents lived in a two-parent household, 5 of these were biological parents, and in 3 cases, one of the parents was a stepparent.

6.2.2 The final sample included in the present study

Ten young adults were interviewed as they had participated in the Time for a Future Project (TFFP) and received psychoanalytic psychotherapy as adolescents. As adolescents they were referred through the Child and Adolescent Mental Health Services (CAMHS) to the TFFP for psychoanalytic psychotherapy treatment. All of the young people were involved in the TFFP between 2002 and 2012 and were no longer engaged in this psychoanalytic psychotherapy at the time of these interviews. The young people all knew the researcher who had previously interviewed them, at TFFP re-assessment intervals (six months, one year, two years, four years, and six years), prior to, during and post their experience of psychoanalytic

psychotherapy. As a consequence, there was a familiarity, and a degree of trust already established with the research interviewer.

6.2.2.1 Description of the 10 participants interviewed in this study when they were adolescents

Half of the adolescents of that time had been hospitalised prior to their referral for psychoanalytic psychotherapy. Four adolescents had one parent or both parents of CALD background (including Asia, Europe and the Middle East), with 1 adolescent having a parent who was an indigenous Australian. Five adolescents had experienced the death of a parent, 3 had lost their fathers, and 2 had lost their mothers. At referral, their mean Global Assessment of Functioning (GAF) on the DSM IV was 46 with a standard deviation of 7 (range 35 to 60), and their mean Global Assessment of Relational Functioning (GARF) was 51 with a standard deviation of 12.2 (range 38 to 80). At the six-year re-assessment, their mean Global Assessment of Functioning (GAF) on the DSM IV was 62 (range 50 to 81).

6.2.2.2 Diagnoses of the participants as adolescents referred for TFFP psychoanalytic psychotherapy

Six of the adolescents had a known history of child abuse, with 3 having experienced child sexual abuse. Seven of the adolescents were diagnosed with parent-child relationship difficulties. Ten had diagnoses that could be grouped under depression, anxiety, and post-traumatic stress disorder, with 7 having had a history of suicidal ideation, attempts or deliberate self-harm. Two had diagnoses of pervasive developmental disorder, (Asperger's-

Syndrome) one was diagnosed with psychosis, one with an eating disorder, and another with reactive-attachment disorder. All had more than one Axis I diagnosis on DSM IV.

6.2.2.3 Age adolescents commenced psychoanalytic psychotherapy: frequency, and duration of psychoanalytic psychotherapy

The 10 participants interviewed in this study, at the time they were adolescents received weekly psychotherapy, with 2 adolescents seen twice weekly for different periods over the course of their treatment. One adolescent was seen fortnightly in the last stages of that treatment. As displayed in Table 1 below the mean age when psychoanalytic psychotherapy commenced was just over 16, and the mean duration of psychoanalytic psychotherapy was just under two years.

Table 1: Age and length of psychotherapy of adolescents included in study (N=10, 9 female)

	Age commenced psychoanalytic psychotherapy	**Length of psychoanalytic psychotherapy**
Mean	16 years, 2 months	1 year, 9 months
Range	13 years 3 months to 18 years	7 months to 4 years, 9 months

6.2.2.4 Description of the young adults at the time of this study

Ten young adults were interviewed about their experience of psychoanalytic psychotherapy as adolescents. The average age of the young person at interview was 24 years, with a range

from 20 to 27.9 years. The mean length of time since completion of psychoanalytic psychotherapy was 6.4 years, with a range from 4.9 years to 9.4 years.

Seven of the young people were single, with 2 living independently and alone, one living in supported accommodation with one other person, and 4 living at home with a parent. Three were in relationships, one of whom was married with children and living independently. One of these three was transitioning from supported accommodation to independent living, and the other living at home with a partner and parent.

Three young people had attended university, another 3 had done further training certificates or study. Seven were involved in working either full-time, part-time, or doing voluntary work. Three had not done further study and were not employed, one of whom had developed a serious medical condition. Two of these people were isolated and not occupied in interests outside the home.

6.2.3 Description of 13 potential psychotherapist participants who provided TFFP psychoanalytic psychotherapy

At the commencement of psychotherapy with the 22 TFFP adolescents described in Section 6.2.1.1, there were 13 psychotherapists, and some saw more than one adolescent. They were all female, and the mean age of the psychotherapist was 42 years (range: 28 to 56 years) and the mean number of years they had worked specifically with adolescents was 11 ½ years (range: 1 to 27 years). Six were child psychotherapy trainees, and 7 had completed their clinical training (ranging from first year out to 7 years post training). All were qualified in at least one, and up to three disciplines/clinical treatment methods. Previous trainings included

education, family therapy, nursing, psychodrama, psychology, welfare, social work, and youth work.

The psychotherapists all had a common training in child and adolescent psychoanalytic psychotherapy through the Master of Child Psychoanalytic Psychotherapy (MCPP) at Monash University. To be accepted into the MCPP each trainee had to have a bachelor's degree in a discipline area, and a minimum of two years of experience working with children and or adolescents. The MCPP training was one full training day per week over three years which included three discrete weekly child, adolescent, and parent psychotherapy supervisions, lectures and seminars, and a twelve-month infant observation. In the fourth year a minor thesis was completed.

All psychotherapists had the same training which meant that they were grounded in the same theoretical and clinical principles. The MCPP provided a basic object relations psychoanalytic psychotherapy framework, incorporating the theories and concepts of Sigmund Freud, Anna Freud, Klein, Bowlby, Bion,Winnicott, and current post-Freudians and post-Kleinians, thus, incorporating the three schools of the British Psycho-Analytic Society (Kohon,1986). Therefore, a uniform theoretical and clinical training underpinned the psychoanalytic psychotherapy that was offered, aside from the natural variation in personality, clinical and life-experience.

All of the psychotherapists received weekly supervision for each adolescent they saw for psychoanalytic psychotherapy in the TFFP and their supervisors had all supervised in the MCPP training and had been trained themselves in the Monash MCPP.

6.2.3.1 Description of the psychotherapists when they commenced with the adolescents who agreed to participate in this study

Twelve young adults consented for their psychotherapists to be interviewed. A total of 6 psychotherapists were interviewed in relation to psychotherapy with 10 adolescents. Three psychotherapists had single interviews, 2 were interviewed twice as they each saw 2 participants, and another psychotherapist was interviewed 3 times as she saw 3 adolescents. One psychotherapist, who saw 2 adolescents, was unable to participate due to ill health.

The data from 3 psychotherapist interviews were excluded, as it transpired that one adolescent still had some occasional sessions with his psychotherapist, another's ex-patient did not consent to be included in this study, and a third psychotherapist had not completed the MCPP training. Thus, a total of 7 adolescent psychoanalytic psychotherapies were ultimately analysed from the perspective of 4 psychotherapists who had separate narrative interview for each adolescent they worked with in psychotherapy.

All of the 4 psychotherapists were women, and 3 had trained in more than one profession prior to undertaking child and adolescent psychoanalytic psychotherapy training. Three had training in social work, 2 had training in psychology, 2 had training in education, and 2 had training in family therapy.

The average age of the 4 psychotherapists was 45 years with a range from 35 to 52 years. Their average length of time working with adolescents was 13 years, ranging from 3 years to 20 years. One psychotherapist was working in a school, one was in private practice, one was in community health and private practice, and another was working in CAMHS. Two had

completed the MCPP, and 2 were in their first year of the MCPP training when they commenced working with the adolescents in psychoanalytic psychotherapy.

6.2.3.2 Description of the 4 psychotherapists at the time of this study

Of the 4 psychotherapists interviewed, 3 continued to work as clinicians and psychoanalytic psychotherapists in a mix of private and public health. One was working as a public servant in senior management and programme development.

6.2.4 Clinical directors of CAMHS

Two pilot interviews were conducted in December 2010 and the interview protocols were subsequently modified to enhance an understanding of the director's views on the culture and functioning of child and adolescent mental health services in Victoria over the decade of 2002 to 2012, as well as how CAMHS may have been shaped by the needs of the diverse communities it served, which encompassed seriously mentally ill adolescents. It was also hoped to learn the Director's views on how psychoanalytic psychotherapy might fit into the complex context of CAMHS.

All 7 clinical directors of CAMHS who originally approved the TFFP study in their services were contacted by letter and then telephone. There were 6 males and one female clinical director, and all were trained as Child and Adolescent Psychiatrists, 4 in Melbourne, while 3 had trained overseas in the UK or Canada. The 7 directors were highly experienced clinicians, and their trainings included a combination of approaches including psychoanalytic.

The directors had extensive experience in consultation to Government Departments on child and adolescent mental health treatment services and policies.

6.3 Summary of 3 participating groups

The ten young people seen in this study were an extremely troubled group of adolescents when referred to the TFFP with multiple comorbid diagnoses on DSM IV, and a mean GAF which was in the middle of the range covering "*serious symptoms or serious impairment in social, occupational, or school functioning*." (A.P.A. 1994). Five of the adolescents had suffered the death of a parent, and some had been abused as children. The average length of treatment in psychoanalytic psychotherapy was less than two years, and most were seen weekly. Whilst these adolescents continued to struggle with psychological issues over the years, at the six year follow up their GAF score had improved, and they were functioning reasonably well in the range representing "*some mild symptoms or some difficulty in social, occupation or school functioning*" (A.P.A. 1994). None of the ten participants were psychotic at the time of the current study.

The 4 psychotherapists who provided treatment to 7 of the adolescents were all women who were highly trained in more than one discipline or clinical modality and experienced in working with adolescents. The psychotherapists all completed the same training in psychoanalytic psychotherapy through the MCPP and received weekly supervision on their TFFP adolescent psychoanalytic psychotherapies from MCPP psychotherapist supervisors. Unfortunately, not all psychotherapists of the adolescents in the study were interviewed due to ill health and restrictions that were applied to the sample, thus there were 3 adolescents who do not have a corresponding psychotherapist interview.

An outstanding accomplishment was the participation in the present study of all 7 of the Directors of CAMHS at the time the TFFP study began.

6.4 Responsiveness of participants

All participants were enthusiastic and responsive, including the most critical of the experience wanted to give feedback, and were keen to convey in detail their experience of psychoanalytic psychotherapy

6.4.1 Impact of interview break

Notes were taken at each young adult interview during the 10-minute break organised after the first part of the interview. In these notes the researcher recorded observations, transference and countertransference phenomena experienced. In the first part of the interview the feeling states of the young adult were more intense. However, not everyone had that intense emotional response, and the researcher noted thoughts about attachment style and the length of their therapy as possible explanations. For some, it was as if their immersion into reflecting on their experience of psychotherapy collapsed time and they were back in their adolescence with the powerful feelings that evoked, and this caught them by surprise. A couple felt the loss of the special intimacy of the therapeutic relationship and wondered about going back into therapy.

Notes at the end of the interview were made in relation to the impact of the break. It appeared it gave the young adult space to move out of that immersion into their past. In the second part of the interview the interview questions invited more analytic thinking about their

adolescent self and experience of psychoanalytic psychotherapy from their current position as a young adult inclusive of all their development and experiences since then. At the edges of the break there was opportunity for them to chat. It was observed that the emotional tone shifted to a more relaxed, thinking and evaluative position and they were able to present their competent, adult selves.

CHAPTER 7

FINDINGS 2: YOUNG ADULT'S REFLECTIONS ON THEIR ADOLESCENT EXPERIENCE OF PSYCHOANALYTIC PSYCHOTHERAPY

The narrative interview transcripts of ten young adults recruited to the study concerned their lived experience of participating in psychoanalytic psychotherapy following diagnosis with serious mental illness during adolescence, and these transcripts were subjected to systematic thematic content analysis. The chapter sets out the findings of this qualitative analysis.

The chapter begins with an account of how that analysis was carried out. Then, the findings in respect to each of the domains of enquiry explored by the interviewer with each young adult are detailed. This is done in terms of the higher order themes emerging across the interviews of all ten participants. Finally, an integrative summary of these findings is presented.

7.1 Process of arriving at the findings

Ten broad domains of enquiry were embodied in the open-ended interview question protocol as described in Chapter 5 section 5.4.1 and in Appendix (VI). The Miles and Huberman (1994) method of thematic content data analysis was employed, as also described in Chapter 5, Section 5.7, and exemplified in Appendix XIV and Appendix XV.

The analysis began by punctuating into emergent themes the interview narrative of each young adult and entering the material in a table or matrix (see Appendix XV matrix 1), resulting in a second matrix with punctuated data in one column and corresponding emergent

themes in the other column. Further refinement of themes resulted in successive matrices for each individual adolescent within each domain, condensing themes into higher order themes when overlap was detected. Potential quotations that illustrated themes were asterisked, with a page reference so that they could be traced back from the final table of themes (See sample of Matrix 2 and 3 in Appendix XV).

Next, all participants' emergent themes were combined in a single, large Matrix 4 (see Appendix XV) in terms of higher level, or more abstract themes. These themes were abstracted using a further three matrices, resulting in the final Matrix 7. Moving from Matrix 6 to Matrix 7 involved condensation of themes which created brevity, but abstraction and preservation of anonymity were also at play. The process of abstraction of themes, into successive matrices that took place, clearly involved interpretative analysis.

It is possible to trace each higher order theme back to the original emergent themes contributed from each transcript. Thus, this systematic method resulted in a comprehensive and transparent view of the process of analysis and of the group of young adult's reported experience itself.

Asterisks indicated original quotations, in the penultimate matrices, but these were not retained in the final matrix, to further preserve the anonymity of individual participants. Quotations of course highlighted the young adult's lived experience in their own words, and these are introduced into this chapter to illustrate particular themes. For the sake of brevity, it was decided to limit quotations to a maximum of one per higher order theme, and to choose quotations which represented the general experience of the group as far as possible. To further safeguard anonymity, a principle of using a spread of quotations from different

participants was adopted. It was also thought to be useful to include quotations that had specific future utility for the possible conduct of adolescent psychoanalytic psychotherapy.

The distilled higher order themes in the final matrices for each domain of enquiry are presented in Section 7.2 below. To further enhance the meaning of the group narrative of the adolescents' experiences, the final higher order themes are presented in each instance, in each matrix, from the broad or general through to those that are more in-depth or abstract in meaning.

7.2: Domains of enquiry

The interview protocol elicited narrative responses from psychotherapy participants in ten broad domains of enquiry.

These were:

- difficulties during adolescence at the time of referral
- socio-cultural context of adolescents
- overall experience of psychoanalytic psychotherapy
- the young adult's view of the psychotherapists experience of the psychoanalytic psychotherapy
- the young adult's view of the psychotherapeutic relationship
- the young adult's view of how the psychotherapist saw the psychotherapeutic relationship
- the impact of psychoanalytic psychotherapy on other relationships
- the process of therapeutic change and its influences
- the difference made by psychoanalytic psychotherapy

- the impact of the research project on the psychoanalytic psychotherapy.

The original ten domains resulted in 17 Tables or Matrices. The final themes relating to each domain of enquiry are discussed from most to least commonly mentioned. Finer detail as to contributing themes and comments help clarify their meaning.

7.2.1 Domain of enquiry: Difficulties when referred to psychoanalytic psychotherapy as adolescents

The interview question relating to this domain of enquiry entailed two parts "When you think back, what sort of adolescent were you and what was happening?" It was asked later in the interview, but the results of the analysis of the responses to the first part of the question are presented here, in the interest of setting the scene for the unfolding narrative of the participants' reflections on their psychoanalytic psychotherapy experience. This question elicited frank and open discussion on the part of most participants and provided a picture of how the adolescent was functioning at the time of referral to psychotherapy. Table 2 below displays final matrix summarising themes which emerged describing the adolescent's difficulties at the time.

Table 2: Adolescent: Difficulties when referred to psychoanalytic psychotherapy as adolescents

Higher Order Themes	Number of participants mentioning these themes
Reasons referred to therapy	**6**
Lived in out of home care	**3**
Troubled behaviours	**5**
External diagnoses or observations	**8**
Impacted by external events, trauma & loss prior, during & post therapy	**10**
Troubled internal experience	**10**

Six participants mentioned material related to reasons they were referred to psychoanalytic psychotherapy. Three spoke of having suicidal thoughts, engaging in self harm including overdose, and hospitalisation. Other reasons included being referred when the CAMHS Case Manager was leaving, or after missing a term of school. Another theme was not knowing who arranged the psychotherapy referral or why. One participant articulated:

"*I don't know how I would have gone through with it, like actually hanging myself or anything, but I did fantasise about it quite a lot. Went through a bit of a suicidal phase, and wanting to commit suicide and thinking a lot about it*."

Three young adults raised the theme that they were in out of home care whilst in psychotherapy. All three were in foster care arrangements negotiated through Church, the Department of Human Services-Child Protection (DHS-CP), or, privately through a friend. One described a foster care situation with no routines or structures:

"*I could stay up and do whatever I wanted. I didn't go to school, I did home schooling. I could just sleep or eat, and do whatever I wanted, whenever I wanted. So I didn't have a normal adolescence at all. I wasn't controlled in any way*."

Five participants described various types of troubled behaviours pre-psychotherapy. Three mentioned as themes experimenting with drugs and or alcohol and clubbing; three also mentioned risk taking, rebelliousness, recklessness and pushing limits. Two spoke specifically of life-threatening behaviours, impulsivity, and multiple suicide attempts. Various other themes included aggressive behaviours; promiscuity; preoccupation with dieting and exercising and gaming all night on the internet.

The views of others were raised as themes by eight of the ten young adults. Three had been diagnosed with an eating disorder, and one saw others as more worried about her eating than she was. Two mentioned that there was external recognition of the negative impact that family dynamics were having. One talked of having multiple diagnoses, and others talked of specific diagnoses such as Asperger's Syndrome, Schizophrenia, Anxiety and Depression. One spoke of friends thinking there was something wrong with them.

All ten of the young adults described the external events, of trauma and loss impacting prior, during and post psychotherapy as a theme. Eight reported physical or mental illness, addiction or death or suicide by a parent, grandparent, or sibling. Four had been abused as children and four had felt hurt by parental separation or divorce. Two had been bullied at school, and another had to leave home because of physical confrontation. One described an attitude to parental loss during adolescence:

"*I sort of had the idea that you could just get over it and have the grief just be done, like in a couple of months and you wouldn't feel sad anymore, and that was just it. Like I didn't know that it was something that would affect you for a long time, or that it was okay to be really upset about it*."

All participants also described troubled internal experiences as a theme, with six declaring they felt depressed or sad. Four felt overwhelmed, out of control and having difficulties in thinking. Four also experienced increased feelings of aggression in adolescence. Three spoke of feeling lonely and paranoid, two of being dissociative, and two of having distorted body image concerns. A range of other internal experiences included confusion, lack of a sense of identity or self-worth, feelings of guilt, insecurity, and low self-esteem, strong negative self-criticism, feeling detached, feeling conflicted about behaviour not compatible with religious beliefs, missing contact with mother; anxiety and worry about being judged, and whilst wanted to be something, hiding aspirations. One participant painted a vivid picture of her internal state:

"*It was like… a whirlwind. I don't know if you know what I mean when I say I was always thinking really fast. Like there was always a million thoughts going around my head, um. Like looking back on how I … there was no time when I was ever happy. <pause> There wasn't. It was like I was incapable of feeling joy… or happiness*,"

7.2.2 Domain of enquiry: Socio-cultural context of the adolescent

7.2.2.1 Description of home, school, and neighbourhood as adolescents

The young adults were asked what it was like being an adolescent growing up in their neighbourhood at the time they were in psychoanalytic psychotherapy and the themes from this question relating to socio-cultural context emerged into three distinct areas which were divided into three tables. This question was asked at the end of the interview, but the findings have been presented here as they provide some context for the young adults' descriptions of their difficulties as an adolescent. The table below portrays the themes described regarding the adolescents' home, school, and neighbourhood.

Table 3: Adolescent: Description of home, school, and neighbourhood as adolescents

Higher Order Themes	Number of participants mentioning these themes
Neighbourhood	**3**
Family/living situation	**6**
School & its culture	**4**
Impact of geographical isolation & lack of infrastructure	**3**

Three participants commented on their local neighbourhood as a theme, saying they came from a low socio-economic neighbourhood. One perceived there was less educational pressure on peers from lower socio-economic backgrounds in their neighbourhood and it was easier to fit in.

"*Well we lived in commission housing, so you, you didn't really have anyone that was hanging with the riches or anything like that. .... Around... sort of... my peers from you know the commission housing, I really felt like I sort of did fit in a bit, like they were a bit. There were no real expectations, like most of them didn't go off and go to Uni.*"

Six young adults described their family or living situation as a theme. Two reported that they had experienced multiple out of home placements. Other responses were quite varied as follows: good, supportive family with good relationships, Christian family but religion had little role in life, family was middle-class living in a low-income area, moved around a lot growing up, life very restricted prior to going into foster care, and exposed to vastly different types of people and an anti-social culture in residential care.

Four participants,' raised the theme of their school, and its culture with three mentioning the different adolescent cliques at school, and two commenting that there was some bullying. Other comments were that their school had a poor reputation, one school was described as large with multiple campuses with students from culturally diverse backgrounds, another school had a good school culture in the main, although there were some problems, and another said drugs were not part of their secondary school culture. One described school cliques as:

"… there were like a lot of bitchy people at my school like those typical bimbo bitches that put everybody else down. Just stupid"

Three participants talked about the theme of geographical isolation and lack of infrastructure, and its impact upon adolescents in their area. Two talked of there being nothing to do in a

country town, and groups becoming involved in anti-social activities, and two also spoke about how such circumstances meant that some adolescents became lonely and disconnected. One talked about there being nothing for adolescents to do in the area, and there being a lack of mental health services for adolescents there:

"… they only started getting that kind of service there when I was like 18, 20, and that's for adults, so um… yeah, there wasn't really much out there to help you, not much to do, so generally, you got up to mischief. ... Walking the streets at 3am, doing not much,... graffitiing, um stealing road signs, ... breaking into boatsheds, ... making bombs, and setting them off on the beach."

7.2.2.2 Interests and behaviours of the adolescents

A second sphere of the socio-cultural context of the adolescents was placed under a higher order theme of interests and behaviours, and the various themes that were described are displayed in the table below.

Table 4: Adolescent: Interests and behaviours as adolescents

Higher Order Themes Level 2	Number of participants mentioning themes
Interest in sport	**2**
Interest in music	**6**
Maintained creative interests	**3**
No interest in experimenting with substances as a teenager	**3**
Reflections on adolescents	**4**
Influence of internet, gaming & chat	**3**

The theme of sport was an interest raised by two participants. One became passionate about watching seasonal sports on TV, whilst the other loved to be engaged in physical activity.

Six young adults reported an interest in music for various reasons such as: EMO music reflected how the person felt back then, two others liked heavy metal, and one liked rhythm in heavy metal and drums which sounded angry so she could exercise to it. Three listened to the radio and watched TV as a way of keeping up with the latest music, but for one, the former was a way of helping her get to sleep. Another started attending musical festivals, and for three participants, drugs and alcohol became combined with the experience of music, one talked of techno or grunge being great dance music when drunk at clubs. Music tastes and what radio station one listened to were also influenced by what was considered cool in the peer group.

Three participants maintained creative interests as adolescents, and all of these participants were interested in Japanese Anime films, drawing, and Manga cartooning. One reported that drawing gave a sense of finishing something, but that creativity could be dampened by lowered mood.

Three participants expressed no interest in experimenting with substances as teenagers. Two thought getting drunk was stupid, and sometimes dangerous. One felt fearful of the rowdiness and potential violence in a drinking environment, and thus did not go to parties. Another participant was not interested in alcohol, and oblivious as to whether her peers took drugs or alcohol. One participant's attitude towards alcohol and smoking of peers is described:

"*I found it really stupid for them to um... go over to behind the gym sheds, and um... smoke, trying to do so without getting caught. And you would always hear about the parties they had the weekend before, and how they would always talk about getting plastered and that sort of thing*."

There was a theme of negative appraisal of the stage of adolescence by four participants. Whilst there was an acknowledgement that people varied, their overall conclusion was that teenagers tended to be immature, loud, petty, and thoughtless. Comments included:

"*adolescents pick on others for fun without thinking about how they are hurting others*," "*teenagers are arseholes*," "*there are good teenagers dealing with the usual stuff who aren't violent and aggressive*," and "*teenagers are rats now compared to before*."

The theme of the internet, gaming and chat influences was discussed by four participants. At the time there was no Facebook, and it was mostly My Space and MSN, but two participants talked about internet chat having a big social influence upon them. It was described as a place where people could talk about things after school, and a way of communicating about parties. One saw chatting online as being linked to identity, escapism, and being more private than using a telephone at home. Another participant lived a virtual life through role-playing games online, and found games helped occupy the mind without needing to think about other worries, and it also kept the mind sharp. The benefits of gaming were described:

"*... it's also about… little achievements, little things that you can do that are only significant to you, but on a smaller scale as compared to life, so you've got something to help you feel*

fulfilled when you're stuck. It helps me feel like I've achieved something, while... rather than sitting there staring at a wall."

7.2.2.3 Peer culture, behaviours, and sense of belonging as adolescents

The third domain that was described under the adolescent's socio-cultural context was that of peer culture and behaviours at the time, and the adolescent's sense of belonging within that peer culture. The themes produced under this domain are portrayed in Table X below.

Table 5: Adolescent: Peer culture, behaviours and sense of belonging as adolescents

Higher Order Themes Level 2	Number of participants mentioning these themes
Peer culture & behaviours	**8**
Peer activities & conversation	**4**
Basis for friendships	**4**
Sense of connection & belonging to a peer group	**4**
Minimal or no connection with peers	**5**
Felt didn't fit in with peers	**6**
Peer factors contributing to experimentation & acting out	**5**

Eight young adults described the culture and behaviour of their peers at the time as a theme. All of these participants referred to there being a lot of drinking, some drug taking, and having sex too young. Two described how the focus was on the 'here and now' and two talked about how people dressed to express their feelings and group identity. Others made

various comments such as most of the girls had boyfriends, boys had a negative attitude towards the girls, it was a culture where one proved oneself through risk-taking, people rebelled against their parents, adolescents would hang out at the train station, and that people were trying to individuate. One participant summed up a combination of these themes:

"*… the guys had to be like hard, tough and basically yeah, like criminals. And the girls were sluts or… if you didn't do it, if you didn't sleep with someone, you didn't do that you were a fucking, you were like a frigid or, there was nothing you could ever do that was right, nothing ever. It was... it was really shit. I think back to that, and I fucking hate it. Fucking hated that time in my life, hated it.* "

Four participants described a theme of typical peer activities and conversations which included talking together about varied topics such as school, relationships, dating, politics, movies, books, television series, music soundtracks, and religion. One participant described typical peer group activities as:

"*Adolescents what did we do? Go to the movies, or if we could afford it, as (it) became really expensive. Or we just… we didn't really do anything. Like you think, you hear about people in the 50s, and they'd go out and do stuff. Never did it, you'd just go home and sit in front of the TV, and go on MSN. Online I think a lot of the stuff happened, a lot of the social stuff happened I think online*."

The basis of adolescent friendships was a theme described by four people and involved various aspects such as proximity - being in the same classes at school, sharing common

interests and aspirations, similar parental expectations of rules, and achievement. One participant described changing friendship groups in order to have more fun:

"*I thought that they were more fun, that's at the time. I thought they were more fun. Like they were sort of a bit louder, and more outgoing, and would...you know...when we were down the street, we would talk to people, talk to other people and make friends and stuff like that*."

Four of the participants described having a sense of connection and belonging to a peer group that they had been close to at school, where they had enjoyed being with each other, and that they still maintained contact. However, half of the participants raised as a theme having minimal or no connection or belonging to a peer group. In this group of respondents, reference was made to not hanging out with others, being at home alone a lot on the computer, and not having friends in the neighbourhood. One didn't think she had normal friendships then, and another had a limited number of friends, but contact was not maintained. The following is a description by one participant:

"*I never really hung out with people my age. I didn't really hang out with anyone. I always did things on my own. I wouldn't call myself a loner, I wasn't quite a loner, cause a loner is someone that uh... shuts themselves out, I never shut myself out. I... was out there. I did stuff. It's just that no one did stuff with me*."

Six of the participants reported feeling like they didn't fit in, and this included one person who had identified as feeling part of a peer group. Four of these participants observed feeling like an outsider or disenfranchised if they did not embrace behaviours such as drinking,

smoking, adopting a way of dressing, making out or going to parties. Two participants saw themselves as not normal, and therefore outcasts. In the words of one young adult:

"*Like even at school, like I couldn't relate to, like... when I was still at [**....**] High, I couldn't relate to anybody, like... who was… like... living a normal kind of life. I was the outcast, like weirdo, like I only really had one friend at the time, and we would always be like a very intense relationship based on our negative feelings about ourselves, and the world."*

Factors contributing to acting out and experimentation amongst peers emerged as a theme for half the participants. Three participants talked about drug-taking or cutting as a way of coping with upset, but experimentation with drugs was also linked with curiosity, and the influence of peer associations or partners. Two talked of maintaining a negative lifestyle of drinking and drug-taking because of peer pressure and fear of rejection, and one reported losing friends when she stopped these behaviours. One spoke of the addictiveness of cutting and the relief it brought, and that made it difficult to stop. Another talked of drinking and sex as a way to fit in or belong. One participant described how alcohol elevated her mood, and capacity to socialise:

"*I didn't feel. Like... if I knew I was going out and drinking, I would actually be excited to go out, you know... versus like... if I wasn't drinking, like... I didn't want to go out. Or like... I'd go out, but I'd still think about all these depressive thoughts. I went through a stage where I did drugs as well, but it was an intermittent, like... a passing-through stage so...* "

7.2.3 Domain of enquiry: Overall experience of psychoanalytic psychotherapy

Analysis of the domain of enquiry relating to the overall experience of psychoanalytic psychotherapy revealed higher order themes forming five sub-domains or groups, namely the beginning, the structure, the helpfulness, the unhelpfulness, and the ending of the psychoanalytic psychotherapy experience. The final matrices for each of these sub-domains are presented and described below.

7.2.3.1 Beginning psychoanalytic psychotherapy

When responding to the broad question about the experience of psychoanalytic psychotherapy, all ten participants reflected back to when they began psychoanalytic psychotherapy. The themes that emerged are displayed in Table X below.

Table 6: Adolescent: Beginning psychoanalytic psychotherapy as adolescents

Higher Order Themes Level 2	Number of participants mentioning themes
Initial recollections of beginning therapy	**7**
Initial expectations & needs	**5**
Pre-existing strengths	**5**
Comparisons with previous treatment	**3**
Feelings & attitudes at the beginning	**4**
Degree engaged in therapeutic relationship	**5**
Reflection on the processes in the beginning	**3**

Seven of the ten young adults commented on their initial recollections of beginning psychoanalytic psychotherapy, with four doubting how much they would remember, and one unable to remember the beginning. One remembered the first meeting with the therapist and another, the therapist's initial explanation of the process.

Themes relating to initial expectations and needs were raised by five participants. Of these, three reported that they did not know what to expect or what psychoanalytic psychotherapy was, whilst four spoke of their hopes, expectations and needs. One participant recalled a desperate need was experienced at the beginning:

"*I had to find somebody who could understand how terrible it was and empathise with me. And say, you know, it's actually probably normal that you're feeling this terrible and ..., you can't just get over it*"

Half of the participants pointed to pre-existing strengths within themselves upon commencing psychoanalytic psychotherapy. The capacity to engage, reflect and work was raised by these participants. Four were open to talking and exploring their lives, and one reported being "highly motivated to fix things." One remarked:

"*I do remember ... things that we talked about, like... thought patterns.... And this is the type of person I am, I would go away and think about them.*"

A third of participants indicated this psychotherapy was different from previous treatment. One participant considered:

"*It was more just exploring what was going on in my mind .... wasn't as practical.*"

Themes concerning actual feelings and attitudes towards psychoanalytic psychotherapy at the beginning revealed reserve by participants. Ambivalence was mentioned by two participants, whilst others remembered feeling overwhelmed, more depressed, reluctant to participate, or needing more time to build trust. One person reflected:

"*I think the thought of going to therapy ... sort of in the initial stages made me feel more depressed, knowing that that was what I was going to go and talk about"*

Half of the young adults raised the theme of actively engaging in a relationship with the psychotherapist at the very beginning. Of the others, one commented on not engaging initially, while another perceived the psychotherapist was of a similar personality:

"It's just one of those things that you just find people who are like you and you start talking, and it's just either you get along or you don't."

Three participants reflected on more specific aspects of the process of beginning. Where one mentioned mental blocks interfering with talking about her most serious feelings at the start of therapy, the others spoke of building on a collaborative relationship and continuing in the hope that psychoanalytic psychotherapy would work for them.

7.2.3.2 The structure and context of psychoanalytic psychotherapy

Table x below demonstrates that all ten participants were able to respond to prompting questions about the structure and context of psychoanalytic psychotherapy, and made mention of the themes of the length, frequency and or setting of the therapy.

Table 7: Adolescent: The frame: Structure and context of psychoanalytic psychotherapy

Higher Order Themes Level 2	Number of participants mentioning these themes
Overall structure, length, frequency & setting of psychoanalytic psychotherapy	**10**
Some structural flexibility provided	**3**
Value of a private space	**2**
Broader context of psychoanalytic psychotherapy	**2**

Eight recalled the time, day, frequency length and need of routine. Six remembered furniture, toys, the view, or the relaxed feel of the room. Two reflected that they struggled to remember aspects of time or structure. One found it difficult to stay within a 50-minute time-frame at first, while yet another stated:

"*It was the same time, same day. That was good. I liked that because I needed structure at that time, in my life as well. I mean everybody needs it at any time, but I really had none. So, that was one thing that was set, and I knew what was happening, and what time.*"

The importance of flexibility was a theme raised by three of the participants, such as when adaptation of structure had been needed, perhaps change in location or times to fit with work or school, or assistance with negotiation of a crisis via telephone contact.

The value of a private, confidential space was commented upon by two participants, highlighting how this made them feel cared for. One summed it up:

"*I had someone who listened and someone who was able to spend .... sounds very selfish, but I had a whole time just for me*."

The broader context of the psychoanalytic psychotherapy and its interrelationship with other systems was raised also as a theme. Two participants detailed school liaison, family support and CAMHS treatment. One described how both school and psychoanalytic psychotherapy together helped because:

"I went to the psychoanalytic psychotherapy during the week, and I'd go to school, and it would come to me together .... from going there and going to school."

7.2.3.3 Helpful aspects of psychoanalytic psychotherapy

In the interview most people talked readily about their overall experience but sometimes prompting or clarifying questions were asked to expand on the material for those who were less loquacious. For example, "How was it helpful?" or "What was positive about it?" would be used to elicit further information when someone said it was helpful or positive. The resulting higher order themes are displayed in Table 8 below.

Table 8: Adolescent: Helpfulness of psychoanalytic psychotherapy

Higher Order Themes Level 2	Number of participants mentioning these themes
Globally positive experience	**5**
Changes & outcomes	**7**
Positive skills, knowledge & attributes of therapist	**9**
Description of therapeutic processes	**10**
Importance of the relationship with the therapist	**5**

Half of the participants remembered psychoanalytic psychotherapy broadly as a good experience, with three of these saying they could not recall any negatives.

Seven participants reported a variety of themes indicating actual positive outcomes of their experience of psychoanalytic psychotherapy. Highlighted were improved self-understanding, they had enough help at the time, mood improvement, skills acquisition, internalisation of the therapist and the process, learning that this type of psychotherapy did not suit, and that learning to cope is ongoing in life. One young adult identified her problems as profound and long-standing, that she was still maturing when she started psychoanalytic psychotherapy, still learning how to think and cope with life.

Nine young adults raised a theme of skills, knowledge and attributes of the psychotherapist as helpful, including respectfulness, friendliness, understanding, politeness, normalising their experience rather than consoling them, commitment, non-reactiveness, calm demeanour, helping to open up exploration of their thinking, empathy, recognising and commenting when progress had been made, using self-disclosure and self-reflection, knowing where to focus and acceptance of difference. One person described helpful attributes of the psychotherapist in the following way:

"(Therapist) was great because she was … very, like... calm and didn't immediately change. Like she wouldn't act shocked at anything, she wouldn't act sad at anything. She wouldn't .... like, she'd just be the same and be that .... like strength. I guess. Just that normality about my bizarre situation. Like most people at the time would be like "Oh that's really sad." Or that's.. She'd say that's really sad but she wouldn't crap on about it. … And I really appreciated that and needed it..."

All of the young adults identified themes relating to helpful psychotherapeutic processes, with six commenting on how it was good to talk to someone. Four commented that it was hard to be specific about how psychotherapy had helped, but another four remarked that the therapist being separate from their everyday life and contributing another perspective helped. Being listened to, and the psychotherapist waiting for them to talk, was seen as helpful by four participants. Two remarked upon the helpfulness of the process of expressing themselves, thinking about their emotions and exploring their thoughts aloud which increased self-awareness and self-understanding. The psychotherapist's understanding of the adolescent was mentioned as helpful in explaining what was happening for them with others. Other helpful processes mentioned were having time-out when behaviours escalated, and then being expected to return, taking time and not rushing, the calming effect of psychotherapy and not having to do homework. The following is a holistic description by one participant of the therapeutic process found to be helpful:

"*I would just sort of start talking about what was on my mind, and umm, she would sort of …. when I came out with statements and things that sort of …. she would sometimes question them and try and like draw out more information, about maybe why I thought that way. Or had I realised I was thinking that way, just to kind of prompt me to think about why I held the*

beliefs or the thoughts I had.... Umm. So it was more just me exploring what was in, going around in my head, but actually being able to speak it out helped me sort of realise. Helps you sort of understand what you're thinking more. Umm. It's sort of, like, everyday things go round and round in your head but when you actually have to articulate them then you sort of ... it makes you realise more what you ... what you're thinking, or the beliefs why you're acting and things like that."

Half of the young adults raised the importance of the therapeutic relationship as a theme. Four spoke of psychotherapist attributes, personality, compatibility, and collaboration as aspects of their connecting with the psychotherapist. Two specifically commented on how the relationship was established over time, through talking about family, and one stated that the psychotherapist had been her only support. One person recalled:

"*I really felt like .... she was someone that I could talk to. Which was why I started to want to go. Like and she was, like .... and I could talk to her about issues that I couldn't talk to my mum or my friends about, like, 'cause I knew it wasn't like she was going to go and then.. I had massive trust issues, I think, with nearly everybody in my life. And she was one person I felt, like, I could trust. I don't know. But I knew that she wasn't going to blab it to everyone*."

7.2.3.4 Unhelpful aspects of psychoanalytic psychotherapy

Six of the ten participants were able to identify unhelpful aspects of their psychoanalytic psychotherapy experience, as shown in Table 9 below.

Table 9: Adolescent: Unhelpfulness of psychoanalytic psychotherapy

Higher Order Themes Level 2	Number of participants mentioning these themes
Globally negative	**1**
Session too short at first	**1**
Cancellation of sessions	**1**
No change or negative experience	**3**
Negative attributes of therapist	**1**
Relationship with therapist	**2**
Premature termination by therapist	**3**

One person viewed the psychoanalytic psychotherapy as globally negative but did not know how to improve it. Another found the sessions too short at first and did not like her psychotherapist cancelling a session.

Three participants identified a theme of no change or negative experience, with two remembering getting stuck in psychotherapy, with no solution to problems and no improvement. The other recalled that her anxiety increased as she became more aware of her sadness and uncomfortable feelings during the process of psychotherapy.

One participant identified several negative qualities in the psychotherapist, including lack of understanding, kindness, caring, humour, or support and being closed off. This participant felt frustrated by the repetition of what she saw as incorrect interpretations.

Two people raised the theme of a power difference in the relationship with the psychotherapist as being unhelpful. One of these citied other aspects of the relationship as unhelpful, such as impersonal style, lack of reciprocity, and repeated comments on the participant's anger towards the psychotherapist. This participant commented:

"*It wasn't a conversation between two people. It was me talking and a brick wall*."

Three young adults spoke of premature termination of their psychotherapy by the psychotherapist as unhelpful. Two people had a sudden end to their psychotherapy as the psychotherapist became ill. One finished psychoanalytic psychotherapy when the psychotherapist moved region and stated that the psychotherapy might have been more helpful if it had been longer.

7.2.3.5 The processes of psychoanalytic psychotherapy

All ten of the participants' reflections on their overall experience of psychoanalytic psychotherapy included themes that broadly fell into two parts 'process' and 'ending' shown in Table 10.

Table 10: Adolescent: Processes of psychoanalytic psychotherapy

Higher Order Themes	Number of participants mentioning these themes
Content of psychotherapy	**6**
Feelings during the psychotherapy process	**7**
Difficulties in remembering specifics of psychotherapy	**6**
Understanding of how psychotherapy worked	**8**
No memory of ending process	**5**
Reasons for ending psychotherapy	**5**
Psychotherapy was not a cure	**7**
Reflections & evaluations now	**7**

Nine had responses which related to the first part of the table, focussing upon the process of psychoanalytic psychotherapy, including themes about content, feelings, difficulties in remembering and understanding of how psychotherapy worked. All of the ten participants discussed themes displayed in the second part of the above table, related to the conclusion of psychotherapy, such as lack of memory of the ending, reasons for psychotherapy ending, psychotherapy not being a cure, and evaluation of the experience.

Six participants raised the content of psychotherapy as a theme here. Three participants recalled drawing and other activities in the psychotherapy, whilst others identified talking about their week, feelings, school, family, difficulties and thought patterns, and one mentioned that medication was not a focus of discussion.

Feelings experienced during psychotherapy were raised as a theme by seven of the young adults. Examples of feelings recalled were they felt safe, felt guilty about worrying the psychotherapist, and felt impatient for changes. One commented that her memory was more about the feeling than the content:

"*I just began to feel more confident in myself, whether or not it was the skills I was being taught through. And like I can't even remember being specifically.... being taught skills. Like whether or not it was just talking and self-realization or like advice that I'd been given or... Like I can't remember specifically what happened, but I remember feeling… like the past for me is probably not about the content that I remember, it's about the emotions that I probably remember*."

Despite the above, six people stated that it was actually hard to recall specifics of the psychotherapy, and four commented on not remembering any particular turning points. One was surprised when she recalled what day she attended psychotherapy.

Eight participants highlighted the theme of how psychotherapy worked. Four found it hard to be specific about this, two discussed privacy and confidentiality, and another two described the therapeutic relationship and its development as being aspects of the psychotherapy process. Others considered being helped by attendance becoming habitual and depression decreasing over time. Three focussed on the role of the psychotherapist, one saying:

"*To be something solid that's never changing ... that's always going to be like that. So that it doesn't affect you in change and that. So somebody who's had a pretty up and down life ... something that's always there at a particular time ... that's not going to be angry or sad about what you say*."

Half of the participants could not remember the process of ending psychotherapy, while half could recall the reasons for ending psychotherapy. Themes here varied. Three reported they were ready to finish, perhaps having become more independent, having left school, or found a job, or just wanting to move forward on their own. Two remembered feeling guilty about missing sessions and felt this was connected with psychotherapy ending. One reported that her problem had remained the same and reflected that she may have been questioning if psychotherapy was worthwhile. One described being left feeling there was not sufficient closure.

"*I, like, caught up with her in an email or something, and we were going to have another session or a follow up or something, but we didn't end up going ahead. But we had some sort*

of contact where I explained that I didn't want to come or something ... like through an email umm, and that was about it. But I always felt bad that I kind of left it abruptly."

Seven participants raised the theme that psychotherapy was not a cure. Four young adults sought further treatment after finishing this psychotherapy. Two were happy with their further treatment, but two missed the depth of their previous psychotherapy. Two stated they were helped enough to move on with their lives. Another two reported that subsequent to ending psychotherapy one had faced further major mental health issues, and the other, major life events that had eclipsed the significance of psychotherapy for them. One observed still being involved in ongoing learning to manage longstanding problems.

Seven young adults were able to reflect back and evaluate their overall experience of psychoanalytic psychotherapy. Themes included that reflections may have changed over time, and that what was thought to be unhelpful at the time was what the adolescent had actually needed. Two spoke of not being able to get to their deeper issues at the time they were in psychotherapy. One expressed sympathy for the psychotherapist trying to finish the session when she was in a heightened state of emotion and wanted to continue, and another felt guilt at not saying goodbye and wished to thank her psychotherapist and let her know she was doing well now. Another commented on needing much more trust than had developed in this psychotherapy, to talk about events that occurred after psychotherapy finished. One person observed that the psychotherapy could not be made quicker, despite her continuing struggle with ongoing issues:

"*Well (its) a bit like… a really thick book trying to squeeze into two hours of a movie. It just doesn't fit, you know. There's a lot of content, and it's like, if you want the full experience, you have to read all of the pages*."

7.2.4 Domain of enquiry: View of the psychotherapist's experience of psychoanalytic psychotherapy

When asked about their perception of the psychotherapist's experience of the psychotherapy, most participants were taken aback. However, upon reflection, all ten were able to respond to this domain in some way, as revealed in Table 11.

Table 11: Adolescent: Adolescent's view of psychotherapist's experience of psychoanalytic psychotherapy

Higher Order Themes	Number of participants mentioning these themes
Not focus then, hard to tell	**7**
Unable to reflect or remember now	**1**
Directly communicated	**1**
Hope was positive	**2**
Capacity to reflect and evaluate now	**5**
Indirectly deduced through observations and feelings	**6**

Seven participants broadly commented that thinking of the experience of the psychotherapist had not been their focus, and secondly it was hard to tell because the psychotherapist did not overtly reveal her own experience. One participant was unable to reflect or remember about this at the time of the research interview. One young adult however, was clear about the psychotherapist's experience, as it has been directly communicated.

Two participants expressed the theme of hope that the psychotherapist liked them and found their contact a positive experience.

Five participants showed a capacity to reflect back upon the experience and evaluate how it may have been for the therapist. Three thought it would have been a good experience, predicated on positive progress and outcomes. Another elaborated upon the theme that the more difficult the adolescent the less positive the experience for the psychotherapist. Two thought the psychotherapist might have been disappointed in their behaviour and how the psychoanalytic psychotherapy ended. Two reflected on how they were back then, and that the psychotherapy might have been emotionally overwhelming, exhausting and even distressing for the psychotherapist. Another mused that the complexity of the psychotherapy may have been interesting to the psychotherapist.

Six participants indirectly deduced through feelings and observation what might have been the psychotherapist's experience. Three felt at the time, that the psychotherapist experience was positive and two had a sense of that experience through observation. One observed "she saw our shared humanity" and another had seen the size of her file and realised how much the psychotherapist had thought about her. One noted:

"*You could tell by the tone of her voice that she was getting frustrated.*"

7.2.5 Domain of enquiry: View of the relationship in psychoanalytic psychotherapy

All ten participants were able to respond to the question "What do you remember about your relationship with your therapist?" The higher order themes that emerged here are displayed in Table 12.

Table 12: Adolescent: Adolescent view of the therapeutic relationship

Higher Order Themes	Number of participants mentioning these themes
Difficult to remember	**5**
Positive relationship connected to outcome	**2**
Difficult to separate the relationship from the experience	**2**
Therapist qualities influenced the relationship	**7**
Adolescent qualities influenced the relationship	**4**
Relationship at the beginning	**3**
Time needed to build relationship	**5**
Nature of relationship	**7**
Reflections on loss of relationship	**3**

Initially, half of the participants reported a theme of struggling to remember the relationship, as it had been some years since psychotherapy. Two raised the theme that it was a positive relationship linked to good outcome, according to one, keeping her alive. Two participants struggled to separate the relationship from the experience, equating them as the same.

With further reflection, more participants became able to comment on their experience of the therapeutic relationship. For seven participants, the theme arose that the psychotherapist's own qualities influenced the relationship. Three emphasised the psychotherapist's responsive listening, and two the psychotherapist's non-judging, independence and maintaining of privacy, as beneficial to the relationship. Others mentioned a range of qualities as important, such as dependability, respectfulness, caring about progress, being fun, and giving a welcoming smile. Only one reported finding she was not getting anything from the psychotherapist, which made her feel nothing for the relationship at the time.

Their own qualities influencing the relationship were also raised by four participants, with two mentioning they were naturally open and talkative. One enjoyed being observed and noticed, whilst another felt guilty for not attending and was less open to discuss things. Another reported being actively avoidant and hostile towards building a relationship:

"*... just incredibly rude, abrupt, closed off, um… nasty, really nasty sometimes. So, I… you know, if anything, it was me not wanting to build on that at the time. But it did… it did build, because I kept going*."

For three participants the theme of the relationship at the beginning emerged, with one describing an immediately trusting relationship, one an ambivalent relationship and a third a negative reaction to the therapist. One observed that previous counselling had helped with trust:

"*I think I trusted her from the beginning, because um I'd been seeing, I'd been at CAMHS um ... and had to talk quite a bit...*"

Beyond this, five participants discussed the theme that it needed time to build a relationship and enhance their capacity to talk. The benefits of going at one's own pace, and it taking time to develop closeness, understanding, trust and shared humour, were all mentioned as important. In the words of one young adult:

"*I think it was just time. Just time. It's the same with me now. Like I won't tell, you know, people - intimate details of my life when I've just met them. It's just time. It takes time to build a relationship*."

Seven of the participant's comments contributed to themes concerning the overall nature of the relationship. Three described it as friendly, two as valued and another two as a meeting of compatible personalities. Other remarks were that it was consistent, serious, had clear boundaries, was collaborative, allowed the expression of anger and frustration, and was a space to sort out differences. There was the capacity to talk about problems and daily things, and that it could be humorous, and did not always involve negative things. One example of the value of the relationship was described thus:

"I looked forward to going to see her every time we had a session. I didn't want to pass any of the sessions up, even if I had plans with my friends or anything like that. 'Cause some of the sessions were at lunch time so I didn't miss classes. I really looked forward to going in the room and seeing [her,] and talking as much as I could."

Three participants reflected on the loss of the psychotherapy relationship, speaking of how the relationship was missed when it ended, and expressing the desire to talk with the psychotherapist again. One thought upon reflecting back, she was enabled to talk, as the therapist felt like a friend.

7.2.6 Domain of enquiry: View of how the psychotherapist saw the relationship

Most participants struggled to respond to the question "How do you think the therapist saw your relationship with them?", for this domain of enquiry. All ten participants attempted a response, however, as set out in Table 13.

Table 13: Adolescent: Adolescent's view of how the psychotherapist saw the therapeutic relationship

Higher Order Themes Level 2	Number of participants mentioning these themes
Unable to determine	**8**
Good based on observations	**2**
Direct evidence that said relationship important & valued	**4**
Hope saw as positive	**3**
Retrospective speculation	**5**

Eight participants felt unable to determine how the psychotherapist viewed the psychotherapy relationship with them, six initially saying they simply did not know. One commented that the psychotherapist revealed little, and the focus was on her, not the psychotherapist. The

two other participants considered the psychotherapist saw the relationship as good, based on observation of no negativity being expressed by the psychotherapist.

Four participants went on to raise the theme that there was some direct evidence that the psychotherapist valued the relationship and thought it important. One of these reported that the psychotherapist had actually said the relationship was important. Another reported that the therapist was glad she had "turned out okay." Another had wondered a lot about what the therapist thought and said:

"*I actually would say, "You, you're getting paid to be here, but you really don't want to." But she was like, "I am getting paid, but I wouldn't be here if I didn't, if I didn't want to."* "

Hope the psychotherapist saw the relationship as positive was a theme that was alive for three young adults. All hoped the psychotherapist enjoyed the relationship, and one hoped that the psychotherapist saw her as a good person and that she did not see her as hopeless.

Speculation about the psychotherapist's experience of the relationship was possible for five participants. One, whose overall experience was difficult, speculated the psychotherapist saw the psychotherapy relationship as dysfunctional and unhelpful. However, the other four emphasised positive themes. These were that the psychotherapist recognised that the adolescent needed help with difficulties, saw the adolescent as a good patient who talked, perhaps did not experience the adolescent as difficult as the young adult felt she had been, saw there was trust in the relationship, or that the psychotherapist could have seen the adolescent as either a client or a friend.

7.2.7 Domain of enquiry: Impact of psychoanalytic psychotherapy on the adolescent's relationships

In responding to the interview question, "How did psychotherapy impact upon your relationships?" Nine out of the ten participants were able to respond to this domain of enquiry. The themes emergent in their responses appear in Table 14 below.

Table 14: Adolescent: Impact of psychoanalytic psychotherapy on adolescent's relationships

Higher Order Themes	Number of participants mentioning these themes
Relationships prior to therapy	**4**
Degree of impact of therapy on relationships	**6**
Negative impact on relationships with family & peers	**2**
Positive impact on relationships with family & peers	**6**
Positive impact on relationship to the Self	**3**
Therapeutic processes that helped improve other relationships	**4**

Four young adults first mentioned the state of their relationships prior to psychotherapy. Two spoke of having no friends, and two talked of having negative relationships with their mothers. One remarked:

"*...with my mum, I went through a stage, I just couldn't stand it, like beginning therapy, like and particularly before, I just thought she was like the evil queen. It sounds awful, and I'm sure all teenage girls go through that stage.*"

Six of the ten participants raised as a theme the actual degree of impact psychotherapy had on their relationships, two being clear that therapy had no impact on their relationships and two thinking it had a large impact, with comments on dramatic changes. Two participants were unsure of the impact, and two commented more upon the quality of their relationships.

Negative impact upon relationships was mentioned by two people, with one believing that the anger she felt towards the psychotherapist was displaced onto her partner, and the other that her mother became anxious about how she was being represented in the therapy. One spoke of being reliant on her mother to bring her to psychotherapy which created additional strain:

"She didn't want to drive me there. You know it was half an hour to the place and back again. She'd have to wait, she'd have to go do stuff. She'd always be pretty … angry and resentful and stuff. Like she wouldn't yell at me, but she would just be kind of very, <pause> mean about it, like she'd be holding a grudge against me for going there. Didn't like it. It was a push to make her drive me. And she'd always be trying to make me feel guilty for going."

In contrast, six participants presented a theme of psychotherapy as having a positive impact on their relationships with family and peers. Three learned to talk to their parents and two spoke of an improved quality to their relationships. A variety of other positive changes were noted, for example an improved relationship with the mother, and reconnecting with family generally. Improved peer relationships were mentioned, namely becoming held in good regard by peers, learning to initiate a friendship for the first time and learning to make friends, becoming more relaxed and less withdrawn from friends, learning to assert one's own needs more, and not being as upset by the father's behaviour now. One added that her

mother now held a positive view of the benefits of therapy, and the therapist had helped another's father to understand her better. One participant summed it up:

"*I did find it easier to talk to other people. Even though I couldn't talk about all my concerns with dad, at least, um, I could still talk to him maybe a little bit of, um ,"Hi dad, how was work ?" sort of thing, but at least its more than that now. I could talk with my friends a lot easier about my problems*."

Three participants raised as a theme the positive impact therapy had on their relationship to their own self. Comments such as increasing self-esteem and self-confidence, feeling more powerful and no longer suicidal, gaining a capacity to separate and individuate, becoming more accepting and understanding of the limitations and strengths of parents, better understanding one's own mental processes, and developing trust in self and others. In the words of one young adult:

"*I was a doormat like to anyone and everyone in my life I felt like. It took me a long time to stop being that doormat, ... once I got a little bit of self-esteem, which I did, and that was one thing that I think I gained from therapy was self-esteem because I had none at the start."*

Four participants reflected upon the theme of how therapeutic processes had helped their relationships improve. Processes such as validation of feelings, and support helping to build confidence and self-esteem were mentioned. Having a separate space to talk to someone else relieved one young adult from feelings of burdening her mother. The psychotherapist withstanding extreme testing behaviours helped another to learn to trust. One participant

described a process of introjecting positive qualities of her psychotherapist, which was confirmed by others, saying:

"*I'll always be there for anybody no matter what the situation, and I'm not a judgmental kind of person. And I think I developed that through um… (Psychotherapist's) inspiration, in her calm and understanding and not being judgmental."*

7.2.8 Domain of enquiry: Reflections and understanding of difficulties as an adolescent

As discussed in Section 7.2.1 above, a subdomain appeared in responses to the sixth question in the interview (which occurred just before there was a planned break in the middle of the interview), and asked "What sort of adolescent were you and what was happening?" All ten participants responded to this question and in this domain, two tables of themes were developed.

The first table was of descriptive themes presented as Table 2 in Section 7.2.1, labelled as "Difficulties when referred to psychoanalytic psychotherapy as adolescents."

The second table of themes is presented as Table 15 below, encompassing understanding or insights the young adults felt they had developed during or subsequent to their psychoanalytic psychotherapy regarding their difficulties as adolescents. This table forms the first of a series of review tables of themes emerging as participants begin to reflect upon and evaluate their experience of psychoanalytic psychotherapy.

Table 15: Adolescent: Reflections and understanding of adolescent difficulties

Higher Order Themes	Number of participants mentioning these themes
Thoughts about the onset of difficulties	**7**
Description of academic functioning	**5**
Description of personality style	**8**
Thoughts about relationships & how related to others	**9**
Reflections on the role of adolescent development	**7**
Reflections on what learned through experience of difficulties	**6**

Seven of the ten participants' reflections led to a theme relating to the onset of the difficulties that brought them to psychoanalytic psychotherapy. Three of the seven saw these difficulties as beginning in childhood, with one wondering about the impact of anti-psychotic medication on brain development at that stage. Another two identified the transition to year 7 and separation from primary school friends as a trigger for difficulties. Two remembered their depressive thinking beginning in adolescence, with one noticing lacking a sense of self-worth from early adolescence. One mentioned the onset of bullying in grade 6 which escalated further in year 7, while another participant pointed to paternal death in adolescence.

In thinking about themselves as adolescents, school was seen as playing a big part in their lives. Amongst their reflections in this domain, half of the participants considered upon their academic functioning as a theme with three identifying that their problems interfered with their capacity to learn, while two did not complete their schooling. Two noticed that it became harder to do their schoolwork, with one struggling to keep up with the work. Two

struggled with school refusal and one described class group marks being affected due to bullying via exclusion. One reported feeling uncertain about educational and career goals.

Eight participants raised the theme of their own personality style as relevant to their difficulties. Some thought about how personality may have related to their difficulties, whilst others just described how they were as adolescents. Half of the participants mentioned shyness as a theme, whilst three considered that they put other's needs before their own, and two described themselves as oppositional, argumentative, and opinionated when they were adolescents. Other descriptions varied, including being perfectionistic, fearing failure, being creative, likable, and active.

A variety of themes connected to reflections about difficulties in their relationships and how they related to others were raised by nine out of the ten participants. Just under half noted that unresolved emotional difficulties with their fathers impacted upon their relationships with males. Three talked about sibling conflicts and misunderstandings, one made unfavourable comparisons of self to others and siblings. Two talked of longing to belong to a group, two expressed comfort in some relationships whether it was being with family or finding some like-minded friends, and two talked about difficulties in relating, one in terms of it being the adolescent's difficulty, whilst another thought peers could not relate to the adolescent's situation. One reported being withdrawn and another being anxious about socialising. One identified that the relationship between adolescent and mother was not attuned. One was social but did not enjoy socialising, and another could make friends but could not keep them and tested people's boundaries. One described how the boundaries in relationships were discovered:

"...one of my friends I was annoying so much that he actually just hit me straight in the face. So I knew oh, I'd done something that pissed him off too much. Maybe I'd gone too far. And then I started testing what did what, and found out where the line was with which people, and worked out how to stop with a toe over."

Seven young adults reflected on the role adolescent development played in their difficulties. Three stated outright that they did not have a normal adolescence, with one declaring she had normal adolescent problems that didn't feel normal. Two reflected on the search for identity starting in adolescence but that it could be life-long, and another on how this was further complicated by migration. Two also noted differences in adolescence, one in terms of thinking and behaviours, and one in terms of how emotionally charged things felt. Finally, impact of the loss of a parent at this stage of development was heartfelt.

"*I think… losing dad was um… a big shock. And it was also the role that a father plays in a daughter's life,... sort of having that sort of authority figure at home who can sort of look out for you and protect you and things like that, um. So suddenly having him not there, might have been um… might have been one of the reasons why I started to struggle"*

Six participants went on to reflect on themes concerning what they learned through their experience of difficulties as adolescents. Three felt that addictive behaviours such as drinking, eating, and gaming could be a form of escapism or distraction, dieting and exercise can give one a sense of control, and that gaming can also bring a sense of achievement. Two described the consequences of bullying as a trauma that can be ongoing, and that it can lead to not caring what others think. Other spontaneous observations were that adolescents need

to attend school and have a sense of success, you can carry feelings for others, multiple levels of loss can carry into the future when a parent dies young, drinking can increase aggression and adolescent rebellion can create internal conflicts.

7.2.9 Domain of enquiry: Understanding of psychological distress and change in relation to psychoanalytic psychotherapy and other influences

The first question asked following the break in the interview was "What part has psychotherapy played in your management and thinking about psychological distress now, compared to when you were an adolescent?" This two-part question was difficult for most participants to take in, with several asking for it to be repeated. All questions after the research interview break enabled a meta-perspective on the experience of psychoanalytic psychotherapy as participants were asked to review their experience from their current position, rather than reporting retrospectively.

As shown in Table 16 below, while all ten participants raised ongoing difficulties as a theme, all commented on changes alongside these difficulties and some spoke of such changes in relation to their psychoanalytic psychotherapy.

Table 16: Adolescent: Understanding of psychological distress and what influences facilitated change

Higher Order Themes Level 2	Number of participants mentioning these themes
Ongoing difficulties	**10**
Importance of psychoanalytic psychotherapy in changes to managing & thinking about psychological distress	**7**
Other influences on change	**8**
Positive outcomes attributed to psychoanalytic psychotherapy	**7**
Current improved functioning in work/study, social relationships & independent living	**7**
Improved management of internal processes & behaviours	**7**
Reflections on psychological processes in adolescence & childhood	**5**

Eight young adults described ongoing internal and external issues in their ongoing difficulties, with three mentioning physical illness, and ongoing or subsequent mental illness issues as themes. Three spoke of obstacles to further work or study and three of attitudes, thinking and behaviour that had not changed. Two mentioned ongoing gaps in childhood and adolescent memory. One person summed up her family situation where there had been ongoing trauma, loss, and mental illness as:

"*This family is like one big soap opera. It is not fair. It's, like, it should just be like acting in movies, sort of thing. Nobody should be going through this sort of shit*."

For seven young adults themes emerged concerning the importance of psychoanalytic psychotherapy in changes to their management and thinking about psychological distress. Four participants attributed considerable meaning to psychoanalytic psychotherapy's role in helping with a variety of issues such as developing coping skills, giving hope, individuation, reality testing, symptom improvement, increased self-expression, improved well-being and thinking capacity. Three participants saw psychoanalytic psychotherapy as having no influence or minimal influence on changes. One saw psychoanalytic psychotherapy as having no impact and wondered if it had been the wrong treatment for her illness. Another thought it did not contribute to a view of psychological disorders in general, and nor did it provide particular tools. Whilst not seeing psychotherapy as life-changing, it was, however, credited with helping manage anxiety a little, to be able to vent and help open up and talk about problems. One added that it had helped a little with improvement of social skills, and another that it had not really been a long therapy.

Other influences that contributing to change emerged as a theme for eight of the ten participants, and the emergent themes ranged widely. Four considered that maturation and experience over time played a role, and four spoke of how music could be mood altering. Four talked about the role of medication, with two saying it had helped a lot. One had concerns that it had supressed creativity, while another was ambivalent about medication, describing how resultant weight gain had led to relapse. Only one of these four worried about the long-term impact of medication. Three participants mentioned benefiting from exercise, three described how life events contributed to change, three reported the importance of their own internal motivation to change, and three discussed the benefits of creative pursuits such as writing, blogging and art. For some, relationships appeared critical. Two participants spoke about the role of parents and family, another two of friends, two of

subsequent treatment, two about religious readings, faith, and community support, and one the comfort and companionship of having a pet dog. Two raised the mixed contribution of maturity and psychotherapy.

The theme of positive outcomes attributed to psychoanalytic psychotherapy alone was raised by seven participants. Four described ways they had learned to manage their emotions, four spoke of being able to seek further help when they needed it, and four described processes that contributed to internal changes. Three elaborated on how psychotherapy helped them to develop the ability to think, and three credited it as helping them to develop greater self-awareness and understanding. Two talked of how they could manage difficult situations now, two experienced internalised aspects of the psychotherapist, and another believed therapy had helped her to be able to sort out differences in relationships. One described how the psychotherapy process helped to identify emotions:

"*When you are inside your own head and thinking about your own stuff and it just becomes so big, you can't process it and you can't see it from another perspective, but when you are talking to someone about it all of a sudden, like the way they phrase it. I love it because I love how psychotherapists, they just, or psychologists ... have the ability to rephrase what you've said back to you and it is so good in helping you understand umm, how to ... what's going on. You're like, "Oh yeah that ... that is happening for me," and then you recognise your emotion better*?"

A theme related to current functioning in social relationships, study or work and living circumstances emerged with seven participants. Four described how they were now more independent and able to work or study. Three now were able to connect and socialise with

others. Two belonged to a social group, two reported having some close friends and two talked about having a more open communication with their partners. Two were moving into independent accommodation and aspired to work in illness prevention. One mentioned feeling secure in an intimate relationship and another aspired to further study.

A theme of improved management of internal processes and behaviours due to a variety of unspecified influences was raised by seven participants. Five participants described how they had learned skills to stop maladaptive behaviours, and five described attitudinal change such as developing acceptance, and learning that they could choose how to react. Two described how they had learned to recognise triggers for maladaptive behaviours and two had improved in their management of symptoms. One reported that she was now able to grieve. Learning to accept the past was described:

"*I don't think of my life as like having a tough life, or anything like that. I just think of it as ... like that's what's happened. And I learnt it earlier than probably a lot of other people do ... so… I don't know. It's not like uh, I don't ... I try not to think of it in too much of a negative sense*."

Finally, five participants reflected upon psychological processes emerging in childhood and adolescence as a theme. Three described their use of the internet in quite different ways. One used it for research, another used it to zone out and disconnect from reality, and the third used it as a way of making friends online and getting advice. Others talked about a variety of issues, for example that a child left in a high state of distress struggles to learn to think, the ongoing shame and regret at experimentation and acting out in adolescence with drugs and

alcohol, and adolescent developmental influences and how relationships with parents change afterwards.

"*I think it was partially like I did feel like I was reprimanded when I said things. And then part of it was like, maybe the strictness in her parenting that caused me to become a bit secretive, maybe naughty, I don't know. And maybe just part of being a teenager does close off your relationship with your mum*."

7.2.10 Domain of enquiry: Understanding the difference psychoanalytic psychotherapy made

To explore understanding of the impact of psychoanalytic psychotherapy, the participants were asked "How do you think things would have gone if you hadn't had psychotherapy?" As with the previous domain, this domain of enquiry pertains to the review and evaluation of the experience of psychoanalytic psychotherapy. All ten participants responded to this question as indicated by Table 17 below.

Table 17: Adolescent: Evaluation of the difference psychoanalytic psychotherapy made

Higher Order Themes	Number of participants mentioning these themes
Therapy made no difference	**1**
Hard to know or differentiate contribution to change	**3**
There were other important influences for change	**6**
How different now	**2**
Positive changes in in well-being, relationships, functioning & survival related to psychotherapy	**7**
Process of psychotherapy itself was helpful	**7**
Therapy important or most significant influence	**5**

One participant believed psychoanalytic psychotherapy made no difference, feeling nothing had changed. Three participants' responses culminated in the theme that it was hard to know or differentiate what elements contributed to change. The contribution of psychoanalytic psychotherapy, maturation and experiences in life were hard to separate, as all may have played an important part.

The theme that other influences also contributed to change was actually raised by six participants. Three thought that influence and support of friends were critical. Two mentioned school in terms of teachers, one also added the pupil welfare coordinator, while another talked of the structure of school, and how being good at schoolwork also helped. Two mentioned other therapies as relevant, citing a CAMHS day programme pre-

psychotherapy and dialectical behaviour therapy post-psychotherapy. One mentioned family and another also mentioned having a stable relationship as important.

Two participants reflected upon how they had changed within themselves, with one identifying being more reflective now, and the other being less shy and able to talk more. One had learned to trust an internal sense of what was right. Neither attributed these changes specifically to psychoanalytic psychotherapy.

Alongside acknowledgement of other influences facilitating change, seven of the ten participants raised themes around the positive difference psychoanalytic psychotherapy had made in their lives. Psychoanalytic psychotherapy was seen as enhancing well-being, relationships, functioning and survival. Three participants reported a positive impact on their relationships, and one credited psychotherapy as helping with the re-establishment of family relationships. Psychoanalytic psychotherapy also helped the young adult establish and maintain a long-term friendship group. Another said it had help her learn to think about the perspectives of others, and what their feelings might be, and to modify responses that were previously blunt and hurtful. Another felt that social awkwardness would have been worse as in psychotherapy one got used to talking to someone and being clearer in communications.

Six participants identified that psychotherapy probably prevented their suicide, addiction or further decline in mental health, and possible further hospitalisation. Mental stress was lessened. Three did not believe they would have managed to finish school or get a job without having had psychotherapy. Further comments were that psychotherapy had helped

the young adult to get to their present situation, assisting the young adult to look after herself and build a life. One participant described how psychotherapy changed the course of her life:

" *I wouldn't be living, I think, you know. At worst, I probably would've ended up ... in fact it was pretty likely that I would've ended up killing myself or being killed, with the situations I put myself in and how I felt. I've de- ... I wouldn't be ... I don't think I would be here, and if I was, I would be…um… like a shell. I wouldn't really exist, kind of thing*."

The theme that the actual process of psychotherapy was seen as helpful was raised by seven participants. Five however, found that whilst therapy was helpful, they still had problems and needed to have further treatment. Two talked of liking the sessions, feeling helped and feeling better. Other varied responses were learning that emotions could be held. Psychotherapy helped coping with and recognising reality. Psychotherapy was empowering, but took it took years to develop an identity and self-worth, and one participant commented:

"*...it takes a long time to work out who you are. But I've got an identity now, which is something I didn't, I didn't have for many years*."

Half of the participants considered that this psychoanalytic psychotherapy was the most significant influence on their changing. Thinking about all the positive forces in her life, one felt they would not have been enough to prevent her suicide. Nothing had helped to the extent psychotherapy had or had a more significant impact. Another said psychotherapy was the only influence in her life then. Two others thought that psychoanalytic psychotherapy

had been important for them at the time. One believed that without psychoanalytic psychotherapy her progress would have been slower.

7.2.11 Domain of enquiry: View of TFFP research project's impact on psychoanalytic psychotherapy

The final domain of enquiry was broached by asking "What sort of influence if any, do you think the research project had on your psychotherapy?" All ten participants responded to this question, the resulting higher order themes being distilled in Table 18 below.

Table 18: Adolescent: Evaluation of TFFP research impact on psychoanalytic psychotherapy

Higher Order Themes Level 2	Number of participants mentioning these themes
No impact on therapy	**8**
Curiosity about how responses changed over time	**2**
Experience of research	**5**
Positive benefits of research on therapy	**9**

Eight young adults believed that the research had no actual impact, with four making no further elaboration. While two participants explicating, spoke of a helpful impact of the TFFP research on the psychotherapy itself. Two commented that they never thought about the research, another did not believe the research influenced her psychotherapist or the content of her psychotherapy, and another remarked that filling out forms was familiar as that was part of attending CAMHS. One commented:

"*It's not like she was sending you recordings to listen to or anything like that, and then you would go back and give her feedback on it. So I don't think you actually ... probably, apart from the funding side of things ...I don't think you would've had any impact on the content of the therapy*."

Two other participants were curious about what their responses to the research were over time and how they may have changed since being a teenager, as indicated by the following comment:

"*I might've answered it differently back then. I might have said I hated the therapy, and as I said, things change in hindsight, don't they? You view things differently as you get you know, as you get more skills in life.*"

Half of the group spoke of their individual experiences of the research itself. Themes were firstly that research makes one feel like an object being analysed. A second theme was that it was only the emotionally intense follow-ups that were recalled. Third, research sessions felt like therapy, not research. Finally, there was a valued relationship with the researcher that endured over time.

In the end, however, 90% raised the theme of positive benefits for the psychotherapy of the research. Five viewed it as positive in helping them reflect, remember, and think about change in relation to the psychotherapy over time. Four participants described altruistic motives in participating in the research. Three thought if there was any impact on the therapy it was positive. Two observed that the research project gave them the opportunity to access no cost psychotherapy and another thought it had actually enhanced their use of

psychotherapy because they reflected further upon their thoughts and feelings in the questionnaires. One commented:

"*... through the years, continuing the research project has been quite awesome. The fact that I've continued to participate and that I am contributing to something that could help other people, feels very… self, self-gratifying*,"

7.3 Findings 2: Integrative summary

The interview narratives of the ten young adults were subjected to a thematic content analysis focussing on the in-depth reflections of their experiences of psychoanalytic psychotherapy across ten domains of enquiry. This analysis produced seventeen tables of distilled higher order themes, relating to those domains.

Participants raised themes concerning how they were functioning in adolescence when first referred to psychoanalytic psychotherapy. All stated that they had been impacted upon by external events such as trauma, loss, and abuse. This was prior, during, and post psychoanalytic psychotherapy. All ten remembered a troubled internal experience, often having more than one mental health diagnosis.

Family background was described by a majority of the participants, and school and neighbourhood were also described as significant aspects of the adolescent socio-cultural context. Three participants linked anti-social activities with geographical isolation and lack of infrastructure for adolescents.

Music was highlighted as the most frequently reported interest by adolescents, and three reported an association with their alcohol and drug use. However, multiple factors were described in alcohol and drug use such as peer pressure, the desire to fit in, a way of coping with upset, and enhancing the capacity to socialise. Proximity, shared interests, and family expectations were described by four participants as influencing friendships choices. However, half of the group experienced feelings of disconnection and not belonging to a peer group, and six reported not feeling like they "fitted-in".

In response to the first interview question, about their overall experience of psychoanalytic psychotherapy, emergent themes fell into five sub domains, namely the beginning of psychotherapy, its structure and context, its helpfulness, its unhelpfulness and the process and the ending of psychotherapy. Initially people reported being worried that they would not remember very much, and often they were surprised as to what they ended up recalling about their lived experience of psychoanalytic psychotherapy.

Half of the group considered that psychoanalytic psychotherapy was a globally positive experience, with all ten mentioning themes relating to helpful therapeutic processes, and half emphasising the importance of the relationship with their therapist.

In contrast, only one young adult reported that psychoanalytic psychotherapy was globally negative. Six participants, nevertheless, raised particular factors that were not helpful, with three mentioning premature termination of their psychotherapy, and three feeling that their psychotherapy became stuck, with no further change happening.

Eight of the ten young adults were able to elaborate upon their understanding of how psychoanalytic psychotherapy worked, and themes concerning the content and feelings aroused during the process. All the same, half the group could not remember the ending of psychotherapy, and seven raised the theme that psychoanalytic psychotherapy was not a cure.

The young adults had less to say about what the psychotherapist's experience might have been. As expressed by seven participants, this had not been a focus for them at the time of the psychotherapy. Over half were able to imagine what the therapist might have been experiencing nevertheless, through reflecting upon their observations at the time.

The relationship that developed between the adolescent and the therapist was a domain of considerable interest to the young adults. Seven mentioned the importance of specific qualities in the therapist, for example the contribution of attentive listening and empathy to the relationship. Just under half thought that they themselves also played a part, and half raised the theme of needing time to develop a trusting relationship. Seven commented upon the nature of the relationship, mentioning, for example themes involving the importance of commitment, consistency, boundaries, collaboration, and shared humour.

When asked, eight participants felt unable to determine how the therapist may have viewed the relationship. However, half of the group of ten went on to speculate on how the therapist may have seen their relationship.

Over half responded to a question about other relationships in terms of the theme of psychotherapy having a positive impact upon their relationship with family and peers. Just

under half attributed therapeutic processes as also helping to improve their other relationships.

Being invited to comment in a more evaluative way upon their experience of psychotherapy, in the domain of understanding of their psychological difficulties, seven participants raised themes concerning onset and the role of adolescent development, in itself. Nine were able to reflect on their relationships, and how these were impacted by their difficulties, and eight reflected on their own personality style. Half spoke of the impact their difficulties had on their school functioning, and six were able to reflect upon what they had learned through their experiences of difficulties as adolescents.

All ten raised having ongoing difficulties in life, but most, as reported above, raised numerous ways they had changed due to psychoanalytic psychotherapy as well as other influences. Eight acknowledged other influences, and seven attributed positive outcomes to psychoanalytic psychotherapy, including the capacity to seek further help as needed.

Only one of the ten participants thought that psychoanalytic psychotherapy had made no difference. Seven spoke of the positive changes and the helpfulness of the process, including their belief that it had kept them alive, and half of the group saw psychoanalytic psychotherapy as the most important or significant influence at the time they were adolescents.

Finally, eight of the ten considered the TFF research project had no impact upon their psychoanalytic psychotherapy. Half of the group raised the theme of experiencing the ongoing research relationship as of value, and nine spoke of the wider benefits of the research

project. Altruism in participating in the research, in the sense of wanting to give something back to others struggling with mental illness as adolescents was raised as a theme for some participants.

CHAPTER 8

FINDINGS 3: PSYCHOTHERAPIST'S REFLECTIONS ON THE EXPERIENCE OF PSYCHOANALYTIC PSYCHOTHERAPY WITH THE ADOLESCENTS

As described in Chapter 6, seven psychotherapist interviews were included in the data analysis. As there was more than one interview with some psychotherapists, discrete interviews were held on separate occasions regarding each adolescent that the psychotherapist saw in the TFFP. In sum, interviews from four psychotherapists pertaining to seven adolescent psychotherapies were analysed and form the substance of this chapter.

The psychotherapists spoke carefully and thoughtfully about their adolescent patients. They were open with the researcher about the process of psychotherapy, given the adolescents had consented for them to be involved. However, as in all of the data analyses, the researcher needed to take care in selecting quotations to avoid revealing the identity of individual psychotherapists.

The chapter begins with details of how the analysis was performed. The findings for each of the domains of enquiry explored by the interviewer with each psychotherapist about their respective adolescent psychotherapies are then presented. The data from these seven interviews are presented as matrices which summarise the final higher order themes that emerged. The chapter concludes with an integrative summary of the reported findings.

8.1 Process of arriving at final matrices

The findings presented are from thematic content analysis of the narrative interviews of the psychotherapists. Comments presented in this chapter, such as interpretations, inferences, and assumptions are made by the psychotherapists regarding their patients and are the psychotherapist's perceptions of how the adolescents may have been thinking. Thoughts about unconscious processes in the individual psychotherapies that may have been occurring, or were perhaps revealed later on in the psychotherapy, were also reported by the psychotherapists in their narrative interviews.

Analysis of the psychotherapist's transcripts proved complex because, although the psychotherapists were speaking specifically about individual adolescent psychotherapies, sometimes they were also thinking about common threads across psychotherapies or speaking about their own contribution. In the main, however, the linking of common themes across the different adolescent psychotherapies was performed using the previously described method of thematic content analysis of group data in Chapter 5.

As described in Chapter 5, the structure of the interview protocol for the psychotherapists paralleled that for the young adults, with ten broad domains of enquiry for the psychotherapists corresponding to the same domains of enquiry as for the young adults. However, there was an eleventh domain of enquiry here, regarding the psychotherapist's view of the psychotherapist's own relationship with the parent/carer of the adolescent. The eleven domains of enquiry translated into 18 Final Matrices in the data analysis (See Appendix XVII)

The same stepwise data analysis methodology was commenced as for the data of the adolescents detailed in Chapter 7 and described in Appendix XIV. Each individual psychotherapist's raw data for an adolescent psychotherapy was punctuated in terms of emergent themes and typical quotations starred within the first matrix. Further distillation into emergent themes and higher order themes across each domain progressed for a further matrix. The data from the psychotherapist interviews across all seven of the adolescent psychotherapies was then combined. In the following step, themes were grouped in line with the final higher order themes generated by the adolescents. This process expedited the analysis of the psychotherapists' data. As expected, there were additional themes raised by the psychotherapists, and these formed parts of the matrices developed. Successive themes emerging from the group data of the psychotherapists were thus gradually, refined and then combined to produce a final matrix of higher order themes, distilled across all psychotherapist participants' data. The final matrix for each of the eleven domains of enquiry, first set out in Chapter 7 Section, 7.1 is presented below. Some domains gave rise to two or more thematic sub-domains.

8.2 Domains of enquiry:

The eleven broad domains of enquiry comprised:

- difficulties of the adolescent at the time of referral
- socio-cultural context of the adolescents
- the psychotherapist's view of the adolescent's overall experience of psychoanalytic psychotherapy
- the psychotherapist's experience of the adolescent psychoanalytic psychotherapy

- the psychotherapist's perception of how the adolescent viewed the psychotherapeutic relationship
- the psychotherapist's view of the psychotherapeutic relationship with the adolescent
- the psychotherapist's view of the relationship with the adolescent's parents/carers
- the view of the psychotherapist on the impact of psychoanalytic psychotherapy on the adolescent's relationships
- the process of therapeutic change and its influences
- the difference made by psychoanalytic psychotherapy
- and the impact of the research project on the psychoanalytic psychotherapy.

8.2.1 Adolescent's difficulties when referred to psychoanalytic psychotherapy

In responding to Question 7 in the Interview: "When you think back, what sort of adolescent was [name], and what was happening?" the psychotherapists' themes fell into two subdomains, firstly descriptive themes of presenting difficulties, and secondly, themes concerning the understanding of the adolescent's difficulties learned through his or her psychoanalytic psychotherapy experience with the psychotherapist. The first subdomain is presented immediately below and was transferred to this position because it establishes what difficulties, according to the psychotherapists, the adolescents were experiencing at the time of referral to psychoanalytic psychotherapy. The second subdomain is kept in its original position in section 8.2.9 of this chapter.

All of the participating psychotherapists described in some depth their perceptions of the presenting difficulties experienced by the adolescents in the TFFP, as shown in Table 19 below.

Table 19: Psychotherapists: Difficulties of adolescent when referred to psychoanalytic psychotherapy

Higher Order Themes Level 2	Number of participants mentioning these themes
Reasons referred to therapy	**5**
Lived in out of home care	**2**
Troubled behaviours	**5**
External diagnoses or observations	**6**
Impacted by external events, trauma & loss prior, during & post therapy	**7**
Troubled internal experience	**7**

Participants elaborated upon varied reasons for five of the seven adolescents' actual referral for psychoanalytic psychotherapy. As outlined in Chapter 6, six of the adolescents included in this sample, had been known to be suicidal before referral. Referring agents were concerned about serious psychopathology including anorexia, frequent acting out, including at-risk behaviours such as overdosing, and extreme anger. Examples were that the adolescent was living in a fantasy world, engaging in inappropriate behaviour, or experiencing anxiety about moving to the senior high school campus. Some of the adolescents were seen as being out of control. One psychotherapist stated:

"*She was really out of control. She was out of control because no one wanted her, and I think she really felt that ... And um ... you know ... Young people, they're in a family and even if a family is dysfunctional, there's still a level of stability with that, and ... you know ... there's rules even. Her mother did care if she went out at night ... or, you know ... her mother*

cared. But you pop someone in a Resi (residential), unit and who gives a stuff, kind of thing? And yeah ... the Resi units weren't that bad. They actually did care about her, but they were limited in what they could do."

Two adolescents were described as living in out of home care, with one having multiple placements after going into foster care, and the other being in foster care with a friend's family.

Regardless of the reason for referral, participants raised as a theme the nature of five of the adolescents' troubled behaviours. Serious suicide attempts, self-harm, overdoses, destructiveness, drunkenness, and risk taking of all sorts were mentioned. Behaviours could be sexualised, sometimes with provocative dressing, promiscuity, boundary issues and intrusiveness. Sleeping difficulties, pacing, and an inability to sit still were also mentioned. An example of sexualised behaviour was:

"*She's doing this, she's doing that. And I think it was the stuff about her being out there pretending she was a doll, and lifting her skirts and lifting her shirts...*"

For six of the seven adolescents, their psychotherapists commented upon existing diagnoses and their own initial observations. For five of those adolescents, specific diagnoses issues were raised namely borderline personality disorder, complex trauma, pervasive developmental disorder-Asperger's type, depression and suicidality, bulimia, and lower IQ. The psychotherapists of three adolescents emphasised how at-risk they were, and their extreme degree of vulnerability. Participants raised themes related to attachment issues and emotional neediness, psychotic symptoms at times, pressured speech, tangential thinking,

poor capacity for mentalization, impenetrable and rigid defenses, fear of diagnosis, and being in the paranoid-schizoid position. Observations were made about presentation, including appearance being distorted with make-up or child-like dress and behaviour, formal, robotic and affectless speech, or other exaggerated presentations of being excessively naïve, bright, interesting, frightened, sad or strange. One psychotherapist stated:

"She was so vulnerable, in such a ... um… on such a ... um… primitive level. <pause> And also… <pause> I mean it had moved into a sort of, psychosis I suppose. I mean her grasp on reality was very tenuous, really. And so, to be able to… to be in the presence of that, to try and hold that... And she was very intense. She was a very intense young girl"

All seven of the adolescents were described by their psychotherapists as significantly affected by external events, trauma, and loss, occurring prior, during and/or post psychotherapy. For four, the psychotherapists mentioned the deaths of mother, father, or a sibling, for the different adolescents they had seen. For four, themes were raised sexual abuse within the family, or abusive relationships with men outside the family, and in care. Other external traumas mentioned were early maternal separation, emotional deprivation and neglect, later parental abandonment, a fractured family experience, lack of family support, parental illness, mental illness and hospitalisation, parental alcoholism, siblings having difficulties, and relationship break-ups in adolescence.

All seven adolescents, again, were spoken of as having troubled internal experiences. Some psychotherapists used psychoanalytic theoretical descriptions of processes in the adolescent's internal world. These included denial of aggressive feelings or behaviours, psychotic functioning including paranoia, being unable to take in links or connections, paranoid-

schizoid functioning or primitive internal functioning, dominance of the death instinct, presence of a fragmented and fragile ego, and dissociation from sadness through the use of projective identification, acting out or paranoia. Other, more general, descriptions of internal states were that the adolescents were needy, deprived, and sad, worried, or frightened, had extreme mood swings or a tenuous grasp on reality, struggled with becoming an adolescent, or that they struggled with grief, unable to bear the pain of considerable losses.

8.2.2 Domain of enquiry: The socio-cultural context of the adolescent

All of the psychotherapist interviewees were asked to think back to the period of time of the adolescent's psychoanalytic psychotherapy, and then asked, "What was it like being an adolescent growing up in [name] region of Melbourne or the State of Victoria at that time?" The psychotherapist was also invited to think about what it would have been like to be a parent of an adolescent at that time. Using the final tables of themes generated by the data from the young people when asked this question, three sub-domains of the domain of enquiry were discernible.

8.2.2.1 Socio-cultural context of family, school and neighbourhood of the adolescents

The first sub domain identified was a description of family, school and neighbourhood and the themes generated are shown in Table 20 below.

Table 20: Psychotherapists: Home, school, and neighbourhood of the adolescents

Higher Order Themes Level 2	Number of participants mentioning these themes
Neighbourhood	**4**
Impact of geographical isolation & lack of infrastructure	**2**
School & its culture	**5**
Family/living situation	**7**

For four of the adolescents, the psychotherapists spoke about the neighbourhood and for two adolescents the psychotherapists described the area they lived in as low socio-economic with social problems. One psychotherapist spoke of the adolescent's neighbourhood as rough, whilst another lived in an area that lacked employment opportunities. One adolescent did not engage in the neighbourhood, which was a new, working class area.

For two adolescents the psychotherapists raised as a theme the impact of geographical isolation and lack of infrastructure. The psychotherapist described the region both adolescents lived in as "*isolated and isolating*." Various other comments were that the adolescent lacked supports, lacked transport to go out, and had large distances to travel to get to services which were minimal. It was also remarked that "*the isolation would have been a nightmare for parents of adolescents*."

Psychotherapists raised the theme of the school and its culture upon five adolescents. Two psychotherapists described schools that were supportive, provided normality, and enhanced life for the adolescents. One psychotherapist described the adolescent as being at school, but

being disengaged, despite the inclusive attempts made by peers and teachers. One adolescent was described as attending a good school in another neighbourhood, and another was unable to attend a mainstream school. One school was described as having different groups of kids, some that just went home after school, and others who were involved in a drug and alcohol culture.

All psychotherapists described as a theme the family or living situation of the adolescent, and two psychotherapists emphasised a sense of poverty and financial struggle which at times had direct impact on the ability to attend psychotherapy when there was not enough petrol to drive to the session. Two spoke of the difficulties of caring parents that did not have the inner or outer resources to meet the challenges of adolescence, four adolescents were separated from one or both parents through parental separation and family breakdown, and another three adolescents had a parent who had died. One psychotherapist saw the family culture of one adolescent was aspirational in terms of improving their life situation. One adolescent was from a non-English speaking background and life was confined to family, and an awareness of the behavioural expectations within that culture. Another adolescent appeared isolated even within the family context. Foster care was mentioned in two cases, with one adolescent being transient at times. One psychotherapist painted a picture of the isolation of one adolescent:

"*So, I think what it was like for her was ... and you know ... she wanted .. She walked to school, she walked home, she hardly ever went to town, she walked a little bit to town, and tried to go to little things and so forth, but… I … I just think there was little that was alive, that was creative, that was happy, that was joyful, that was supportive*."

8.2.2.2 Adolescent interests and behaviours

For six of the adolescents the psychotherapist's comments contributed to this sub-domain of the adolescent's socio-cultural context and produced only three final themes. Not as much was talked about in this subdomain by the psychotherapists and there was a sense that this information was not so much a part of the psychoanalytic psychotherapy experience.

Table 21: Psychotherapists: Interests and behaviours of adolescents

Higher Order Themes	Number of participants mentioning these themes
Interest in music	**4**
Maintained creative interests	**1**
Influence of internet, gaming & chat	**3**

The psychotherapists of four adolescents raised as a theme the adolescent's interest in music. The adolescents were not only interested in listening to a particular genre of music but often embraced the appearance and dress that went with it. Two adolescents were described as having Gothic-oriented tastes, and one dyed her hair black and wore lots of black clothing. Heavy metal, alternative music and hard rock were mentioned with particular references to groups such as "Offspring" and "Marilyn Manson." One psychotherapist did not recall one adolescent talking about music at all.

The theme of maintaining creative interests was described by one psychotherapist as the adolescent was interested in anime and singing.

The influence of the internet, gaming and chat was discussed as a theme regarding three adolescents. The use of multi-media was less prominent at the time, the internet was less influential, but still a source of information for adolescents. Communication was predominantly by mobile phone and through texting, there was less email and letters were still written to some adolescents around non-attendance. *My Space* which preceded *Facebook* was what was used online. In the words of one psychotherapist:

"*Not much Internet, I mean she was on the computer for school, but I don't remember anything particularly significant from here or there in terms of technology. Obviously had a phone ...um… but it's not the same as it is now*."

8.2.2.3 Peer culture, behaviour and sense of belonging of the adolescents

For six adolescents, the psychotherapists' thematic material contributed to a further sub-domain which focussed on the peer culture, behaviour, and sense of belonging of the adolescent. Four final themes are presented in Table 22 below.

Table 22: Psychotherapists: Peer culture, behaviour and sense of belonging of the adolescents

Higher Order Themes Level 2	Number of participants mentioning these themes
Peer culture & behaviours	**6**
Basis for friendships	**2**
Sense of connection & belonging to a peer group	**3**
Minimal or no connection with peers	**3**

For six of the adolescents, the theme of peer culture and behaviours was discussed. Four adolescents were involved in drinking, including some binge drinking, and drug taking. Using party buses, attending clubs, and rave parties were part of this culture for some adolescents. Other activities mentioned were watching TV, Hippy/New Age interests, interest in bracelets and pretty things, interest in boys and going to peer's homes when the parents were away.

Two of the psychotherapists mentioned as a theme the basis of friendships. One discussed how starting to mix with people who were experimenting with drinking and using drugs meant that behaviour underpinned these relationships. Another psychotherapist talked of friendships developing based on the adolescent having similar difficulties. One psychotherapist commented:

"*I think really the place where [name], connected with people was probably the inpatient unit at CAMHS actually*."

Three of the adolescents were discussed as having a sense of connection as they belonged to a peer group. Two adolescents were described as having friends at school, one belonging to a high achieving group and the other having a group to sit with at school. One psychotherapist gave an example of an adolescent belonging to several friendship groups which encompassed neighbourhood, youth group and school and described her sense of the school group as:

"*the group that she was hanging around at the time, I always imagined them to be a little left of centre and a bit ... a bit more of a kind of geeky, less cool type group really, in some aspects*."

Half of the adolescents had minimal or no connection with peers. Two were described as not being able to connect with ordinary teenage culture. One tried to engage with girls at school, another was on the fringe and stayed home and drank, struggling to make and keep friends. One psychotherapist described the difficulty for one adolescent in connecting with others:

"*I'd get it from the teachers: "There were very nice girls there who actually liked [name] ... who wanted to engage with her. But she kind of rejects or lets them down" ... or... I think she certainly wanted to be part of ... the ... her peer group. It was important for her, and I think she found it confusing. I think she found relationships confusing, she didn't know how to conduct relationships*."

8.2.3 Domain of enquiry: Overall experience of psychoanalytic psychotherapy

All psychotherapists participating responded to the first question "What can you tell me about the young person's experience of psychotherapy?" by referring to all seven adolescents concerned. Analysis of these data revealed higher order themes forming five sub-domains, namely the beginning, the structure, the helpfulness, the unhelpfulness and the ending of the psychoanalytic psychotherapy experience. The final matrices for each of these sub-domains are presented below.

8.2.3.1 The adolescent at the beginning of psychoanalytic psychotherapy

The seven themes emerging from the overall experience of psychoanalytic psychotherapy related to the beginning stage of the psychoanalytic psychotherapy are presented in the Table 23 below.

Table 23: Psychotherapists: Beginning psychoanalytic psychotherapy

Higher Order Themes	Number of participants mentioning themes
Initial recollections of beginning therapy	**5**
Initial expectations & needs	**6**
Pre-existing strengths	**6**
Comparisons with previous treatment	**2**
Feelings & attitudes at the beginning	**5**
Degree engaged in therapeutic relationship	**5**
Reflection on the processes in the beginning	**5**

For five of the seven adolescents, their psychotherapists commented on their initial recollections of the adolescent when beginning psychoanalytic psychotherapy. Themes about how the adolescent presented in the beginning varied. The adolescent was experienced as reliable and engaging, possibly intellectual about it, or the adolescent worked against connecting, but also gave signs of connection. One psychotherapist recalled two memorable drawings produced in the first session. A parent completed suicide during the assessment phase for psychoanalytic psychotherapy of one adolescent. Other adolescents attempted to

present as scary and angry, or were initially very mistrustful, speaking minimally, and sitting in silent fear. One psychotherapist stated:

"*So, I think initially, I think ... I think um ... [adolescent's name] was very ... and rightly so, very mistrustful. And I say rightly so, not 'cause I'm untrustworthy, but because she had a lot of reasons to not trust people in general. And I think that came into the therapy a lot.*"

For six adolescents, psychotherapists raised a theme concerning the initial expectations and needs of the adolescent at the beginning of psychoanalytic psychotherapy. For three of these, the psychotherapists reflected upon the adolescent's conscious and unconscious need for a mother which emerged in the transference relationship, with one adolescent being overt about her hopes for a close relationship with the psychotherapist. Various other responses by the adolescents were gratitude for the opportunity for psychotherapy, or relief that the psychotherapist was less scary and unapproachable than had been imagined. One needed a secure connection, whilst another saw herself as ill and wanted to get better. One psychotherapist commented:

"I was quite surprised to recall how much she did want, and what she thought you know ... what she thought I would provide for her ... you know ... A perfect mother."

For six of the seven adolescents, the psychotherapists commented on the strengths that the adolescent brought to the psychotherapy. Four were described as able to reflect or make sense of things, as wishing to do the work. One was observed to have a lot of ego strengths, two were seen as resilient, and one was described as a 'survivor'. Two adolescents were

experienced as open and able to confide things, and another two had the capacity to engage support, with one being described as friendly and engaging straight away.

Two psychotherapists commented on the impact of prior treatment upon two adolescents' initial approach to psychoanalytic psychotherapy. The adolescents were seen as feeling threatened and vulnerable at first, given a not so positive previous experience. One adolescent was described thus:

"*She wasn't overly impressed, and she certainly didn't feel that it had helped her. So, she really felt like um… she was as vulnerable, if not more vulnerable before she'd um ... she'd been involved. At the same token, she was willing to give this a go.*"

For five of the seven adolescents, psychotherapists raised as a theme the feelings and attitudes of the adolescents beginning psychotherapy. Varied descriptions included having a lack of faith or trust in psychoanalytic psychotherapy, awkwardness, wanting to be liked, to be understood exactly and to be in close proximity, being ambivalent, defensive or needing to be in control, being convinced she could not be understood, and keeping the psychotherapist at a distance. One participant recalled:

"*... In those early, early sessions ... it was sort of like ... just stay over there, I'm not answering your questions ... um you know ... I'm not going to be a party to this. She ... um, yeah ... there was some mocking as well*."

For five of the seven adolescents, psychotherapists commented on the degree to which the adolescent engaged with the psychotherapy itself at first. The style of engagement varied,

with one being extremely positive from the beginning, one being very committed and moving quickly into working with the process, whilst another became more committed as developmental maturity increased. One was described as guarded, so that fear of intimacy limited engagement, while another was more engaged in the beginning than later on.

For five adolescents, participants reflected on the actual processes in the beginning of psychoanalytic psychotherapy. One described the process as initially alien to the adolescent, one adolescent had a lot going on, despite initial resistance one attended regularly and punctually, one was dealing with immediate grief issues, and one was very wary about engaging. The beginning of psychotherapy for one adolescent was observed as follows:

"*I think the psychotherapy process was initially very alien to her. It was not um… even really ... you know ... expressing and exploring her inner um… thoughts and feelings and um… conflicts, and um… particularly at a ... at a deeper level. It was not something that she had ... uh ... experienced*."

8.2.3.2 The role of structure and context of psychoanalytic psychotherapy with the adolescents

All psychotherapists expressed themes in response to the interview question about all adolescents' experience of psychoanalytic psychotherapy contributing a subdomain of structure and context of psychoanalytic psychotherapy. These are presented in Table 24 below.

Table 24: Psychotherapists: The frame: Structure and context of psychoanalytic psychotherapy

Higher Order Themes	Number of participants mentioning these themes
Overall structure, length, frequency & setting of psychotherapy	**6**
Some structural flexibility provided	**3**
Value of a private space	**3**
Broader context of psychoanalytic psychotherapy	**6**

For six adolescents, their psychotherapists made comment on the overall structure, length, frequency and setting of the psychotherapy. Frequency was a theme regarding the psychotherapy of five adolescents, with statements by psychotherapists that three adolescents were seen weekly, one adolescent was offered twice weekly (although this did not eventuate), whilst another adolescent received twice weekly for a time. Comments on the length of the psychotherapy varied, with one psychotherapist mentioning a relatively short therapy for one adolescent, two adolescent psychotherapies being reported as continuing for two years, and another for nearly five years, albeit not always continuously. Various other observations were made about the structure of psychotherapy. For example, structure and reliability provided containment for one adolescent, whilst for another, whilst the fifty-minute time frame was kept, the connection with that adolescent was maintained by telephone when there was discontinuous attendance.

One psychotherapist remarked on the difference increased frequency seemed to make:

"*... there was a period of time where she came twice a week, and I think that probably coincided with um… you know ... probably the ... the height of the ... the best connection we probably had, and maybe the safest she felt*."

For three adolescents, their psychotherapists discussed the theme of structural flexibility, with one deeming it an essential part of meeting adolescent developmental needs. Two psychotherapists spoke of two adolescents negotiating telephone access with the psychotherapist between sessions, when the adolescent was unable to attend as in a crisis, or when distressed and in crisis outside of sessions. Changes in times and frequency were used to maintain an initially fragile connection with one adolescent. One psychotherapist spoke of visiting the adolescent when hospitalised. Another psychotherapist reflected on the function of contact outside of psychotherapy, making it clear that this was not about the adolescent testing boundaries, and had been agreed upon between them:

"*If she was distressed, she would contact me. She contacted, not incessantly in some way, but ... but there were a number of them, and I remember them distinctly. And um… I think uh… there was something containing for her about just speaking with me.*"

Psychotherapists of three adolescents commented on the theme of psychotherapy providing a private space. It was mentioned that it was important that the young person had a space just for her, and the notion of it being a safe space was emphasised by two psychotherapists, with one commenting:

"*I think [Name of adolescent] experienced the psychotherapy as a very safe space, safe and containing space for her - to ...um… work through a range of uh… range of things in her life. At what was a fairly difficult time in her life*."

In relation to six of the adolescents, their psychotherapists mentioned the broader context of psychotherapy as a theme. For six adolescents their psychotherapists spoke about liaison with government funded child and adolescent mental health services (CAMHS), and for some adolescents this involved close work with case managers and psychiatrists. Other services that were sometimes involved were child protection, school personnel, and adult psychiatry crisis teams when the adolescent was older. It was stated that one adolescent felt supported by the combination of services. One psychotherapist commented on the lack of support for psychoanalytic psychotherapy by some clinician colleagues:

"*I think there were voices that felt that it was the therapy that was also contributing to her ... um ... unravelling. And that was quite hard for me, because I had to field the parents, as well as a service. That it would've been better if it were more supportive, but they weren't*."

8.2.3.3 What the adolescent experienced as helpful in psychoanalytic psychotherapy

In responding to the question about how the young person experienced psychoanalytic psychotherapy, all for all seven adolescent psychotherapies the psychotherapists expressed themes regarding the helpfulness of psychoanalytic psychotherapy, as set out in Table 25 below.

Table 25: Psychotherapists: What the adolescent experienced as helpful in psychoanalytic psychotherapy

Higher Order Themes	Number of participants mentioning these themes
Globally positive experience	**4**
Changes & outcomes	**6**
Positive skills, knowledge & attributes of therapist	**3**
Description of therapeutic processes	**6**
Importance of the relationship with the therapist	**5**

For four of the seven adolescents, their psychotherapists believed the adolescent experienced psychoanalytic psychotherapy as positive in an overall way. One psychotherapist, whilst feeling sad for the adolescent's life situation, felt she got something good from her experience of psychotherapy. For two others, the psychotherapist thought there was some value seen by the adolescents in how the psychotherapist was with them. One reflected:

"*I think she saw psychotherapy as something very positive, and perhaps even a bit magical and wonderful... um ... for her. I think she saw it as… um a place for her, where somebody paid her attention and listened and um ... you know ... was there for her. And I think those things were probably quite important as well for her. I don't know that she had a lot of that in her ... you know ... sort of busy family*."

Psychotherapists for six of the adolescents reported as a theme changes and outcomes, indicating the helpfulness of psychoanalytic psychotherapy for the adolescent. Four

adolescents were viewed as in a process of individuation but becoming more independent, one completing school and attending university, another now employed and travelling, with reduced drinking and crises, and one beginning to express her identity through changing how she dressed. For three adolescents, their psychotherapists spoke of improved family relationships, and for two adolescents, the development of more stable and healthy partner relationships. For one, the psychotherapist mentioned more internally focussed changes, such as beginning to understand the impact of early deprivation and neglect, being more able to talk about difficult feelings, and developing a capacity to bear some loss. For some adolescents, the observed changes were more modest, for example, stating that 'S*ome seeds were sown*'.

The psychotherapists for only three of the seven adolescents noted their own positive skills, knowledge and attributes as helpful for the adolescents. Two psychotherapists reflected that qualities such as being non-judgmental, and understanding were helpful. Two mentioned their own capacity to survive, and to not retaliate in a punitive way when the adolescent was being provocative. Other psychotherapist qualities mentioned were being non-controlling, not implementing measures that would fail, being available, and listening attentively. One psychotherapist's stated:

"*I survived her attacks. Um… you know ... and that ... and she sort of grew used to me a little bit too, you know ... I was still around, so that same old issue of just sticking it out ... just staying there and sticking it out, and ... and not retaliating. Um… that that was helpful, or that allowed her at least to ... to you know ... sort of be in the room and come in regularly and everything*."

Psychotherapists raised the theme of helpful psychoanalytic psychotherapy processes in relation to six of the seven adolescents. The process of psychotherapy was considered to help the adolescent to learn, to think and sort out their thoughts with another person. However, for one adolescent, this had been particularly difficult to explore, as indicated by behaviours such as lateness to sessions, or non-attendance. Three talked about the adolescent needing and being provided with containment. Two psychotherapists mentioned the adolescents exploring their grief in the sessions. For one, those sessions when able to explore guilt, loss and grief became turning points. Two psychotherapists noted how deeper layers of difficulty were revealed gradually over time. Trust developed gradually for one adolescent, and yet for another adolescent while there were times when the adolescent and psychotherapist could work together, things were up and down and there were some tough sessions. One psychotherapist tried to articulate the process of an adolescent's thinking problem, thus illustrating the likely use of psychotherapy process:

"*She didn't really… use it as ... as ... like a therapy session, where somebody might come in and talk and we would process what they talked about. She sort of seemed to use it um… <pause> ... I don't know how to describe it, maybe just to sort out her mind, to sort out ... um… some disturbing elements in her mind. Yeah ... and not that other people maybe don't do that, but I think she solely did that almost. As well as maybe engaging with me, and connecting and having a safe space and doing all that, um… she ... She sort of seemed to use it that way.*

Um ... I think her mind ... um ... yeah ... sorting, and maybe showing me how much she was struggling in her mind ... yeah. So, showing, communicating that to me, to someone ... you know ... maybe asking for help in that process."

The final theme in this subdomain raised the psychotherapists of five of the seven adolescents, was the importance for the adolescent of the relationship with the psychotherapist. For these adolescents, it was important or meaningful that the psychotherapist was there for them and did not abandon them. Other comments were that the psychotherapist's presence was important at a significant time in the adolescent's life, and it was an important experience of an attuned relationship. For another adolescent, it was a strongly positive and idealised relationship, while for yet another isolated adolescent, the psychotherapist's approval, guidance and opinions were important. The connection was vital for another who would contact when she felt suicidal. One described the relationship thus:

"*I have a memory of her ... you know ... she was ... sort of ... trying ... you know ... to be an angry young woman, and me sitting back and ... you know ... simply trying to empathise with her, and understand how funny it is to meet someone you don't know and all of that. And that, and her, being able to respond to that. Yeah, so I think ... I think that was, that was kinda helpful. And sticking it out with her ... you know ... not giving up, not abandoning her ... um… being there at a vital time...*"

8.2.3.4 What the adolescent experienced as unhelpful in psychoanalytic psychotherapy

In this subdomain, despite some explicit prompting, the psychotherapists for only five out of the seven adolescents touched on potential unhelpful experiences within their responses to the broad question "What can you tell me about the young person's experience of psychotherapy? These themes are displayed in Table 26 below. Not one participant

identified that an adolescent would have found the psychoanalytic psychotherapy a globally negative experience.

Table 26: Psychotherapists: What the adolescent experienced as unhelpful in psychoanalytic psychotherapy

Higher Order Themes Level 2	Number of participants mentioning these themes
Cancellation of sessions	**1**
No change or negative experience	**2**
Negative aspects of therapy relationship for young person	**3**
Premature termination by therapist	**1**

One psychotherapist mentioned the theme that cancelled sessions would have been unhelpful for one adolescent, during a period of time when the psychotherapist had extended sick leave. The psychotherapist wondered about the process being disjointed, perhaps mirroring an earlier experience when the adolescent's mother was hospitalised.

Two psychotherapists discussed 'no change or negative experience' in the psychoanalytic psychotherapy as unhelpful for the adolescents they saw. One was unsure how much one adolescent got out of the psychotherapy, and the other mentioned the adolescent found the psychotherapy very painful, as there was a negative style of transference from the beginning.

For three adolescents, participants raised as a theme, aspects of the psychotherapy relationship being unhelpful. Two adolescents had difficulties with the boundaries of the relationship, with one seeming quite persecuted by the psychotherapist setting boundaries,

and the other desiring a relationship outside the psychotherapy frame. Another adolescent was overtly annoyed by the psychotherapist taking time in silence, to think and process, and then make transference interpretations on the psychotherapeutic relationship. Boundary difficulties were described for one adolescent:

"*she struggled with boundaries ... so um, you know ... she often got quite close physically in the therapy. She often sort of expressed her desire to sort of be in my life or come home with me or something like that. Not necessarily directly, but sort of, it might've been a bit more indirectly, by wanting to know questions or wanting to know where I lived*."

One participant mentioned the premature termination of psychoanalytic psychotherapy by the psychotherapist as being unhelpful. The adolescent missed the psychotherapist and continued to keep contact by text and phone after finishing. The adolescent needed further help at the time but refused to be referred elsewhere. Denial of the ending of psychotherapy was described:

"*When we finished, [name of adolescent] was adamant she didn't want to see anybody else - adamant. You know ... I would've referred her somewhere, some form of counselling if you know ... it was just supportive counselling at the local council or something, or school or ... you know.... whatever. But she was adamant she just did not want anybody else. So that was tricky ... um, yeah. I did have a feeling of oh… you know, just leaving her with nothing almost, that was ... that was difficult ... yeah ... I think her idealization was so strong and ... you know ... maybe it was also about, if you see someone else, you have to acknowledge that ... that ... the loss*."

8.2.3.5 Processes of the psychoanalytic psychotherapy

All psychotherapists, for all seven adolescents, produced responses touching on the theme of the process and ending of psychoanalytic psychotherapy. The resulting themes in this subdomain are displayed in Table 27 below.

Table 27: Psychotherapists: Processes of the psychoanalytic psychotherapy

Higher Order Themes	Number of participants mentioning these themes
Content of therapy	**5**
Feelings during the therapy process	**2**
Reasons for ending therapy	**7**
Therapy was not a cure	**7**
Reflections now on how the young person's experience could have been improved	**6**

For five adolescents, participants described as a theme the content of the psychoanalytic psychotherapy. In broad terms, relationships and friendships were important for three adolescents, for two, suicidality, risk issues, and the early loss of a parent or sibling were critical. One adolescent brought family of origin and sense of identity to the psychotherapy, whilst for another, the psychotherapist spoke of some content being educative, particularly around protective behaviours. One psychotherapist recalled the adolescent talking about day-to-day things, another adolescent produced repetitive drawings, and another adolescent was not ready to speak about early experiences of trauma and abuse.

The feelings that two adolescents might have experienced in psychotherapy were mentioned as a theme by their psychotherapists. One psychotherapist spoke of the adolescent's ambivalence. There were phases when things were positive, and there was some trust and a more positive relationship with the psychotherapist. The other psychotherapist described it as an intense and emotional experience for the adolescent. Both mentioned the adolescents' need for distance in the relationship at times. Both psychotherapists also commented on the adolescents' feelings towards the end of psychotherapy, with one adolescent being angry, with possible underlying fears of abandonment, and the other perhaps disappointed. One said:

I think she had a lot… of … unconsciously riding on it … that I think was… I don't know … disappointing to her. I didn't … maybe sort of her reality of the world being a rejecting place got played out.

For all seven adolescents, their psychotherapist discussed the reasons for psychotherapy ending. Within this theme, only one reported an ending where the adolescent was ready to finish, with mental health improved in a number of areas. Others spoke of the difficulty in continuing psychotherapy when it was no longer close to where the adolescent lived or attended school. Two adolescents found distance and time were hindrances, and one ended psychotherapy due to completing secondary schooling and planning to leave the area. One psychotherapist was less able to support an adolescent who transitioned from the junior to senior high school campus due to travel distance, and another left family home and moved into supported accommodation in another region. One adolescent remained ambivalent about finishing psychotherapy, and still called at times, one psychotherapist moved regions and there was a planned ending process with the psychotherapy. Another participant was on

extended sick leave when the adolescent was admitted to a psychiatric inpatient unit. One psychotherapist commented on an adolescent needing more time in psychotherapy:

"*I think her capacity to trust, and attach ... you know ... to form a ... I think she needed ... I think she needed more time in therapy um. And ... and needed to have, to be able to do it. To be able to at least commit to sort of coming, and I ... I ... whether it was because it was [name of suburb], which I think honestly was difficult. It was difficult that we had to move. .... I have a feeling it took two hour*s."

For all seven adolescents, their psychotherapists raised the theme that psychotherapy was not a cure, whilst recognising the value of the psychotherapeutic processes that psychoanalytic psychotherapy offered these adolescents, with improvement for example in reflective capacity, there were still difficulties that remained. The psychotherapists of four considered that the adolescents they saw needed longer in psychotherapy. For three, changes had been made, but there were further things to address, and so future work would be required. Further reasons for believing the ending of psychotherapy to be premature were that one adolescent needed more time to work through all her grief, another was unable to process losses, and one lacked a cohesive internal world. Another adolescent needed to do more work on attachment issues. Trust and attachment were still problematic for yet one, and unresolved repetitive themes needed more intensive work for another. As one psychotherapist illustrated:

"*She had a lot of positive transference towards me... she became very attached to me, and I think that in itself is a very important therapeutic tool. So, in that way ... yeah ok, we, we ... something was contained, I think, in the therapy... through that process. ... I believe something was contained, probably contained for her, but not enough... And the other stuff*

wasn't worked through that probably needed to be worked through ... yeah ... for her to ... I think ... function better, and at a level that she probably needed to function."

The psychotherapists of six adolescents reflected on the theme of what could have been done differently, to improve the adolescents' experience of psychoanalytic psychotherapy. The psychotherapists for two commented that it would have been better if psychoanalytic psychotherapy had occurred at a younger age, with one suggesting during childhood. For two others it was stated that it would have helped if Child and Adolescent Mental Health Services were able to support young people after 18 years, and one observed the adolescent was more vulnerable after finishing school. The psychotherapists of two other adolescents thought that additional family support and work would have helped the psychoanalytic psychotherapy process. Two thought more frequent attendance would have helped the adolescents they saw. Other themes were that psychotherapy needed to be longer, that the timing of ending was not good, but at least there had been an ending process, and that one adolescent may have felt too persecuted in psychoanalytic psychotherapy. One psychotherapist reflected on an ending she considered premature:

"*it seemed like the end took a long time and ... you know ... it wasn't a tidy end by any means. It was just trying to hold the thread there and do some kind of a finish ... you know. When I guess we were still in the throes of chaos. You know ... It seemed to me that ... that end period of time, she did start acting out quite a lot ... I think.... Perhaps I could've held on to her and perhaps we could've continued to work. Because I look back... the work wasn't done, the work was just starting*."

8.2.4 Domain of enquiry: Psychotherapist's own experience of psychoanalytic psychotherapy with the adolescent

Upon being invited to reflect upon their own experience with the adolescents they saw in psychoanalytic psychotherapy, the psychotherapists of all seven adolescents were forthcoming with the resulting higher order themes presented in Table 28 below.

Table 28: Psychotherapists: Psychotherapist's own experience of psychoanalytic psychotherapy with the adolescent

Higher Order Themes	Frequency
Memory of person, process & feelings stronger than content	**5**
Still think about young person	**5**
Positive experience	**5**
Psychotherapy evolved to match the perceived needs & functioning of the young person	**4**
Ongoing thinking & analysis of relationship dynamics	**4**
Feelings evoked in the therapist	**7**
Young person needed more than what could be offered	**4**
Emotionally intense, demanding & difficult work	**6**

Initially the psychotherapists of five adolescents made comment upon their memories of the adolescent, the process and feelings being easier to recall than the content of the psychotherapy. For three adolescents the psychotherapists mentioned gaps in their content memory, although not in memory about the process and feelings in the psychoanalytic psychotherapy. One stated early in her response to the question:

"*I just don't remember a lot of it. Now, I do think that's significant. And perhaps does relate to something about the therapy, and about her. So that... really... I feel I've almost blanked out a lot.* "

The psychotherapists of three adolescents discussed having a clear memory of the adolescent and their presentation. Over half revealed as a theme that they still, now, thought about the adolescent. All were extremely keen to know how the young person was now, and what was happening in his or her life now.

Over half of the psychotherapists reported the experience of the psychotherapy as a positive one. Four commenting how the young person had contributed to their learning as a psychoanalytic psychotherapist, and three described the work as engaging and challenging. One psychotherapist remembered struggling with theoretical reading suggested by the clinical supervisor around autism, adhesive identification and the impact of early neglect and deprivation, and how the real understanding came through the experience of the work with the adolescent. Another commented:

"*It was really, really hard. But it was um ...really… I learnt a lot. <laugh> Yes, I did, I learnt heaps. I learnt um… <laugh> you know ... because she ... the presentation was such that you know ... she tried to run rings around me all the time, and so I had to learn to um ... be so clear with boundaries."*

Four psychotherapists raised the theme of the psychotherapy evolving in accordance with the needs and functioning of the adolescent. Three discussed the focus of the psychotherapy, and three described a thoughtful, emotionally attuned method of working with the adolescent. In one psychotherapist's words:

"*... The psychotherapy was very um ... very strength-based, strength-focused. At that particular time, she had a lot of challenges on her plate, and ... you know ... I kept a fairly clear and focused view on working with her defenses in a positive way, um… and was very mindful about where I went in that space at that particular time. She was really very alone in many respects, and ... um ... so I was very mindful of that I think, very deliberate and mindful in the work.*"

Four participants raised a theme concerning ongoing thinking and analysis of relationship dynamics in the psychotherapy. Rich descriptions were given of their reflections on the dynamics within and between the psychotherapist and the adolescent. For example, one was aware of the urge to rescue the adolescent, at the same time as knowing that the adolescent needed boundaries. Others spoke of connections to changes in presentation in the psychotherapy, a decision to write letters as a way of holding on to a fragile thread of connection when the adolescent missed a number of sessions, a sensing when important things were being withheld, and awareness of the emotional impact when talking about feelings of loss. One psychotherapist illustrated deep thinking about the complexity of transference and countertransference relationship dynamics between herself, the adolescent and the family, and mental health systems:

"*...Whatever one's theory is about therapy, and mine is much more an intersubjective relational view, and so there's also the person of the therapist and um… In a way to feel guilty is always my default position, so when I think about that, um… I probably ... I probably give too much weight to that. Maybe? Um ... Maybe not? I don't know (for sure)*."

All seven psychotherapists elaborated on a theme concerning feelings evoked in them during the psychotherapy. A large range of feelings were mentioned. Four talked about protective parental feelings, four described feelings of anxiety, discomfort, and disturbance, and four described their feelings at the end of the psychotherapy. Three remembered feeling admiration for the adolescent, three described feelings of guilt and inadequacy, and three described feelings of sadness. In two cases, the psychotherapy left the psychotherapist feeling bored, sleepy or dissociated, and two talked of feeling overwhelmed. Others spoke of feeling intimidated, intruded upon, amused, cautious or having strong desires for the patient, for example that the family could hold the adolescent, knowing that in reality this was not possible. One psychotherapist used a loose definition of countertransference that developed with a particularly disturbed adolescent, indicating that the psychotherapist had become aware of the adolescent's projection, when she expressed a view that differed from that of the adolescent:

"*I felt like I would be very scary to her, that I was frightening to her, that I could be frightening to her. So around that stuff, I think I would've been quite careful um… But nevertheless ...but ... try to work with it ...but that I guess ... your transference, countertransference. I felt like a ... you know ... the devil - she's the good girl, and I was the devil. I'm the bad guy*."

The theme of the adolescent needing more than what could be offered emerged for four of the seven adolescents. More sessions over time or more frequent sessions were needed, although with three adolescents the psychotherapist wondered if a more experienced clinician was needed. One psychotherapist felt:

"*She was particularly, like I think, I can think of several other cases that were quite challenging for me. And I needed to do a lot of work, and I needed to be there for them. But… I think maybe I... my feeling is that maybe she was even more so. What she needed, how much she needed, and for how long she needed and the depth of it she needed. You know ... that, I don't know... but I feel that I would've really had to have gone into that for her, to then… you know, separate from me*"

How emotionally intense, demanding, and difficult the work was, arose as a theme for six participants. Four emphasised difficulty, one saying that in comparison with psychotherapy with a lot of adolescents, this was incredibly challenging. One commented that "*At times it was hell, but it was rewarding too*." Two of the psychotherapists discussed the difficulty of sitting with not understanding, and at times bizarreness. Two spoke of how frightening and acutely aware they were of holding for the adolescent the risk of suicide and/or madness, containing not only the adolescent, but their own worry as well. Two others mentioned the difficulty when psychoanalytic psychotherapy was not understood well or supported by their colleagues. Other themes were that it is hard to sit with strong feelings and remain thinking, how careful one needed to be managing and working with rigidly held defenses, and the difficulty of enduring fifty minutes of being stared at in silence. One psychotherapist highlighted how hard and isolating it can be as a sole psychoanalytic psychotherapist in a region:

"*...it's so intense, and so, so deep and so outside the cultural and societal kind of norms... you know... Like we're in a different world when we're in that world, aren't we? And that's why ... I guess ... I'm saying ... if ... that ... the thing about being here, like even though we have a*

few people now, it's nice to have a few people I can talk to... about, you know ... It's sort of not the norm to think and work like that, at that kind of level."

8.2.5 Domain of enquiry: How the adolescent saw the psychotherapeutic relationship in psychoanalytic psychotherapy

All seven psychotherapists responded to the question "How do you think the adolescent saw your relationship with them?" The higher order themes emerging appear in Table 29 below.

Table 29: Psychotherapists: How the adolescent saw the psychotherapeutic relationship

Higher Order Theme Level 2	Frequency
Use of the relationship	**5**
Perception of therapist's role	**4**
Adolescent capacities influenced the relationship	**3**
Therapist qualities influenced the relationship	**2**
Attitude towards relationship	**6**
How saw the loss of the therapeutic relationship	**2**

The psychotherapists of five adolescents reflected specifically on the adolescent's actual use of the relationship as a theme. It was thought by their psychotherapists that three adolescents would have seen the relationship as a working space, with comments about working together, trying to make use of the psychotherapist and it was seen as a safe and nurturing relationship. Two believed it was a relationship wherein the adolescents knew he/she could communicate thoughts and feelings, with one psychotherapist experiencing some competitiveness and challenging in the relationship from the adolescent, and the other commenting that the

adolescent was able to communicate anger and ambivalence through missing appointments. One psychotherapist spoke of the complexity of the adolescent's changing view of the relationship, incorporating changing projections:

"*I think it was complicated by the hats she put on me, you know, so... um ... if I was the abusive, mean person, she saw me like that. Um... If I was helpful, she saw me like that. Um ... so I think it ... At the end of the day, um… I mean look, maybe she ... I don't know. I actually don't know, and that might just be part of the whole thing*."

For four of the participants, the adolescent's perception of the psychotherapist's role emerged as a theme. Three commented that the adolescents had an experience of boundaries in the relationship, with different reactions to the boundaries such as understanding, frustration or confusion. Two stated the adolescent knew the psychotherapist was there for them through the experience of the relationship, seeing the psychotherapist as there to support, understand and help. A possible experience of the boundaries in the relationship was given:

"*I think it was probably something she saw as a good thing in her life, but um… you know ... maybe it confused her a little bit. Maybe it was confusing. I couldn't tell her things about me, you know ... all that sort of stuff. She wanted to know more about me, and I think be closer to me, than what she could be. So, on that level, it might've been a little bit confusing for her, or difficult*."

For three adolescents', their psychotherapists reflected on the influence of the adolescent's capacities upon their view of the psychotherapeutic relationship. Various themes included the adolescent having the capacity to use the relationship to think and reflect, one consistently

testing the boundaries (being good at wheedling information out of the therapist), a history of complex trauma, and dissociation impacting on the adolescent's capacity to trust and form a relationship.

Two psychotherapists spoke about qualities of the psychotherapist that two adolescents might have viewed as affecting the relationship. Themes were mentioned such as attentiveness and thoughtfulness, trying to understand, knowing at what level to process things, and having staying power.

The actual attitude of six of the adolescents towards the psychotherapeutic relationship emerged as a theme for three of the psychotherapists. Two adolescents were perceived to have positive regard towards the relationship. For four adolescents, their psychotherapists were aware of their attitude to the relationship waxing and waning, with a strong negative transference in one adolescent, or else the complications of mixed projections, seeing the relationship through a paranoid lens, or feeling superior to the psychotherapist. Four adolescents were perceived to have a need for a close, mothering relationship, to meet more informally, to have a more personal and reciprocal relationship, and perhaps experienced disappointment that these desires were not met. As one Psychotherapist stated:

"*I think she would've liked if we met in cafes and ... you know ... had a more... friendlier relationship... if I'd let her know things about me and my life. I think ... I think ... she… I think she... um ... perhaps in the end she might've seen the value in that, but for a lot of, I don't know ... she might still prefer it like that. But um ... I think for a lot of the therapy, she, you know ... she wasn't just testing me, I think she actually would've liked to be closer to me in that way. Now I don't think that would've been helpful for her necessarily, but I think she*

was so… desiring of … of … of a relationship of mothering..... she would've loved someone who ... who could come and look after her and come to her rescue literally."

Two psychotherapists discussed how two adolescents would have viewed the loss of the relationship, and both commented on the difficulties of a premature ending, and potential feelings of abandonment. One psychotherapist elaborated upon being left with not knowing what happened, after the adolescent drifted away from psychotherapy, indicating perhaps how the adolescent had needed the psychotherapist to hold the responsibility for abandoning the relationship.

"*I was attentive to her, I was thinking about her, I was trying to understand her, I was trying to help her understand, I was trying to help her get some… some strengths ... you know. So… so I was also there for her some of the time. It wasn't just like I dropped her. But I don't know what it would've felt like to her at the end ... to her at the end ... whether it was just ... I don't know what happened there, whether it was just too hard or too much or ... But I, I didn't do it, I didn't leave her."*

8.2.6 Domain of enquiry: View of the therapeutic relationship with the adolescent in psychoanalytic psychotherapy

In this domain of enquiry, all of the psychotherapists responded to the question of "what do you remember about your relationship with the adolescent?" and the resultant five higher order themes are displayed in Table 30 below.

Table 30: Psychotherapists: View of the therapeutic relationship with the adolescent in psychoanalytic psychotherapy

Higher Order Theme - Level 2	**Number of participants mentioning these themes**
What psychotherapist brought to the relationship	**7**
Reflections on loss of relationship	**2**
What the young person brought to the relationship	**5**
Therapeutic role	**6**
Nature of relationship	**7**

What they themselves felt they brought to the relationship was spoken of as a theme for all seven of the adolescent psychoanalytic psychotherapies. The psychotherapists mentioned their commitment and caring towards four adolescents that were seen, with one describing the psychotherapist as a constant in the adolescent's life. Three specified their capacity to listen to, hold and think about the adolescent, and described specific skills such as attentive listening, trying to understand the young person, withstanding attacks, and sitting with intense and uncomfortable feelings. Other attributes were the capacity for flexibility, by adapting the psychotherapy to fit the context, the use of the psychotherapist's own self and being an experienced psychotherapist. One psychotherapist expatiated on the parameters of flexibility:

"I worked as a psychotherapist in um… in a system that didn't really recognize that as a … as a … as a… skilful and important way of working, as part of a continuum of ways of working. I had to really develop a way of um… of making it work within the context that I

was in. And I think um... that, from my training onwards, I have sort of learnt to do that a bit. And I think that sort of helps with young kids like her, because I don't think others would've necessarily have had a session on the park bench, or changed the day and time to make sure we had it that week, regardless. So, there was some flexibility, as long as we really held what was really important to the process, I was prepared to alter, and I think that helped enormously."

Two psychotherapists advanced the loss of the therapeutic relationship as a theme for two of the adolescents. One divulged feeling she had let the adolescent down, and another, that she still thought about the adolescent, especially during her current work with adolescents.

What the adolescent brought to the relationship was identified as a theme by five psychotherapists. Three recalled the adolescent they saw as interesting, intelligent, and bright, one talked about the adolescent's ability to hear and process interpretations, and another about the potential of the adolescent. There were a variety of other themes including the adolescent's capacity to bring difficult material and work with the psychotherapist and having a strong need for a safe relationship. Another felt an adolescent had limited capacity to do the work, due to pressured speech probably making it difficult to think and process, and it was unclear what could be taken in. A description of one adolescent was:

"And she was bright... you know ... it was really sad. I mean I hope she's doing well, because she certainly had potential to do well, somewhere inside herself. And she was an interesting, bright girl. Very sensitive girl."

The therapeutic aspect of the relationship was discussed in great depth as a theme, by six psychotherapists. Three broached the process of developing containment, commenting on helping to "*Hold the adolescent together*," and being a positive, stable, and reliable figure for the adolescent. Two psychotherapists stated that their priority was to work with the process of the relationship, to recognise intensely communicated experiences, and to retain at all times the capacity to think. Two specified the challenging of adolescents in specific situations when they were engaged in at risk behaviours. Other aspects of facilitating the process included working with the transference, providing a safe space for freedom of expression, and working with projective identification communications. Actively working with systems in the adolescents' lives, possessing a protective role, and helping the adolescent develop protective skills, were also highlighted. One psychotherapist detailed the intensity of the role with an example of the communication of an abuse process, and while recognising that communication, concurrently keeping herself separate from the adolescent, and alive to being treated as both the victim and the perpetrator:

"*It could flick to be, you know... she would put me in the position of perpetrator, that I had done something to her, that I hadn't understood her, or that I, you know ... had said the wrong thing and set her off. Or hadn't been there in the way she wanted me to be...*"

The final theme in this domain mentioned in relation to all seven adolescents was the overall nature of the relationship. For psychotherapists of four adolescents their experience of the beginning relationship was variously described as an engaging experience, a connection was felt towards the adolescent that occurred quickly and felt good. There was a need to establish what psychotherapy was with one adolescent from the outset, with another there was maternal transference from the beginning, and for one it was a fearful start. Two psychotherapists indicated the ongoing, complex, part-object relating nature of the

relationship, whilst another talked of a predominantly negative transference in the relationship. One therapist described the relationship in terms of the transference:

"*... there is maternal transference, but um… <pause> there is part, you know ... part-object transference ... and um… <pause> and who was I to her, in the transference? I think she played that out. The um… the confusing part-object transferences of ... um… the wished-for ideal mother, and also the ... um… confusing unknown, untrusting… un-trustable ... uh ... mother. I think that was all at play, for a desire for ... she saw me as ... a, you know ... the wish for a mother, but also there were all the other elements, the other aspects of maternal transference, which were the darker, darker side of maternal transference*.

8.2.7 Domain of enquiry: View of psychotherapist relationship with the parent/carer

All psychotherapists were asked "What do you remember of the adolescent's parent/carer?" This question was not asked of the young person, and thus constituted an additional domain of enquiry for the psychotherapists. In amplifying the emergent themes involved here, no direct quotations are given, as these tend to reveal particular family contexts and hence are considered to be inappropriately exposing of the identity of participants in the research. All responded to the question and four final themes emerged, as displayed in Table 31 below.

Table 31: Psychotherapists: Psychotherapist relationship with the parent/carer

Higher Order Theme	Frequency
Parental involvement in treatment	**5**
Parental concern regarding adolescent	**5**
Parent & therapist relationship	**6**
Influences on parenting	**7**

Five psychotherapists raised as a theme the parents/carers actual involvement in treatment. Three commented on parents' own treatment by government funded child and adolescent mental health services (CAMHS) which provided case management for most of the adolescents seen. One psychotherapist liaised with CAMHS for the purpose of facilitating support for the mother, another understood that parent sessions were often cancelled with CAMHS, and another, that some undermining of the psychotherapy with the parents occurred in the system. The frequency of the psychotherapist's contact with four adolescent's parents/carers was described as ranging from minimal contact to additional contact with extended family. One reported never meeting the parent of one adolescent, and nor did that parent engage with the school.

Parental concern for five of the adolescents was proposed by their psychotherapists with the psychotherapists explicitly mentioning four adolescent's parents cared about them. Comments made were that parents wanted the best for their adolescents, and were well-meaning and committed, and one stepparent wanted to develop a significant relationship. Two psychotherapists talked about the parents' feelings about the adolescent's difficulties, including their fear of the adolescent's suicidality, parental guilt and ambivalence, particularly when wanting the adolescent to leave home, and safety concerns with younger

siblings. Only one psychotherapist mentioned an absence of caring for an adolescent where there was no parent/carer involvement, and a sense of longstanding emotional neglect and deprivation.

The relationship between psychotherapist and parents/carers was a theme for psychotherapists of six adolescents, who commented on the parent/carers' attitude towards and understanding of psychoanalytic psychotherapy. Psychotherapists commented upon the parent/carers' support of three adolescent's psychotherapy, saying, they valued and facilitated the continuation of psychotherapy for the adolescent. Other various attitudes were expressed in parents' being desperate for help in dealing with the adolescent, or the parental relief that the adolescent improved, or that the parents/carers lacked a clear understanding of the nature of psychotherapy. One thought the mother may have seen psychotherapy as making her daughter worse, as there was increased rebellion. Another's carers were cooperative but may have steered the adolescent towards other treatment. Four spoke about the nature of the parents/carers' contact with them as not intrusive, and some made phone contact when worried about the adolescent becoming more difficult and problematic. Some psychotherapists met with parents/carers regarding feedback and concerns, and one had regular family meetings. Psychotherapists of four of the adolescents revealed their own feelings towards the adolescent's parent/carers, with two saying how much they liked the mothers. One remembered a strong, happy, and motherly carer, whilst another had no memory of the carers. The psychotherapists of all seven adolescents expounded upon the multiple influences on parenting. Here emerged themes about parenting style, variations in the parenting situation, parents' struggles with their own difficulties, and challenges in parenting adolescents with difficulties.

The psychotherapists of six adolescents described an array of parenting situations, encompassing single parents struggling financially, blended families with split loyalties, traditional roles with challenges in role adjustment when parental death or separation occurred, large chaotic families, and foster care arrangements. Five of the parents/carers were known to have their own difficulties, and three psychotherapists described the mothers as meek, frightened, lost, overwhelmed, fragile, vulnerable, and unassertive. Four parents were struggling with grief around spousal loss through death or separation, and one psychotherapist mentioned fears surrounding family secrets.

Four psychotherapists commented on parenting styles and attitudes of parents/carers towards five of the adolescents. One reflected on a mother who brought up good children who had to be tough and independent, while others mentioned protectiveness, permissiveness, setting of limits on out-of-control behaviours, and the desire to be a perfect mother. Four elaborated on the difficulty's parents/carers were facing, such as finding the appropriate emotional distance from the adolescent, struggling to manage difficult projections from the adolescent, and feeling helpless or strongly tested.

8.2.8 Domain of enquiry: View of the impact of psychoanalytic psychotherapy on the adolescent's relationships

All psychotherapists of the seven adolescents responded to the question "How did psychotherapy impact upon the adolescent's relationships?" The distilled themes are displayed in Table 32 below.

Table 32: Psychotherapists: View of the impact of psychoanalytic psychotherapy on the adolescent's relationships

Higher Order Theme	Number of participants mentioning these themes
Relationships prior to psychoanalytic psychotherapy	**5**
Degree of impact of therapy on relationships	**5**
Negative impact on relationships	**2**
Positive impact on relationships with family, peers & others	**5**
Acquired new skills which helped relationships	**2**
Developed capacity to form more intimate relationships	**3**
Improved relationship with self	**4**

A description of the adolescents' relationships prior to beginning psychoanalytic psychotherapy was raised as a theme by psychotherapists of five adolescents. There were a number of contributing themes mentioned. For example, the adolescent was treated differently at home, felt like a servant, was contained by the father, was rejected by the extended family, and was angry with the mother. One adolescent was described as fairly sociable and able to mix with peers, whilst one had unresolved issues regarding early maternal separation, another tested people's limits, and one adolescent's behaviour contributed to rejection by others.

Four psychotherapists raised the theme of the degree of impact that psychoanalytic psychotherapy had on five adolescent's other relationships. One psychotherapist had no idea, and another commented that there were few people in the adolescent's life, there would have

been little impact. Other comments were that exploration of relationships and repeated patterns led to positive changes, or that the adolescent became angry at treatment at home and became more assertive. One believed psychotherapy gave the adolescent an experience of intimacy and developing the capacity for authentic depth in therapeutic relationship may have generalised to other relationships.

Only two psychotherapists discussed as a theme a negative impact on relationships. One young person outgrew some peer relationships, whilst another became more argumentative with her mother, less constrained in relationships where there had been some long-standing difficulties and was conflicted about behaviour and attempts to individuate. One psychotherapist described the process:

"*I just think some of that stuff was different, and probably created ... because some of the stuff was coming out, created more a conflict at one level..... She was like "I can't stand this hurt I'm doing to my mother" ... you know um… when she started to get a little movement in that. And not always be ... you know ... perfect, always thinking about the other, and being a little bit naughtier herself. I think that disturbed the equilibrium."*

The psychotherapists of five adolescents spoke of the positive impact psychotherapy had on relationships with family, peers and others. A variety of changes were noted. These included increased assertiveness, becoming less of a joke with peers, making new friends and going out more, relationships becoming more solid, improved relationship with teachers, becoming more interesting to others, seeking help at school, and looking for attachment figures. One psychotherapist commented:

"I suppose the fact that she did ... she did get into slightly more age-appropriate things, so she was less of a ... a joke, less of a little baby doll to the kids you know. She was doing more age-appropriate things."

Two psychotherapists raised the theme of the adolescent acquiring new skills. One psychotherapist described the adolescent developing interests online, and the other described the adolescent as having more of a capacity to think, reflect and plan.

Psychotherapists for three adolescents, raised the theme of the adolescents developing a capacity to form more intimate relationships. These psychotherapists described the adolescents forming a stable relationship, with one noting that it was a healthy intimate relationship. One commented:

"*.... She was actually able to see and work through what was happening for herself and why that was the case. All the way through to really finding this ...um, this um… current partner, her boyfriend at the time, which was a... and she was able to see how ...so... much healthier than her previous relationships. So, I think she used that space um… very effectively to explore all of that and what it meant. Yeah. Even actually her relationship with her teachers, and how that panned out, and how she negotiated in that space during VCE. Work as well. So, she did ... She was actually very sort of open and reflective in that space*."

Finally, three psychotherapists described how psychoanalytic psychotherapy improved four adolescent's relationship with the self. The adolescent became able to individuate and grow, able to recognise and understand her own needs more, became stronger, became a tiny bit more insightful, became able to accept not being perfect and to consider her own needs, or

became able to process guilt and other feelings around loss of a parent. One psychotherapist concluded:

"*.... there were a lot of changes that had they been able to be maintained, would've been quite helpful for her. You know... In terms of peers, in terms of her understanding something about her own needs, and ... you know ... acknowledging that.*"

8.2.9 Domain of enquiry: Reflections and understanding of the adolescent's difficulties

The seventh question in the interview asked, "What sort of adolescent was [*name*] and what was happening?" All Participants responses generated two subdomains of enquiry, the first of which is presented in Section 8.2.1 above, relating to descriptions of the difficulties the adolescents were experiencing when first referred to psychoanalytic psychotherapy. The findings for the second subdomain emerging are distilled in Table 33 below and relate to themes that reflect upon understanding of the adolescent's difficulties, as the psychotherapists got to know them better through psychoanalytic psychotherapy.

Table 33: Psychotherapists: Reflections and understanding of the adolescent's difficulties

Higher Order Themes Level 2	Number of participants mentioning these themes
Thoughts about the onset of difficulties	**7**
Description of academic functioning	**2**
Description of personality style	**7**
Thoughts about relationships & how related to others	**7**
Reflections on the role of adolescent development	**7**

All psychotherapists for the seven adolescents developed themes in this subdomain of enquiry, with all commenting on the onset of the adolescents' difficulties. One psychotherapist mentioned potential genetic predisposition for mental illness. For three adolescents, psychotherapist's determined onset related to early infancy, describing maternal mental illness, consequential vulnerability in attachment, and early abandonment issues. For four adolescents, psychotherapist's considered onset was in early childhood, when traumatic events occurred such as death of the mother, lack of separation and individuation from the mother, and childhood sexual abuse. Two identified events occurring during adolescence, as symptomatology appeared to be precipitated by the death of a parent, by unavailability of a grieving parent, or by various other losses.

Two psychotherapists articulated theme of academic functioning being intertwined with other difficulties. One adolescent's academic performance had deteriorated following the death of a parent. Another channelled her energy into studying removing the focus upon her other difficulties.

All participants raised as a theme how personality style interacted with adolescent's difficulties. One described the distrust of one adolescent as connected to an attachment style which shifted between hostility, ambivalence and disorganisation. Another adolescent's attachment style was functioning at an imitative level with an inability to understand the world. Two described a bright carefree superficiality, friendliness, chattiness that masked a more real, quiet, sad and withdrawn state for one adolescent, while for the other what was underneath was unable to be approached. Two psychotherapists pondered on the use of defenses. One, reflected upon an adolescent giving an illusion of capability, control and coping that was reinforced by defenses of intellectualisation that could be rigid,

perfectionistic and evangelical, and another, of an adolescent experiencing obsessional traits, with repetition and fixations on people and themes. Other related personality traits noted were, seriousness, quirkiness, impulsivity, theatricality, and high sensitivity. Two psychotherapists mentioned the impact of the role of the personality trait of resistance, despite trauma. One of these stated:

"*I think she was ... you know ... despite all the vulnerabilities and the crises, I think she was a survivor. I'd have to say that. I think she ... um… I think... Well, as I say that, I don't know where she's at. But I think she… I think she's got a fighting spirit in her, and there is a kind of a survival! If you want to put it in theoretical terms, she obviously exhibited a lot of death instinct stuff, but I do think there were various points, back and forth, towards the life instinct as well ... um You know ... given what she's experienced, that she's still alive, is actually - wow, that's not bad*."

For all adolescents, their psychotherapists mentioned the theme of relationships, and how the adolescent related to others. Five adolescents were described as having extreme difficulties in relationships and this was characterised by identifying as an outsider with peers, isolation, few friends, difficulties in connecting, struggling to form relationships, trying to control relationships and, for some, suicide attempts when relationships broke down. Three psychotherapists mentioned sibling rivalries affecting difficulties for three adolescents, and another two mentioned sexualised behaviours, and difficulties with boundaries. Two described infantile, primitive emotional relating to others, and another spoke of the adolescent struggling with the oedipal position and loss. One psychotherapist commented:

"*I think she was a, perhaps a… an isolated adolescent, someone who was isolated socially, but also maybe psychically as well, so I think there was a lot going on in her mind ... that um… that was isolating, that kept her maybe apart from other people. And yeah, she didn't really speak about friends much*."

In reflecting upon the understanding gained during psychoanalytic psychotherapy for these adolescent's difficulties, all psychotherapists raised the theme of the role of adolescent development for the seven adolescents. All discussed aspects of identity development and associated tasks in adolescence. Five of the adolescents were observed to struggle around identity, including sexuality, confusion around sexual identity and asymmetrical psychosexual development. Other identity issues included not knowing what to study, experimenting with dress and image, and lack of individuation. Three adolescents were very behind in their adolescent development, struggling with oedipal issues, overwhelmed by the task of separation, and confused and frightened by adolescent tasks as a whole. Two were quite rebellious and involved with serious risk-taking. The psychologically precarious developmental position of one adolescent was described thus:

"For some reason, the thought of sexuality came up ... and um… <pause> and oedipal issues ... and I… <pause> ... I think she was very um... I think she was very overwhelmed by… <pause> um ... the tasks of adolescence of separating ... and um… <pause> I mean certainly she had a very sort of fragmented ego or sense of self, and ... um ... so that, that was completely at war with the normal developmental tasks of adolescence that she was trying to meet. And I think, perhaps that just overwhelmed her."

8.2.10 Domain of enquiry: Understanding of psychological distress and changes in relation to psychoanalytic psychotherapy and other influences

In this domain of enquiry, all psychotherapists were asked "what part do you think psychoanalytic psychotherapy played in the adolescent learning to manage and think about her psychological distress?" This domain was challenging for those who had not had contact for a number of years. However, all of the psychotherapists did respond to the question, and the resultant higher order themes concerning psychoanalytic psychotherapy with seven adolescents are presented in Table 34 below.

Table 34: Psychotherapists: Understanding of psychological distress and what influences facilitated change

Higher Order Theme	Number of Participants mentioning these themes
Importance of psychoanalytic psychotherapy in changes to managing & thinking about psychological distress	**2**
Other influences on change	**1**
Positive outcomes from psychotherapy	**6**
Current social functioning	**1**
Improved management of internal processes & behaviours	**3**
Ongoing difficulties	**1**
Reflections on psychological processes in adolescence & childhood	**2**
Contributing psychotherapy processes	**6**

Only two participants mentioned material related to the question about the importance of psychoanalytic psychotherapy in changes to two adolescents' management and thinking about psychological distress. Initially both said they did not know. One then commented that the reflective capacity of the young person stayed the same. The other psychotherapist hoped something was of use and thought no harm was done and perhaps there was a little bit of good.

Only one psychotherapist mentioned other positive influences on change. Long term involvement with the same protective worker, and some financial remuneration providing stability were noted. One psychotherapist believed psychoanalytic psychotherapy had meaning:

"It's not like we spent a year doing all kinds of strategies ... you know. It's… it's like... we tried to go to someplace more fundamental. So, I mean I obviously can't help but think that that's worth something."

However, in relation to psychotherapy with six of the adolescents, a theme of positive outcomes of the psychotherapy emerged. Improvements were described in depression, developing a sense of capacity and hope, more disposed to seek help in the future, behaviour more age-appropriate, development of better protective skills, increased capacity for reflection, ability to be quite open, and improved functioning at school. It was noted that there was less risk-taking, and adolescents remained alive. One adolescent became able to bring experiences of the world into the psychotherapy and spoke of both internal and external experiences. The improvement in one adolescent was described:

"*I do think she became um… quite psychologically minded, and um ... really spoke in sessions with quite an understanding that blew me away ... for ... when, especially compared with earlier on*."

One psychotherapist mentioned current social functioning as a theme and that psychoanalytic psychotherapy seemed to provide the adolescent with some steadiness which enhanced social ability.

A theme of improvement in adolescents' management of internal processes and behaviours was described by three psychotherapists. It was observed that the adolescent was no longer overwhelmed by emotions, coped better, and had greater ego strength, and that self-harm and suicide attempts had decreased.

For only one adolescent, the psychotherapist spoke about ongoing difficulties, and that whilst the adolescent had improved in some ways, problems remained with reliance on denial as a defense, and an emerging loss of emotional and behavioural regulation.

Two psychotherapists identified the attempts of adolescents to complete normal psychological processes of childhood and adolescence whilst in psychotherapy. The psychotherapist of one adolescent remembered the adolescent was eventually able to internalise that the psychotherapist was there for her, and another adolescent was beginning to complete tasks associated with separation and individuation reflective of an older adolescent.

Processes within the psychotherapeutic relationship were seen as contributing to changes in six of the adolescents by their psychotherapists. Examples of such psychotherapeutic

processes are specified here. For two adolescents, the importance of a safe space, to project, connect and disconnect was raised. Two psychotherapists expounded upon the role of containment and holding what the young person could not tolerate, working with the transference, and having a working therapeutic alliance. Other observations were that the structure of psychotherapy was containing, and that the psychotherapist needed to withstand the negative transference. The adolescent being able to think together with the psychotherapist, about difficult experiences including sadness, was raised by another. One psychotherapist gave a fulsome description of these processes for one adolescent:

"*...This was a very safe container for even the most dreadful of thoughts and feelings of... "I can't go on", of unbearability, "this is too big" and .....the overwhelmingness. And ...um... so, there was that which I think helped ... to ... enabled her to feel like she was able to hold it together. Because she was really holding herself together. And then I think that it was really around how you work with um… defensive mechanisms. ...Um... And the word 'titrate' would probably come to my mind again too, because it was as much about working with the strengths, and working with, to build and strengthen, and to just titrate the bits that needed to, in a doable, a psychologically doable way, along the line. So she also progressed, but at the same time, didn't feel an overwhelming sense of ...you know..."I can't do it, there's too much, there's no hope", which is really where she was when I first met with her. So… a bit of it was ...was um ... giving her a space which she did not have before. And then a bit of it was ...to um... to build and improve I think, the incredible ...um… the... positive defensive mechanisms that she actually had there ... Um… but not to the extent of regressing and denial and so on, that would've been particularly unhelpful. So, it was really finding the right balance in there for her.*"

8.2.11 Domain of enquiry: Reflections on the difference psychoanalytic psychotherapy made to the adolescent

In this domain of enquiry, the participant was asked "How do you think things would have gone if the young person had not had psychotherapy?" The psychotherapists of all seven adolescents responded here, with the final themes presented in Table 35 below.

Table 35: Psychotherapists: Evaluation of the difference psychoanalytic psychotherapy made to the adolescent

Higher Order Theme	Number of participants' mentioning these themes
Hard to know or differentiate contribution to change	**3**
There were other important influences for change	**3**
Therapy important or most significant influence	**3**
Process itself was helpful	**3**
Positive outcome in well-being, relationships, functioning & survival	**7**

The psychotherapists for three adolescents raised the theme that it was hard to know or proportion what influences contributed to change. One liked to think psychoanalytic psychotherapy had made some long-term difference, a second did not know, and the third was not sure what was due to psychotherapy and what was attributable to the adolescent's own resources.

Three psychotherapists mentioned other important influences for change. One talked about the adolescent's strengths, and the other two, about the support from school, with one remarking the school staff 'genuinely cared and were interested.' One adolescent's strength in remembering and reflecting was highlighted:

"... The thread was held by both actually, by her very much so as well. She would come into the sessions ... actually ... often very much picking up where we left off. Which, given that it was a kid, and she was working, and she was doing VCE, and there was so much else going on, is probably pretty remarkable."

Three psychotherapists raised the theme that psychoanalytic psychotherapy was important or the most significant influence for the adolescent. Psychotherapy seemed timely or occurred at a turning point for the adolescent who was at risk. One commented on risk and the value provided by psychoanalytic psychotherapy:

"*I think sometimes for those young people, it is helpful to connect with them when they're at risk, yeah, so I think generally um… I think can be helpful. Sometimes people would say that's not a good time to offer therapy um… especially psychoanalytically based therapy, but I actually think for those young people, um it can be quite helpful because it can build an alliance if you ... if you are there at a time when they need to make themselves safe and when they are very vulnerable*."

For three adolescents, their psychotherapists spoke about the difference the actual process of psychotherapy seemed to make. Various benefits were described, whereby the adolescent had a taste of internalising a helpful space, there was a reflective space for understanding, or

the adolescent valued the constant relationship and regular sessions over time. One eloquently described what she believed the process of psychoanalytic psychotherapy gave the adolescent:

"*... an understanding, a reflective space where you can sit and think, and you don't have to act out and paranoia doesn't have to ... um... rule you. Where you can actually tolerate feelings, and that you can be tolerated, and ... um... start trying to understand those things. So, I think that's what the therapy offered her, and ... um… and... I would hope… that that experience was internalised, and that she carried that into, to other ways of functioning in her life. And that if she had not had it, there would've been just more externalizing, and that her internal world would have been much more impoverished. And so, I think it enriched her internal world, and I would hope that ... um… like Freud, memory traces, echoes of that, some small part had remained with her*."

Psychotherapists of all seven adolescents mentioned as a theme positive changes in well-being, relationships, functioning, and survival related to psychoanalytic psychotherapy. Three of the adolescents discontinued or decreased externalising, acting out and self-harm, and they had not killed themselves. Two, thought that psychoanalytic psychotherapy had enabled the adolescents to continue their schooling. Various other observations were an improvement in depressive symptoms, progress being made, the adolescent had increasingly able to stay in touch with reality, less at risk, defenses did not increase in rigidity, the adolescent being able to seek further help, and the adolescent ceasing to replicate self-destructive patterns of crisis-driven relating. One psychotherapist, when reflecting on the possible trajectory for an adolescent if psychoanalytic psychotherapy had not occurred, stated:

"...not that I'm beating my own drum, but I do shudder to think, I really shudder to think ...Um… I… I imagine she would've just kept acting out, maybe until she was deceased, I don't know. I guess ... I guess um… <sigh> ... You know... I guess she would've had more contact with mental health, with CAMHS and then adult mental health... more contact than what she did"

8.2.12 Domain of enquiry: Reflections on the research project's impact upon the psychoanalytic psychotherapy

All of the psychotherapists responded to the question "Thinking back what sort of influence if any, do you think the research project had on the psychotherapy?" The research project referred to was of course, the Time For a Future Project (TFFP) that had conducted follow up assessments, often during the course of long-term treatment, at yearly and then two-yearly intervals for six years. Four higher order themes resulted and are displayed in Table 36 below.

Table 36: Psychotherapists: Evaluation of the TFFP research upon the psychoanalytic psychotherapy

Higher Order Theme	Number of participants mentioning these themes
No impact on psychotherapy	**3**
Experience of research	**4**
The research project made psychotherapy possible & provided additional support	**6**
Independent value of research	**3**

For three of the psychotherapies, psychotherapists stated that the research had no impact on the psychoanalytic psychotherapy itself. Various themes were raised. There was no impingement, it did not interfere, there was no impact on therapist role, therapy has its own life, and it was never talked about. One psychotherapist concluded:

"*I don't think it impinged upon it. I remember at the time I always knew when she'd met with you or whatever. And u... There were times when, and she would also, there was an acknowledgement from both around times that we would both be reflecting along the way, but… it didn't play a huge, huge part in there. Um… and I think because the transference within the psychotherapy was really quite raw and real, there was a sense of um… safety in that space anyway*,"

Psychotherapists of four adolescents talked about experience in participating in the research. One wondered if the follow-up questionnaires made a difference to the psychotherapy, while another commented on the structure and support provided by the research project. One commented clearly that what happened in the therapy room was independent of the research:

"*I never felt intimidated by it, it wasn't... it wasn't in the room. And it wasn't like I felt like I had to... you know… show off or be some kind of a way. I just felt like we could be real about it all...*"

For six of the psychotherapies, the positive benefits of the research re: psychoanalytic psychotherapy was reported as a theme. All commented on the Time for a Future research project having enabled the provision of psychoanalytic psychotherapy and clinical

supervision. Three also discussed how the research provided extra support and reflection. One psychotherapist summed up the sentiment of the group:

"*I think it was fantastic because… you know... it allowed... um... firstly it allowed that work, um... because CAMHS weren't doing that work, they weren't in that position to do that work, they didn't have people necessarily who were trained to do that work ... um... and also, they weren't really...you know... allowed, almost. It was… you know... it was difficult, I think. I think the CAMHS I was at... I mean I'm thinking about the CAMHS now, they just don't do any treatment now. Um… Back then, fortunately they did do some. Um… but um yeah... there's just no way, psychotherapy would've been possible, without the project...yeah. I think so, so important! Because you're talking about the most vulnerable people that you can imagine, really*."

For three of the adolescent psychotherapies, a theme emerged that there was an independent value in the research. One adolescent was interested in the research itself. All three adolescents were commented upon as having a positive ongoing connection with the research after the psychotherapy had ceased, and that it provided another form of care. In the words of one psychotherapist:

"*... just the idea of following someone up for so many years and connecting, is bound to be a real gem for those young people, I think. It keeps them kind of thought about*."

8.3 Findings 3: Integrative summary

A thematic content analysis was used to analyse the data from seven psychotherapist interviews related to the psychoanalytic psychotherapy of seven of the ten adolescents

discussed in Chapter Seven. In conducting the analysis, it was surprising how closely the themes emerging from the psychotherapists' interview narratives paralleled those found in the adolescent narratives. The final matrix structure for the adolescents did in fact provide a template for the development of the final matrices in the psychotherapists' data.

In the first domain of enquiry, the psychotherapists outlined the difficulties the adolescents were experiencing when referred for psychoanalytic psychotherapy. They described extremely at risk, vulnerable adolescents with complex mental health and trauma issues, comorbid diagnoses, and early attachment-based difficulties. According to the psychotherapists the adolescents were referred for treatment for a variety of reasons including inappropriate behaviours, dysregulated feeling states, and symptoms of depression, anxiety and psychosis.

The socio-cultural context of the adolescent was a domain that enhanced the description by the psychotherapists of the adolescent's circumstances when they presented for psychoanalytic psychotherapy. This domain of enquiry resulted in three sub-domains, firstly a description of the family, school, and neighbourhood of the adolescents, secondly, the adolescent's interests and behaviours, and lastly, the peer culture, behaviour, and sense of belonging as described by the psychotherapists.

In the first subdomain the theme of neighbourhoods was raised, and lower socio-economic areas with limited employment opportunities and social difficulties were described for half the adolescents. In addition, the theme of geographical isolation and lack of infrastructure was seen as having a significant impact on some adolescents. However, the theme of school and school culture was seen as an extremely important mitigating factor for many of the

adolescents, and the positive attempts by the school community to engage students were highlighted. The final theme regarding all of the adolescents was their family and living situation. Four of the adolescents were separated from at least one or both of their parents, with two in out of home care, and three with deceased parents. One was from a culturally and linguistically diverse (CALD) family. A theme of limited internal and external resources in the parents of four adolescents was identified, and for two adolescents limited financial resources impacted on their ability to travel to their sessions. One family was described as aspirational, and another adolescent was seen as isolated even with the family environment.

In the second subdomain regarding interests and behaviour, the majority of adolescents were not only interested in listening to music, but embraced the fashion associated with the genre, bands and performers of their choice. Particular reference was made to heavy metal, alternative, hard rock and gothic music cultures. Other creative pursuits such as singing, and anime were identified. Finally, a theme related to the influence of the internet, gaming and chat was described. At this time communication was predominantly texting on mobiles, and whilst multi-media was less prominent than the present day, it was still a significant source of information for adolescents.

The third subdomain related to peer culture, behaviour, and sense of belonging, and resulted in several higher order themes which revealed half of the adolescents were isolated and disconnected from peer culture. Over half the adolescents used alcohol and drugs, and particularly took part in binge drinking. For some clubbing and rave parties were part of their experience, some spoke of their interest in boys, watching TV, and visiting peer's homes when the parents were absent. Two psychotherapists observed that having similar difficulties and mixing with those who were drinking and using drugs appeared to be the basis for the

development of some friendships. Only three adolescents were observed to have a connection to a peer group through school, and only one appeared to have additional connections in the neighbourhood and community. Half of the adolescents had minimal or no connection with peers, with some unable to link with teenage peer culture at all.

The third domain of enquiry was the overall experience of the adolescents in psychoanalytic psychotherapy as perceived by their psychotherapists. Like the adolescent data, the themes here divided into five subdomains. Firstly, at the beginning of psychotherapy, themes noted were the strengths of the adolescent, including reflective capacity, desire to work and other ego strengths. Other comments related to the influence of prior treatment on engagement and the process of engagement with the adolescent being unsure what to expect but having strong needs for a close nurturing relationship.

The subdomain of enquiry relating to the structure of psychotherapy was considered by all psychotherapists as important for containment of unconscious and conscious projections which were potentially harmful to the adolescent or others. Themes about the safety and privacy of psychotherapy, and the flexibility of the psychotherapist were seen as important in maintaining an ongoing connection for adolescents. Most discussed the importance of working with other systems in the adolescents' lives.

The majority of the psychotherapists identified the processes of psychoanalytic psychotherapy as helpful to the adolescents, allowing time for trust and understanding to develop in the relationship. A thoughtful, attuned relationship was seen as important for the adolescents in helping them move towards positive change.

No participating psychotherapists identified psychoanalytic psychotherapy as a globally negative or unhelpful experience. However, a few identified as unhelpful the cancelling of sessions, and premature termination before the adolescent was ready to finish. Three psychotherapists identified that the boundaries established in the relationship might have been experienced as unhelpful but were needed, particularly for adolescents where there had been boundary transgressions.

In the fifth subdomain, all psychotherapists discussed the reasons for ending psychotherapy. Only one observed that the adolescent was ready to finish, while increased distance and time taken to get to psychotherapy were the main overt contributors for ending for some others. Psychotherapy was not considered a cure as the adolescents still had considerable difficulties, and all psychotherapists,' hoped the adolescents had got enough from their psychoanalytic psychotherapy to achieve their development tasks, and that they would seek help again if and when it was needed. Most commented on how the experience could have been improved if some adolescents had been seen either, as children, or more frequently, or for a longer treatment, and if services like CAMHS remained involved after the adolescents turned eighteen.

The psychotherapists gave rich descriptions of their experience, with most continuing to think about the adolescents and wanting to know how they were going. Most reported a positive learning experience that was challenging and engaging. Four described how the psychotherapy evolved to match the perceived needs and functioning of the adolescents. Most described the work as intense, and difficult requiring ongoing thinking and analysis of the relationship dynamics, strong transference and countertransference, and of the vulnerability of the adolescents in general.

The psychotherapists reflected upon the adolescents' view of the relationship according to their understanding of the psychotherapist's role, the psychotherapists' qualities and the adolescents' capacity to use the relationship to do the work of psychotherapy. Participants raised themes concerning six of the adolescent's attitude towards the relationship, this varying from positive to mixed, and dependent upon the adolescent's internal state at the time.

All participants viewed their relationship with the seven adolescents in terms of what they as psychotherapists brought to the relationship, and most considered what the adolescent brought to the relationship as well. Most discussed the theme of the therapeutic role, and all described the nature of the relationship. These themes were examined in great depth and were integrated with process observations within and between the psychotherapist and the adolescent in their relationship.

The psychotherapists reported on their recollections of the parent/carers, with most having had minimal contact, since the parents were seen by CAMHS. The psychotherapists experienced most parents as supportive of psychoanalytic psychotherapy and concerned about the adolescent. All participants indicated that the majority of parents struggled with their own mental health and grief issues, minimal finances, and sole parenting of adolescents who were very disturbed and unwell.

The impact of psychoanalytic psychotherapy on the adolescents' relationships was viewed as positive. Five adolescents with considerable difficulties prior to psychotherapy were observed to have positive changes in family, peer and other relationships during psychoanalytic psychotherapy. Adolescents were observed to acquire new skills, develop a

greater capacity for intimacy, and an improved relationship to the self, which was observed to help in their relationships overall.

In the domain of understanding the adolescents' psychological difficulties, all psychotherapists had thoughts about the onset, with three adolescents, their psychotherapist's reflected upon difficulties arising during infancy, for four adolescents it was in early childhood, and for two, losses occurred during adolescence. All considered personality and attachment factors, with two noting the resilience of adolescents under extraordinary circumstances. The psychotherapists of five adolescents described them as having extreme difficulties in relationships and experiencing considerable isolation. All alluded to themes in adolescent development, with the psychotherapists of five adolescents reporting them as struggling with aspects of their identity. Three adolescents were reported as overwhelmed and confused by the tasks of adolescence because they had not reached that stage of development emotionally.

In the domain of changes due to psychoanalytic psychotherapy, the psychotherapists of six adolescents perceived positive outcomes from psychotherapy, which included improvement in symptoms, well-being, and behaviour. Self-harm was also reduced. For six of the adolescents, their psychotherapist's spoke about the contributing psychotherapy processes that enhanced change.

Whilst there was acknowledgment that there were other influences on change, and that it can be hard to apportion these influences, three participants considered that psychoanalytic psychotherapy was either the most important or most significant influence at the time. For all seven adolescents, their psychotherapists considered that the positive outcome in their well-

being, relationships, functioning, and survival were related to psychoanalytic psychotherapy. Three adolescents had been at high risk of death by suicide, and they remained alive.

Finally, the impact of the TFF research project on the psychoanalytic psychotherapy was explored with the psychotherapists. Three believed the research had no impact on the substance of the psychotherapy, but the psychotherapists of six adolescents extolled the positive benefits of the research, as it had enabled the provision of psychoanalytic psychotherapy and clinical supervision. For three adolescents, the psychotherapist also regarded the research as having an independent value as it held the adolescents in mind over time and provided an ongoing connection after the psychotherapy had ended.

CHAPTER 9

FINDINGS 4: DIRECTORS OF CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) OPINIONS CONCERNING THE CONTEXT OF ADOLESCENT PSYCHOANALYTIC PSYCHOTHERAPY 2002-2012

The directors were asked to reflect upon the context and potential future place of psychoanalytic psychotherapy in the public health system. One domain of enquiry was comparable to a domain for the young adults and psychotherapists namely that concerning the socio-cultural context of the adolescents during their TFFP psychoanalytic psychotherapy which occurred between 2002 to 2012. The directors were interviewed between 2011 and 2012 and made concerted efforts to recall and reflect on the preceding decade in CAMHS.

For each domain of enquiry, the higher order themes that emerged are presented and discussed, beginning with broad and general themes, and progressing to those that are more specific and in-depth, illustrated by typical quotations from transcripts. When considering the data, it is noted that the directors definitely spoke in a general way, as they did not know which particular adolescents were included in this particular study.

9.1 Process of arriving at final matrices

The method of systematic thematic content data analysis conceptualised by Miles and Huberman (1994), and described in Chapter 5, was used to analyse the interview narratives of the seven director participants, in respect of each of the domains and subdomains of enquiry. The distilled higher order themes for each domain reduced to nine matrices overall, which

included three subdomains in the CAMHS context domain of enquiry. These findings are presented successively in Section 9.2 below.

9.2 Domains of enquiry:

As described in Section 5.4.3 of Chapter 5 the interview with the directors of CAMHS embraced six domains of enquiry. These were:

- expectations of the TFFP research
- socio-cultural context of the region for adolescents
- the CAMHS context
- what clinicians need, to work with seriously mentally ill adolescents
- thoughts about working with adolescents with serious mental illness
- the place of psychoanalytic psychotherapy theory and treatment in CAMHS.

9.2.1 Domain of Enquiry: Expectations of the Time for a Future Research Project (TFFP)

Each director was asked "Thinking back to when this project began in early 2002, what expectations, if any, did you have regarding the project in CAMHS?" All seven participants spoke of their expectations of the TFFP and the final themes emerging in this domain are presented in Table 37 below.

Table 37: Directors: Expectations of the TFFP

Higher Order Themes	Number of participants mentioning theme
Project provided an additional clinical resource of psychotherapy	**5**
Reservations about psychoanalytic psychotherapy treatment	**3**
Psychotherapy provided would benefit some clients	**4**
Research would be beneficial	**7**

Five directors expressed the theme that the project provided an additional clinical resource to their range of services. Factors such as the treatment not carrying a cost for the service, providing the service with extra staff, and providing a treatment that was not otherwise available, were mentioned. One director explained that the service would not have paid for the treatment. Some stated that over the past decade some services had acquired free psychology clinics, attached to psychology training in universities which sometimes could provide medium term work. Another commented on the need for extra treatment referral options.

"...At a selfish level, there [the TFFP] was another avenue in which one can refer cases on following assessment, rather than us having to take on .... the cases as they presented to us."

The theme of reservations about the use of psychoanalytic psychotherapy for adolescents was raised by three directors. Two believed that it would not have been the treatment of choice, suitable for only a small proportion of clients would be suitable. Anxiety was expressed that clients mainly came from disturbed family backgrounds and exhibited conduct problems.

Other considerations were that the teenagers were hard to engage, family dynamics made it difficult to form a working relationship, and that family therapy would be a more robust treatment. A consideration for one director was communication around the psychoanalytic psychotherapy within the service:

"I think the challenge for us was how to integrate... um sort of... parent work and case management with the psychotherapy, and make sure there were good structures and good communications. So that it wasn't, ... it wasn't sort of... walled off as someone going to see a private therapist, and you'd never quite knew what was going on. Or the private therapist didn't know what we were doing with the family work."

The theme that psychoanalytic psychotherapy would benefit some clients was tendered by four of the seven directors. Two believed there would be a positive benefit for some and would at least do no harm. One commented that the CAMHS clinicians themselves believed that psychoanalytic psychotherapy was helpful. Two other directors described access to psychoanalytic psychotherapy as a valuable opportunity. One was confident in the standard of care provided by the psychoanalytic psychotherapists through their knowledge of the specialised training the psychotherapists had received. Another lamented a decreased capacity to provide ongoing psychoanalytic psychotherapy in the service. The general difficulty of providing ongoing treatment to clients was described:

"*... It was ..... difficult in having, first of all, staff who were trained and qualified [with]... post graduate qualifications in doing this work. Also, just difficulty with the volume of referrals coming in, to have staff that were able to do that... As, at that time, as I recall,... we were probably, say... it was sort of that wave or Tsunami ... but it was probably the time we*

were getting more crisis presentations, so there was much more of a focus on trying to do more crisis interventions. And it was very difficult in the volume of work to be able to wall off time, to do that [psychoanalytic psychotherapy]. So for us it was like a great opportunity, as I recall, to think, "We've got some extra opportunities, now for providing ongoing longer term therapies which we wanted to do, but didn't feel we had the staff, because of the demand at the front end.""

The final theme distilled from all seven directors' responses, was that the research aspect of the project would be beneficial. Two directors specifically talked about the benefits of the research for the clients and their services, and one wanted to build research connections. Six of the directors spoke about the benefit of investigating the effectiveness of psychoanalytic psychotherapy with adolescents, and of possible outcomes. Various comments supported clinical research, stating that it was an opportunity to add to research on psychoanalytic psychotherapy, in particular, because its relative efficacy was being questioned, and that eclecticism in evidence-based treatments was desirable. Hopes were expressed by three directors that psychoanalytic psychotherapy would have good results, that the research would be useful, with clear findings of a degree of effectiveness for particular problems. One said:

"*...I thought that it would, or might, provide evidence to show whether or not this was an effective treatment, and whether there were particular problems that it was more effective for, and that it was least effective for*."

9.2.2 Domain of enquiry: Socio-cultural context for adolescents in the region

Five of the directors were asked the question "Thinking back to 2002... What do you think it was like for adolescents growing up in the [*name*] region of (Melbourne or Victoria)?" The two directors who helped with pilot interviews were not asked this question. However, the narrative of one of the directors in the pilot interview added to one higher order theme in this domain.

The directors worked hard to remember 2002, and generally spoke about the ensuing decade. Some directors found this question difficult to answer because they did not want to make generalisations, and this issue had not necessarily been their focus as a CAMHS director. There was a tendency to relate it to the CAMHS service, its operation within the region and the CAMHS population that sought treatment. Four final higher order themes were distilled, as presented in Table 38 below.

Table 38: Directors: Social-cultural context for adolescents in the region

Higher Order Themes	Number of participants mentioning themes
Overall youth in the region were a typical adolescent population	**3**
Description of rural & metropolitan regions & their different challenges	**5**
Role of social media	**2**
CAMHS youth extremely high risk, exhibiting high risk behaviours, vulnerable & deprived	**5**

One theme emerging for three directors was that youth in the region were typical of adolescent populations generally. Youth in the region were thought to be typical of a lower socio-economic group, with some social disruption and violence.

Five of the seven directors raised a theme concerning differences and challenges facing rural as opposed to metropolitan areas within regions. Two spoke specifically about the challenges facing rural communities which were mainly of Anglo-Saxon heritage, and how adolescents struggled with access to appropriate services, lack of social support, and isolation. One commented on the lack of anonymity in rural areas, and how this lack of privacy and potential stigma impacted upon adolescents needing to access mental health services.

Only one director described their metropolitan region as having reasonable resources and infrastructure. Three commented on their CAMHS servicing large geographical areas, with diverse populations, and lacking resources and infrastructure. Two of these spoke of the challenge of meeting the needs of such populations over a large region, including the problem of the time needed for service clinicians to travel great distances. Two others expanded on the challenges to providing a service to a population growth corridor, where limited resources and planning created problems for adolescents. To describe the population explosion in the growth corridors, the lack of planning for adolescents, and this leading to boredom and sometimes petty crime. One of these directors commented:

"*...There were not many resources yet .... so, they formed gangs, meaning they would be hanging around in railway stations. So, ... say, ... [name] railway station .... has a notoriously bad name to it. .... And the other thing - they do hang out .... in... shopping malls... If you look in terms of the [name] area .... they form gangs along ethnic lines ....*

Which can be [a] strength. It can be [a] weakness .... as well. ..... There wasn't the traditional cultural activity, - music, sport, - those sorts of activities that the young kids could do."

Two directors raised the theme of social media and its rapid change over the decade. One commented on the increased shifts in internet and phone use by adolescents. The other commented on the changing role that social media itself has, remarking that ten years previously the debate had been whether or not to email clients, and how far that had shifted with the growth of social media.

The final theme in this domain, raised by five directors was the differences in the nature of the adolescent population seen in CAMHS as compared to the general adolescent population. Adolescents referred to CAMHS were seen as being from high-risk, vulnerable groups, including traumatised children in out-of-home care, or residential units, those who had experienced extreme levels of abuse and trauma, adolescents with no family or in closed religious groups whose adults chose isolation from the general community. The CAMHS population was described as coming from backgrounds of extreme deprivation, disorganisation, and disadvantage. One director spoke of these problems:

"...in public mental health services .... the kids that present are .... from disadvantaged, and deprived backgrounds, where there is disorganisation, parental personality disorder, parental psychopathology, poverty, generational impairment in social relations and parental functioning..."

Four directors described at risk behaviours, such as alcohol and drug use, self-harm, non-attendance at school, and hanging out in malls. One director described a culture of alcohol misuse, an increase in substance use, and a shift over the decade from opiates to the current epidemic of crystal meth. A prominent "Emo" culture (a specific youth subculture), self-harm and suicide risk, was seen as increasing over the decade. Two directors particularly focussed on non-attendance at school, with one commenting in detail:

"Sometimes they've had huge school absences and their school achievements are pretty minimal ...um ...Their basic ...mm... literacy, numeracy is really terrible, so we've got secondary problems with these young people, and they may have learning problems as well that haven't been identified. ...Um ... And there is a bit of complacency, particularly if they've got behavioural disturbance. That ... um... it's not their right to actually ...YK... It ***is*** *their right to be going to school and, somehow that gets... that falls off the equation of trying to look at how to link them in. Or there is no appropriate school, mainstream school that can actually manage them and tolerate them. So, they've really dropped out of education, which is going to be such an additional burden for them on top of whatever their psychiatric, psychological problems are."*

9.2.3 Domain of enquiry: The CAMHS context

Two broad questions concerning the context of CAMHS were asked of the directors. These were "What were CAMHS like back in 2002?" and "How might CAMHS differ now?" In this domain, then, the directors reflected upon how CAMHS were in 2002, when adolescents were first referred to the TFFP, and also upon how change had occurred in CAMHS in the ensuing decade until 2012, when the interviews were conducted. Emergent themes appeared

to fall into three groups and so three subdomains were created here. The first comprised descriptions of client and staff groups, and service functioning, programs, and processes. The second encompassed themes of service growth and change. The third related to themes concerning challenges and controversial debates around the practice of child and adolescent mental health over this period. The subdomains are presented in sequence as set out above.

9.2.3.1 Description of CAMHS client and staff groups, service functioning, processes, and programs

In the first subdomain, the responses of all seven directors filtered into the four final themes presented in Table 39 below.

Table 39: Directors: Description of staffing, functions, processes, and programs of CAMHS

Higher Order Themes	Number of participants mentioning themes
Descriptions of the CAMHS client group as vulnerable and high risk	**4**
Description of CAMHS clinicians (gender, age, training & experience) & recruitment difficulties	**5**
Description of functioning of service, programs, training, support & processes	**6**
Difficult work and criticisms of service models & functioning	**6**

A theme describing the level of disturbance of the client group was raised by four of the directors. Three of these described the group as high risk and vulnerable. Two of these

directors specifically explained that it was the mandate of the public system to provide a service to those with serious mental illness, and thus to focus on the needs of high-risk groups. Difficulties were described in providing a service to adolescents who felt pressured to attend appointments at the service, rather than being able to attend of their own accord. The nature of the individuals' disturbances obviously affected their responses to the service. Adolescents with non-attendance at school and those who were not engaged in school or any other programs were especially resistant to attending a CAMHS. One director commented that there were different groups of adolescents, and that there was a lack of early intervention for high-risk groups. He had observed four groupings of adolescents, one that had no significant mental health issues and did not need services, a sizeable number with minor but significant mental health issues managed by GPs and private practitioners, those with significant issues who were not in crisis and their difficulties had gone undetected, and the at-risk teenagers who get a service due to severity and complexity of presentation. This director considered that through lack of early intervention adolescents were not referred to CAMHS until they had reached mid-adolescence, were in a state of crisis, and lacked school or other environmental stability.

Another director articulated that there were increasing child mental disorder rates across all ages, linked to fractured social connections, lack of supports, and lack of predictability and manageability in young peoples' lives. These high rates were considered to be not just a product of war-torn countries, but occurring in competitive, consumer driven and individualistic societies as well.

Description of the clinicians employed in CAMHS was a theme for five of the directors. Three considered the impact upon staff of their CAMHS covering a large geographical area.

Two of these articulated themes related to difficulties in recruitment, as the further regions were from the city or large rural centres, the harder it was to recruit. Often young clinicians with potential would be appointed and then move elsewhere to improve their career paths. At times recruitment and maintenance of positions was challenging, necessitating strong attempts to support staff in isolated areas. Another director described how the further the distance away a community was from the CAMHS, the less staff could understand the community's needs, so that the capacity of CAMHS to link with the community and its local services was lessened.

Four directors made further comments describing their respective CAMHS clinicians. One described an experienced multi-disciplinary, large, strong, stable, connected staff group with minimal turnover, a variety of skills and interests, and each of whom did a spectrum of things. As it was a large group, not all clinicians ended up working with every type of presentation, thus only some staff members were attuned to working with out-of-school adolescents. Another director described typical CAMHS clinicians in a rural area, as comprising a core group of experienced, skilled, resourceful, Anglo-Saxon females over the age of 40, with a few males and entry-level clinicians. There was an emphasis on working with the local community. Another service had staff who had limited experience working with adolescents as compared with children. One director talked about a high turnover of staff and hypothesised that this was related to gender, stating:

"I don't know what the turnover is, but it's usually fairly high, as predominantly a female population. Quite a lot go off to have families, some don't return, or go into private practice. With the new mental health items, there's been a kind of exodus from the public system."

A theme describing the functioning, programs, processes, training, and support within CAMHS was richly detailed by six of the seven directors. Two directors emphasised that CAMHS had retained a child orientation, as they were not embedded in adult mental health services. Their emphasis was on children in CAMHS, and one reported 50% of their services were for children less than twelve years old. One director believed that services in Victoria were well organised. Two of these directors stated that their services had multiple approaches and programs across all age strata. Comments included there were weekly meetings of multi-disciplinary, multi-modal, multi-age strata and multi-specialist teams, there was a range of one-to-one work with adolescents, there was openness to treatment diversity, eclecticism of approach was encouraged and hoped to be retained, there was a spectrum of age-appropriate programs, a variety of treatment modalities, a specialist focus on working with young kids and a healthy debate and respect for multiple approaches. Further, two directors emphasised developmental focus, clinical formulation and complexity in the CAMHS perspective. Thus, developmental theories and clinical skills were incorporated in formulations, and both emphasised the importance of multiple diagnoses and psychodynamic systemic formulation for implementing a workable management plan. One director described the approach of his CAMHS service thus:

"*...the bulk of our patients seem to have significant emotional and behavioural problems ..... really related to their growth and development in the context of their biological, social and family environment. So, the labelling of the patient as required by many people… is only one component of our understanding. So, the formulation means the understanding, what is going on with this particular person, that will become the important thing in terms of drafting a management plan. And also, the implementation of it, in a pragmatic and workable manner. ... Okay.... So of course, by doing that, we're talking ... a lot of skills involving the*

clinician in their understanding of it, because there can be so many theories about why a person develops certain symptoms or personality traits ..."

One director spoke of being unable to provide psychotherapy in a metropolitan growth corridor. Theirs was a crisis-driven service, involving consultation to three hospital emergency departments, which the community had discovered was the quickest way for an adolescent to get an inpatient admission. In contrast, a director at another metropolitan region was comfortable with the service's functioning, thought it was running smoothly and that there were no major problems. Intake, allocation and assessment processes and procedures were well worked out, so that there was no wait list, and people were seen soon after the first contact. The majority of cases were concluded quickly, but a minority continued for various lengths of time. Allocation considered staff capabilities, and intake predicted what treatment and staff match was the best for the client's needs. There was some outreach to one area, but this was sometimes found to be as difficult for the adolescent, as was attending the CAMHS centre itself:

"... Some came under duress because they were clients of the Department of Human Services, and saw coming to the clinic as a way of getting their case worker off their back, rather than uh… their preferred way of spending their time. But um… outreach and seeing young people in their own patch, was only occasionally used. Not because we had any kind of objection to it, but because just engaging them in a an agreement whereby that would happen ah... was just as fraught with difficulty as arranging for them to actually come and keep an appointment. Either way, they're not famously reliable."

Five of the seven directors described staff training, supervision, clear clinical processes, and staff support as essential in their services. One emphasised that new clinicians were well supported, and external facilitators provided supervision. Another reinforced that supervision was expected, and that there was a focus on staff training and supervision. One described staff support, and supervision as provided by public sector psychiatrists in their service. Another emphasised the necessity for good standards of clinical supervision, support and accountability. Yet another director of a large region described central support through phone supervision and bi-monthly consultant flights to lone clinicians in isolated communities. Unsupported staff had been found to leave the service.

The final theme, raised by six directors in this subdomain, involved recognition both that CAMHS was difficult, and that CAMHS service models and functioning could often be criticised. Four directors described the work in CAMHS as hard. Various comments were that there were routine but difficult challenges, that the work is especially hard in community teams, and that staff burn out with complex cases, such as those involving anorexia and borderline personality disorders.

From a different perspective, four directors focussed on the criticisms of CAMHS during the relevant decade, with four also acknowledging there was a need to improve links with community services. Processes cited as needing improvement were the engagement and sharing of information more easily across services, acceptance of referrals from protective services when the adolescent was not in permanent care, and improved connection with schools and teachers. One director commented that CAMHS and Child Protection in the region had similar difficulties, with insufficient resources and high staff turnover due to burnout. Another commented that there was no infant psychiatry embraced by CAMHS, and

also that CAMHS had a tendency to have a blaming stance, for example in respect of parents. Yet further criticisms of CAMHS functioning included a lack of early detection of mental illness, inflexible assessment processes, being a family focussed, office-based model, considering the clinicians' needs rather than the clients', and split loyalties for disciplines, caught between their local team requirements and that of their state-wide discipline groups. This director was strongly critical of the CAMHS responsiveness for an exceptionally large region:

"We didn't have community teams as in assertive, go- to- people's- home, meet-people somewhere- else teams. We had a child and adolescent team here. It was based here in the building. They never went outside the door. Everyone had to come to them. Well, I mean, that meant of course about a third of the adolescent population was excluded [be]cause they were never going to come here. When I say a third it was probably more like two-thirds."

9.2.3.2 A decade of growth, change and shift in focus for CAMHS

Responses of all seven directors to "What were CAMHS themselves like back in 2002?" were distilled into a second subdomain, relating to changes in CAMHS from 2002 to 20012 encompassing the five final themes presented in Table 40 below.

Table 40: Directors: A decade of change for CAMHS

Higher Order Themes	Number of participants mentioning themes
There was a lot of change at the time	**1**
Multiple demands for CAMHS to change from external & internal sources	**7**
Service gaps change processes systematically planned by CAMHS	**5**
Reactions to change varied amongst CAMHS staff	**3**
Multiple changes were implemented	**5**

One director summed up the themes here by commenting that there was a lot of change happening at the time. This director further added that there was always a lot of change in mental health and CAMHS, but particularly across this decade.

All seven directors identified a theme of multiple demands for CAMHS to change, emanating from multiple external and internal sources. Four directors emphasised an increased focus on CAMHS efficiency, involving outcome measures, and accountability for service delivery. Two spoke of increased administration, increased bureaucracy, tighter management, increased scrutiny of practices, and a demand to justify what the service did and how the budget was spent. More rigour was described around supervision, standards of care, review structures for critical incidents, and improvement in data collection and analysis. One director described this process as moving from autonomy to accountability of CAMHS.

Two directors observed that there was an increased community and political demand to provide mental health services for adolescents, and this was emphasised by the Department of Health and Human Services (DHHS), with increased referrals due to increased publicity and information to community services. CAMHS were actually directed, it was said, to take more adolescent referrals. In addition, two directors identified that the services needed to be more responsive to crises in adolescents. There was a government Departmental focus on youth suicide responsiveness, with provision for extra training in crisis assessment. Another director identified access challenges, and waiting lists could no longer be run, as disturbed adolescents had been waiting too long or not getting a service. Culturally diverse groups were not referred to CAMHS, and nor were their adolescents accessing what the service offered. Outreach resources were seen as needed to improve access for disturbed adolescents, and the service needed to expand its focus to the growth corridors and future demands.

Two directors reported that CAMHS resources were increased across the State around 2002. One director spoke of growth and freedom to develop services and change their delivery, and that with the establishment of new teams there was good morale, a culture of learning, experimenting, professional development, study and research opportunities and academic university links. One recounted becoming a larger more comprehensive service, with child and adolescent inpatient units, and that there was multi-disciplinary access and visiting psychiatrists for new rural services. The other stated that since 2007 there had been further psychiatry discipline resources to regional CAMHS, with only one regional CAMHS not having regular psychiatry outreach to more remote areas.

Three directors reflected on a reduction of time spent on direct clinical work that was occurring, although the reason for this was unclear. Nevertheless, there was a departmental

demand to increase the proportion of face-to-face work. Long term therapy was not provided, the length of contact being about eight sessions in one service. Another commented that CAMHS outpatient costs were greater than those of private practitioners, and waiting lists were still a problem for most CAMHS services. Work practices were examined, and one director noted that providing secondary consultation only would lead to loss of skills, and dissatisfaction for clinicians.

Within the CAMHS themselves, different models designed to meet the needs of adolescents had been called for by three directors. Two directors commented that in the face of a lot of change, the traditional approaches were not meeting or serving the needs of people very well. One director emphasised the service for older adolescents was not good. Another director observed that there needed to be more services, so the quality-of-service delivery was better, and that the transition zone between adolescent to young adult was badly catered for.

Within CAMHS again, one director and his service identified they had a poor understanding of traumatised refugees and their fears of psychiatric services, and poor understanding of their indigenous communities. They needed to be more responsive, and increased collaboration with other services was needed. This director summed up the demand for change in the early 2000s:

"*It was probably just a time of a lot of change and us becoming aware that the more traditional approaches were not really capturing this huge need. And we were recognising we were drowning in the need as well. So, we wanted to go out there and see who was requiring the service. But there was a bit of trepidation that we wouldn't be able to cope with that volume, so we needed to be thinking much more, as we are now, around secondary*

consultation models and partnerships. As well as that, trying to retain the capacity, linked in with this project [TFFP]- to be able to do long term work, so that we didn't .... only provide brief crisis type interventions. So that was the risk I s'pose - to try and look at demand management and still preserve that... um ...And have staff who had capacity to work - both in longer term therapies and in shorter term therapies."

Five directors raised the third higher order theme of both CAMHS and the Department identifying service gaps, and of CAMHS developing a planned, systematic change process. One director considered that a first step to increased responsiveness was mapping the diversity of the geographical region, and that regional needs and access issues required reflection regarding their client group. Two directors discussed the need to learn from work done elsewhere. One director proffered we could learn from British examples. Another director spoke of the distinction between public and private treatment in the U.K., with a more pragmatic management of resources than Australia.

Two directors suggested that change in terms of research and quality care processes were needed. One director advocated development of a learning and enquiring organisation, which could analyse how it worked, through reflective practice. The other indicated that the population requiring a service had to be defined, as well as effective treatment through monitoring quality of service. Treatment should be consistent, reliable, and obsessively delivered, as recommended by research.

One director stated that different service provision models needed to be examined, and another commented that change takes time, and there needed to be a demonstrated cost-

benefit analysis. The latter director summed up a suggestion for initial proper funding of services which can then be assessed for their effectiveness:

"*I think the problem has been that they've not actually invested properly in a tool that is based on the Australian Survey and other information, to estimate the extent of the need, and cost the impact of that need on our society. Cost a decent service, build a proper model like Tolkien 2, or something else that is more evidenced based, and cost* ***that****. And show Treasury the money that's going to be saved by funding mental health services properly, and building not just the third tier, specialist tier, but building a second tier more effectively, and skilling up primary care more effectively. [Be]cause they haven't done those bits properly, and they're the bits that need to deal with the majority of the problems*."

Only three directors raised themes relating to the varied reactions of CAMHS clinicians to the demand for service change. One director described staff as accepting, and responsive to service demands, and recognising the reality of the situation. Another director identified some fears about working with other age-groups, being swamped by increased demands, and that there had been some complacency in continuing familiar practice, despite recognition that there was a responsibility to change. The third director reflected on initial conflict around a new model of care, with a strong opposition among staff to a separate adolescent team. Here, the director said, there had been powerful resistances to change, and a battle to change the CAMHS model over many years.

Finally, five of the seven directors raised the theme of implementation of multiple changes by CAMHS over the decade. Two described making links with universities for research and establishing training clinics with formal academic positions. Two reported increased and

improved collaboration with other services such as Child Protection, setting up multi-sectorial review panels, and introducing partnership models which evolved to a consortium of services, providing training for a new service. One service was actually relocated, and another changed its service models to provide better access, integration of services and new services at different sites. Two directors reported program closures, decreased services for younger children and increased services for adolescents. One described an adjustment in workloads based on age, and a shift to more family work. The change in ratio of pre-schoolers and adolescents was estimated by this director in this way:

"*... In the earlier years, a quarter of our caseload were pre-school age, and a quarter of our caseload were adolescents. So, by 2002, ... about 10% pre-schoolers, and about 45% adolescents,*"

9.2.3.3 Challenges and debates concerning CAMHS across the decade

Challenges and debates within CAMHS across the decade were raised by the directors, resulting in the creation of the third subdomain of the domain of enquiry concerning the CAMHS context. All seven directors' narratives raised themes that contributed to this subdomain, as shown in Table 41 below.

Table 41: Directors: A decade of challenges and debates about CAMHS

Higher Order Themes	Number of participants mentioning themes
Present challenges compared to past decade	**3**
Resource challenges	**7**
Controversial Issues	**7**

Three directors commented on the higher order theme of current (2012) challenges facing CAMHS, and how they had changed over the preceding decade. One considered that the demand upon CAMHS was greater and the volume of referrals had become "incredible." This director identified several challenges across the decade, namely maintaining CAMHS specialisation which required specialised teaching, further training and staff support, secondly retaining a developmental focus and being more than a crisis service, thirdly meeting the demand for adolescent skill sets without neglecting the needs of children and infants, fourthly fearing the adult paradigm would become dominant, and lastly retaining the apprenticeship model of training. However, the other two directors stated that the challenges faced in 2002 and 2012 were the same, with one noting:

"*I think that child and adolescent mental health is not just the Cinderella of Psychiatry .... Psychiatry is the Cinderella of Medicine. But it's almost like it's a shade, or a ghost, in that it's just massively neglected. And so, the challenge of trying to meet need with less than half - much less than half the resources that's required, has really exercised most directors, and it has burnt me out...*"

The second higher order theme named by all directors was the challenge to attain resources over the decade. All of them commented on the insufficiency of resources to CAMHS, and five spoke of their various adaptations to this situation. Themes here were acknowledging the limits of government funding, and doing the best with what they had, working out where best to focus limited resources, isolated rural clinicians' obtaining back up from adult teams and central CAMHS consultations, and vocalising the need for further resources. The consequences of insufficient resources were variously described. For example, it was stated that data were recorded but not analysed, there were unfilled clinician positions, consumer

group positions went unfunded, and so did teaching and training. Two directors expressed an attitude of scepticism in relation to promised funding, one about extra resources attached to a proposed new model for CAMHS, and another based on past experiences of unkept promises.

Three directors discussed the impact of insufficient resources on the availability of services, with one saying his/her CMAHS had no resources for overnight crises. A director of another service with no inpatient unit saw this as a problem but remarked that this affected a small minority. The other director commented that CAMHS were simply not able to see enough adolescents in high-risk groups.

Five of the directors detailed the impact of insufficient resources on staff. Staff burnout and exodus from the public system were discussed by three of these. One director described adaptations in staff flexibility, resourcefulness, and collaboration with other services, while another described negotiating waitlists with another service's inpatient unit. One commented that staff who wanted to develop their clinical skills further left when the service began to provide a crisis only focus, that there was a resulting lack of experienced staff at the grassroots level, and that it was extremely difficult to recruit new staff in these circumstances.

Four of the directors spoke of the lack of critical mass in teams. One declared that smaller teams lose efficiency, specialisation, and skill development. Three spoke of critical mass being an issue for rural outposts and community teams in particular, and another described how for large geographical areas with multiple locations there needed to be specialist staff located at a home base service and a sessional outreach model. The latter director had found that specialist staff would leave if there was no collegial support from those that shared their interests, and that single practitioner positions in isolated areas were unviable, stating:

"*I think if you have a service like [name] service, that is a very big area to cover, with multiple centres of service delivery, you are far better to have your team co-located in a base, and [to] service those areas on an outreach basis. Because you will have then a multi-disciplinary staff who do a variety of work, who support each other, and are… are not too troubled by having to outreach on a sessional basis. But to be located by yourself, miles from anywhere, doing everything, - [a] recipe for staff turnover*."

Three directors further commented on the theme of differences in resources between metropolitan, semi-rural and rural services, with one stating that rural CAMHS had substantially less money, and that there were huge funding discrepancies between rural and metropolitan CAMHS. Another spoke of growth corridors with no additional resources and significant rural components that were not factored into funding for STD calls, travel distance and necessary infrastructure. The other spoke of the lack of inpatient resources for adolescents in rural areas. If there were only two ambulances, it was not always possible to get transport of an adolescent to the city in the evening, necessitating creative alternatives to keep the adolescent safe until such transport was available:

"*... So, you might be talking with the paediatric ward, and saying ... "This young person needs to be in hospital, can we have them there?" They'll be specialled [additional funded nurse with specialist psychiatric training]. Making all of those arrangements to try and make it happen. Or talking with parents about your concern around somebody's safety, and making it very clear that ... overnight, parents had to really look after their child in terms of safety, and what that meant ... um ...Or very occasionally, for older adolescents who were very disturbed, the adult unit. Needing to talk with the adult unit about "Can we have this*

young person overnight?" And "Yes, they'll be specialled again ... by [a] CAMHS clinician on the ward.""

The final higher order theme raised by seven directors, pertained to three controversial issues or debates within CAMHS over the decade. The first was that of medication use, and five directors expressed varied views regarding the role of medication in CAMHS. Two directors expressed the view that pharmacology had a minimal role, with one stipulating that medication was an "*aid to treatment and not a solution in itself*." Three spoke of using medication with psychotic illness or severe depression with a clear biological component, and as an aid to cognitive behavioural approaches for anxiety. Two directors specified the need for early medication for psychosis in adolescents.

Attitudes towards medication were discussed. One director commented that in the Australian context there was under-utilisation and an anti-medication stance, but Child psychiatrists in the region were appropriate in their use of medication, but improved use would result from better liaison between psychiatrists, paediatricians, and general practitioners. Another director considered that over-use of medication occurred, without a strong evidence base. Yet another director observed that the use of medication was seen by some as a failure, and this was partly related to the child focus in CAMHS training, rather than accommodating adolescents, who had different requirements.

A second theme of debate, raised by three directors, was that of the increased Departmental emphasis on evidence-based interventions. One director stated that cognitive behavioural therapy (CBT) had been the most researched of the psychological treatments, was more accessible, and was used by more psychologists, but that there was evidence for good

psychosocial care as being therapeutic as well. This director also discussed research on the role of medication and supportive therapy, which showed both were beneficial in severe depression. The question surrounding the ethics of providing treatments without an evidence-base was raised. Two directors were concerned about an overemphasis in the mental health field on randomised controlled trials (RCT) as the only kind of evidence base. One described this as limiting creativity. The other considered that RCTS are reductionist, and not relevant in a system that deals with great complexity. Further, a treatment without an evidence-base can be useful, and it is flawed to see it as ineffective. One remarked:

> "*... we appear to be in a time where things have become a bit reductionistic, and people want it to be... um... standardised in some way, and measured in some way, and ... everybody getting the same thing? ... And I actually think that that's unfortunate. That we will be doing young people a disservice ... if that's the way that services all go. ..... People go "Well here's the evidence" ... What's always tricky about "Here's the evidence" is that there are other things that are ... valuable, useful ... effective, that can't necessarily be measured in the same way*."

The third controversy, identified by five directors, concerned the emerging government policy that is CAMHS extend availability of treatment, from birth to 25 years of age. No longer would CAMHS service the young from birth to 18 years of age, moving beyond older adolescents into young adulthood. This had begun to be implemented in some regions towards the end of the decade, as a response to political recognition of the unmet mental health needs of young people between the ages of 18 and 25 years. There was uncertainty in the field about how this change would progress in other regions, and it appeared to be associated with a great deal of anxiety amongst the directors. These five were aware of a gap

in services and a failure to attend to the needs of people aged 18 to 25. However, there were reservations and concerns regarding the planning process, identification of the model to be used, and different model applications between regions. There were fears about insufficient resources, and about being able to preserve the developmental perspective and skills base of CAMHS.

Three directors expressed the debate very clearly and recognised young people between 18 to 25 years of age did need more services, and that adolescents may be better catered for by CAMHS. However, these same directors were fearful of insufficient resources, which would create a depletion of available resources to the younger age groups, particularly children and pre-adolescents, and were concerned that the promised additional resources for the extended age group would not be enough. One thought the CAMHS model was more inclusive, and was better to be extended to older adolescents, while one other observed the model of service used in the adult mental health sector had excluded young people in practice. Further, it was identified by one director that there was a clash between the adult psychiatry model and the CAMHS model in their treatment frameworks. This director discussed how the adult psychiatry model was best seen as a medical model, and that CAMHS and adult psychiatry had fundamentally different views on mental illness and feared that the adult psychiatry model would be the model that would prevail as a dominant model, leading to a loss of intellectual rigour and a loss of multiple conceptual frameworks in child and adolescent mental health.

Another of these directors was particularly critical of many aspects of the new model emerging. Themes included poor planning that had taken place thus far, that the impact of the youth model was unknown, pressure on the extension of CAMHS functions when there

were existing operational problems, that developmental, systemic, and psychological models would not be incorporated, and that it would be better to keep CAMHS, adult psychiatry, and youth services separated. This director was concerned that it could take years to recover from the damage done by re-structuring the system as was occurring.

One director summarised the changes over the decade and the new 0-25 model with a more positive slant:

"... I think quality of service delivery is hugely better than it used to be. I think it's a transient glitch that it has ... reduced the availability of services for younger age strata. Hopefully, that will be corrected in due course, because the… dawning light has been - the young people needed more services than they were getting and are now starting to get what they should be getting, not fully, but I mean a lot better than they were. And uh… a time will come for the correction."

9.2.4 Domain of enquiry: Working with adolescents with serious mental illness

Directors were asked the question "What are your thoughts about working with young people with serious mental illness?" All seven voiced thoughts in this domain. As the mandate of CAMHS was to work with the most seriously mentally ill, their responses were very much focussed upon CAMHS functioning and models of service delivery. The seven directors' narratives were reduced in this domain to the higher order themes depicted in Table 42 below. The order of these themes tapers from conceptualisation of service delivery and practice, through specific service delivery issues, and finally to the therapeutic relationship formed between clinician and adolescent.

Table 42: Directors: Best work practices with adolescents who have serious mental illness

Higher Order Themes	Number of participants mentioning themes
Models of practice to be supported by research findings	**5**
Collaboration of services and systemic conceptualisations of care	**5**
Flexibility in access, eligibility, assessment processes & setting	**6**
Large, multi-disciplinary, highly trained staff group provided with clear supervision & support processes	**7**
Building a therapeutic relationship	**4**

The higher order theme of the importance of research supporting the use of any model of practice was recommended by five directors. Four spoke about the biopsychosocial approach. One remarked how the linkages between the psychological and biological were unknown a decade previously, but that research was now revealing the mechanisms of biology, psychology, and social interrelationships. Two directors spoke about research evidence-base for treatments, and one discussed the need for discipline or rigour in conducting research and evidence of effectiveness. Another commented that there was a lack of 'gold standard' RCT, double-blinded studies in CAMHS age groups, and therefore:

"*I think we have a problem sometimes of what kind of evidence do we have, and understanding that,....so… to... to then inform well why are we saying this is useful? Um so... I think that's an issue, for us...*"

Five directors raised the specific theme of collaboration between services and systemic conceptualisations of care. Three talked about the benefits of CAMHS collaboration and liaison with community services, with one seeing it as enhancing the continuum and consistency of care, and another advocated shared electronic records across services. A third director suggested that CAMHS could monitor, through service links and good relationships between services, those adolescents who were at risk, and consequently provide an earlier intervention. One director viewed the work with consumers and carers as helpful, and that young consumer consultants, in particular, gave valuable feedback to services. Another director proffered that structural change was needed, but a genuine community-based model required a different conceptualisation at a senior political level, as it involved loss of control and authority over resources. This thesis was further elaborated:

"*... The less direct control and authority you have over your staff and your resource deployment, ...ah... the less easy it is to meet departmental key performance indicators, and other management sort of criteria that you're judged by. So that's how they're set up, that's a departmental systemic problem, an organisational problem. There's no incentive to change it, because it can only be changed by … really senior political kind of thinking - "We're going to ... arrange our key performance indicators, and our program budget allocation on the basis of how the services are deployed and get maximum effect for our dollar ... for the community, not for the department." - "They're focused on the department, not on the community*."

For six directors a higher order theme emerged of services needing to be particularly flexible in their access, eligibility, assessment processes, and setting locations. Four directors spoke to the emergent theme of service eligibility and access issues for adolescents. One director

observed that inflexible service structures were unhelpful and another that there was a need for a flexible youth-oriented service. Another director considered eligibility criteria were far more flexible in CAMHS compared to adult psychiatric services, stating that adolescents with eating disorders, for example, were seen in CAMHS but not in adult services, which led to discontinuities between the two systems as the adolescent moved into young adulthood. CAMHS covered a varied population of adolescents, and there were fears over the decade that increased demands would lead to eligibility restrictions. One director made several pronouncements, that the appointment-based model was not the best match for adolescent needs, that even services with drop-in capacity still had mostly appointments, that stigma was a barrier for adolescents needing to access CAMHS, that a school-based or youth-centred service would be better, and many mental health programs would be better placed in community settings.

Four directors raised the theme of family involvement and assessment processes with seriously disturbed adolescents. Three discussed the importance of beginning with an assessment, diagnosis, and formulation, in order to inform management and treatment of adolescents. One described in detail the nature of assessment in one CAMHS, which looked at the nature of difficulties, set change goals, selected a treatment modality, and monitored progress. Another director was critical of the CAMHS assessments, describing them as too long, resulting in a high dropout before they were completed. It was better to have a shorter assessment, as particularly disorganised families ended up having extended assessments. One director further concluded that individual therapy was not the best treatment for adolescents from disorganised, deprived backgrounds, which were common in CAMHS. Another director noted that the involvement of families had changed, over the decade 2002-2012, with assessments being more flexible, demonstrating:

"*... An increasing dialogue between a clinician, and a family and a young person about what's going to work for you now. And, if now is not the right time, okay... come back when you think it is..... That ... I think it's that kind of stance.... has changed*."

Two directors discussed the theme of the setting for working with disturbed adolescents. One director thought that an adolescent setting, such as a youth-based centre or school-based service was best, but that location was not as important as the skill of the therapist. Another director mentioned the theme of assertive outreach, stating this was needed by disturbed adolescents and "*office-based practice without follow up lacked responsibility to the community*."

All seven directors brought forth the higher order theme that a large, multi-disciplinary, highly trained, and well supported staff group was required to treat disturbed adolescents. Six mentioned the need for a broad range within the group of theoretical perspectives, interventions, and treatment modalities. Four participants expressed the need to have a developmental focus. Three spoke about it being helpful to have exposure to a broad range of trainings. Two spoke of the necessity for supervision, clear processes and staff support. A range of views were further expressed in this area, namely that the context is relevant in biological interventions, treatment needs to be tailored to the client's needs, there are common skills across all age groups, a larger staff group allows for specialisation, and a multi-disciplinary team is important. One director gave an example of how a successful, quality team was developed:

"...They ...felt that they were working in a place where their skills were valued, they had an opportunity to do whatever they were really keen on doing, and ... had ... colleagues to share it with. And ... a climate of ...um... positive support for continuing education and scientific presentations. And [you] couldn't get that in other places, so they stayed..... Pay wasn't the issue, status wasn't the issue. Work was the issue."

The final higher order theme, raised by four directors, in the domain of working with adolescents with serious mental illness, was building a therapeutic relationship with the young person. Interestingly, in this domain of enquiry, these directors shifted from taking a macro view to taking a micro view of working with disturbed adolescents. Two directors specifically identified the importance of the psychodynamics of engagement from which the therapeutic relationship grew. Various other aspects to building a relationship were described by one director, such as having a collaborative stance, and listening to the adolescent's priorities and stated needs, and further commented that this dialogue, involving listening to what the adolescent wanted to change, had improved in CAMHS. Another director commented on how thinking together with both the adolescent and the family was the key, that it did not matter if the therapist's conceptualisation was incorrect, because what mattered was the family thinking about the issues and how to change things. The therapist needed to detect the issues early and perceiving the client's communication would encourage early and constructive change. One director spoke of the importance of the psychodynamics, so that even when prescribing medication there needed to be a relationship with the adolescent and the family. Another director emphasised not blaming families, stating that sitting with the risk of suicidality is extremely hard, and it is important to bring others in to help. The need to tolerate risk and anxiety was further described:

"*...Hospitals are, risk adverse, which means there can be a trend to... um … think about how you minimise risk rather than sit with risk. And ...um... I think sometimes that can be unhelpful for young people - like - you can't admit everyone to hospital. Not that that necessarily stops young people killing themselves ... in hospital...*"

9.2.5 Domain of enquiry: What enhances clinicians' work with adolescents experiencing serious mental illness

In this domain, directors were asked "What do you think best equips clinicians to work with young people with serious mental illness?" Their narratives reduced to five main themes in this domain, and the final higher order themes are displayed in Table 43 below.

Table 43: Directors: Factors clinicians need to work with adolescents with serious mental illness

Higher Order Themes	Number of participants mentioning themes
Participation in ongoing training, education & supervision	**3**
Specific knowledge, education & training	**6**
Ability to work with systems	**4**
Particular personality characteristics & abilities	**7**
Ability to build a therapeutic relationship	**4**

Three directors raised a theme concerning the need for staff participation in ongoing training, education, and supervision. All three described a culture of working in CAMHS that was about continual learning, additional training, and supervision of clinical work, and it was

considered by one, as a "*lifetime education*." One director advocated being able to present, discuss and think about new ideas as important for clinicians. Another spoke of clinicians needing exposure to both child and adult mental health service paradigms, while yet another, spoke of further training in trauma, dual diagnosis, and substance use being necessary.

Six directors further emphasised that specific knowledge, education, and training are required for clinical work with disturbed adolescents. One went into detail about the specific knowledge and skills base, including being able to do a range of one-to-one work, to have a specialist problem focus working with adolescents, including a knowledge of substance use which is a growing problem in adolescence. Four directors mentioned the need to have knowledge of multiple treatment approaches, and three of these directors highlighted the critical importance of a developmental perspective on adolescence. Another considered that generalist skills and personality traits of the clinician are more important than knowledge which can be learned, for example, the capacity to balance privacy and confidentiality with safety issues in adolescent clinical work.

The ability to work with systems was a theme raised by four directors. Three described the ability to work with systems outside of CAMHS, which included liaison, collaboration, and education with the wider community. Education was seen as reciprocal, in that CAMHS clinicians have a role to skill up the community but can also learn from community services. One commented that clinicians need to be comfortable with systems, as working with adolescents requires working with multiple players. Two directors spoke specifically about working within multidisciplinary teams in CAMHS, and the benefits of learning from other clinicians with different knowledge and training in order to help the patient. Another director

spoke of clinicians' capacity to be pragmatic in balancing the needs of the adolescent with the limited resources available within the system, stating:

"I think we're talking outcome for the patient, and for yourself, is a matter of what is achievable. Rather than setting up a high expectation that you cannot fulfil - you set both yourself and the patient to fail. This is asking for the impossible..."

All seven directors raised the theme of particular personality characteristics and abilities in clinicians working with severely disturbed adolescents. Three directors communicated that the clinician needs to like to work with and listen to young people. One director commented that "*staff who liked working with adolescents got good results*." Three directors highlighted the importance of flexibility, while two talked of ability, creativity, and smartness as important. Others described the importance for the clinician of the capacity for reflection upon one's practice, the need for self-awareness with regard to the therapeutic relationship, experience, and personality in addition to training, and the clinician's personality being congruent with the treatment approach offered.

The final theme here, raised by four directors, is the essential ability to build a therapeutic relationship with the adolescent. Three directors commented specifically on skills of engagement and development of rapport. Two noted the importance of the therapeutic relationship, which for one included being attuned to verbal and non-verbal communications and issues of concern for the adolescent, and for the other included success depending on the working partnership which required patience, non-judgment, and self-awareness. One director believed that establishing rapport and recognising the uniqueness of the adolescent, both developed at the beginning of contact, enabled better diagnosis and management.

Another commented on the clinician needing to have sharp observational skills, which included the ability to read attitude, mood, and responses in adolescents, as well as the capacity to verbalise these observations for reflection with the adolescent. Two directors further commented on the therapeutic change process involved, with one director observing that the clinician's ability to read the adolescent's emotional response could assist the adolescent in improving self-understanding of his or her own behaviour. This director further elaborated that:

"... Therapeutic change is, is a process of...um… understanding …. why certain things go the way they do, and …. an effort to change it to something better, more functional. And whether that's done by talking, or in the course of day-to-day life, or whatever setting the other person is in, ... is immaterial. So, dealing with the resistances and the .... countertransference or whatever, ... it is ... is available to varying degrees depending on where the people are, and what they're doing, and .... how they feel about the .... relationship between the client and the therapist."

9.2.6 Domain of enquiry: Place of psychoanalytic psychotherapy theory and treatment in CAMHS

The directors were finally asked "What place do you think psychoanalytic theories or psychoanalytic psychotherapy treatment have in public mental health services with adolescents?" The responses of all seven directors were distilled to arrive at the higher order themes as shown in Table 44 below.

Table 44: Directors: The place of psychoanalytic psychotherapy theory and treatment in CAMHS

Higher Order Themes	Number of participants mentioning themes
Further research needed on theoretical constructs and treatment evidence-base	**4**
Reduction of resources has limited or negated a place for psychoanalytic treatment	**6**
Reflective practice is beneficial	**3**
Psychoanalytic training is valuable for staff	**5**
Psychoanalytic theories and concepts have a place in CAMHS	**7**
Psychoanalytic treatment has a limited place in CAMHS	**6**

The theme that further research was needed on both psychoanalytic theoretical constructs and the treatment evidence base of psychoanalytic psychotherapy was expressed by four directors. Three voiced opinions on the evidence-base of psychoanalytic psychotherapy treatment, including that its effectiveness is questioned, that it is less effective than some other interventions, that it might be helpful depending on the circumstances, and that "*clinicians vary in their attitude as to its helpfulness or not*." One director considered that while CBT worked for people with depression, psychoanalytic psychotherapy might work for those who have associated relationship problems.

Two directors commented on the heterogeneity of ideas in psychoanalytic psychotherapy, the lack of integration of these theories, and their varied usefulness, with one indicating particular theories that were useful:

"...some of Winnicott's ideas, object relations theories, I think some of [the] attachment theories, adaptive, like with Fonagy and .... Target. I think those kinds of theories are really very employable in child and adolescent psychiatry."

Two directors also indicated the need for further research into psychoanalytic theories, such as operationalizing concepts like projection, and that "*loose thinking needs to be updated with modern methods of evaluation of mechanisms*." One commented that research now supports psychoanalytic theory and developmental processes, and research can examine its tenets. Over one director's career, the view of the brain had moved from being seen as fixed, to one of being able to change, and so, that director stated, the rejection of psychoanalytic theory as explanatory but without predictive value can now be countered:

"[It]... can now seem to actually have ... a potential validity in saying ...um... conclusions about the developmental processes of.... infancy through to adulthood in combination with life experiences and ... uh... not only life events, but therapy may actually change the brain and its functioning"

Six directors raised the theme that reduction in resources had limited or negated a place for psychoanalytic psychotherapy treatment in the public sector. The impact of limited resources were variously described, with four identifying the erosion of a place for psychoanalytic psychotherapy treatment with respect to growing crisis demands, and the need to justify longer term work. Two concluded that psychoanalytic psychotherapy can have no place at all as a treatment, as, according to one, resource priorities limit this type of treatment and training, whilst the other described it as unrealistic as a treatment in the public sector

because of demand and cost issues. Another two lamented the erosion of externally facilitated reflective sessions for teams, which were run by psychoanalytically trained consultants. One described an experience of external consultation being regularly questioned:

"*...The pressure is the resource, the money that it costs, but sometimes it's also people just not really understanding the value of it. Not seeing it as integral to the work, by seeing it as some kind of... sort of luxury... having a bit of a fireside chat*."

In connection with this latter theme, three of the directors raised a further theme that reflective practice was beneficial. One commented that a capacity to reflect and think about a child's relationship patterns, or one's own responses to a child, is helpful. Two spoke in detail about the benefits of an externally facilitated reflective space. They stated that it helped positive team functioning, helped unpack complex interactions, and that a skilled psychoanalytic clinician assisted inpatient units to understand and manage complex dynamics. One summarised the usefulness of psychoanalytic trained external consultancy as:

"....the value of understanding transference, counter transference, group dynamics... um...Having that capacity to reflect with someone who's an expert is, is vital. So.... I think it's not only in the therapeutic arena and direct therapy, but in terms of staff training and support... I think. It's not the only conceptual framework to use, but I think it brings a ***richness*** *to understanding complex phenomena*."

Five directors proposed the theme that some form of psychoanalytic training was valuable for clinicians. Three identified that such training has a place. Two saw it was a helpful training

and support for clinicians in general, with one adding that a historical component was necessary in educating clinicians. One valued the conceptualizations that arise from that sort of training as they can be applied in a flexible way to all of your treatment programs, and one further commented on young clinicians being attracted to the complexity and intellectual appeal of psychoanalytic training.

Three directors further commented on the loss of trained staff that was occurring in 2012. One stated there were less clinicians trained in longer term psychotherapy, while training opportunities provided by CAMHS were diminishing and subservient to clinical service provision. Another commented that a loss of knowledge or training meant a risk that concepts and their origins were not understood properly, and thus a risk of losing psychodynamic understanding. One spoke of having a lack of post-graduate trained psychotherapy staff, and less allied health staff altogether. One further remarked that a smaller percentage of the workforce had sought formal specialised training. Finally, one was concerned that without psychodynamic understanding and training the workforce would lack the treatment skills needed:

"*...If you don't have a workforce where .... there's the capacity to deliver that kind of intervention for the kids that need it, then that's actually concerning as well. [Be]cause then we become this quite narrowed.... workforce ... in what we can do. And then, rather than being able to tailor our interventions to the needs of the young person we see, we come back to saying "Well, this is all we've got. And ... we get it that it doesn't really suit you, but that's too bad because that's all we have to deliver*."

All seven directors considered psychoanalytic theories and concepts have a place in CAMHS. A range of themes arose here. Five described a role for psychoanalytic theories and concepts in understanding complex interactions. They made multiple and varied observations: any treatment approach needs a conceptual framework and psychoanalytic literature provides a useful framework; concepts like transference helps clinicians in understanding their own responses; transference and counter-transference concepts have infiltrated psychiatry, so that lots of psychoanalytic concepts are used; the concepts and training have a flexible application to individuals, family and groups; psychoanalytic theory is important in assessment and formulation, allowing a richer understanding of phenomena; and psychoanalytic theory contributes to comprehending causes of adolescent difficulties, and has a place in understanding those difficulties from multiple perspectives.

Two directors specifically discussed the historical relevance of psychoanalytic theories, with one observing that it sat within a European tradition, and the other that the United States was stronger than Australia in linking developmental neurobiology and psychoanalytic theory within a psychoanalytic foundation. It was thought that staff needed to be educated about the history of theoretical influences and their origin in psychiatry. One saw that only some psychoanalytic theories were relevant in CAMHS, and that others did not apply. Another director viewed psychoanalytic theory as an essential conceptual framework for informing treatment and making sense of observations in CAMHS, whatever the treatment approach used. This director elaborated on this view of using psychoanalytic theories as a general conceptual framework:

"*...We can make sense of our observations, ... it helps us to.... put forward, sort of... suggestions for change or way of seeing how things are happening, why they are happening,*

what might be different, in a kind of more goal-directed way. And, that if we can do that, we are more likely to be effective... Ultimately, it's what the patient... the client does in their interactions with people, and how they respond and so on,... that's what matters. But not the terminology used or necessarily your framework, but what they do. But your responses to them need to be kind of not capricious, and just impulsive, but... thoughtful. And to do that, you have to have some kind of framework."

The final higher order theme developed from the narrative of six directors was that psychoanalytic treatment has a limited place in CAMHS. Only two directors saw psychoanalytic psychotherapy as having but a small place as a treatment in CAMHS. One of these believed that insight and relationship-based psychotherapy was better suited to adults, and the other thought it was not the most suitable of treatments in CAMHS. However, four directors commented that psychoanalytic psychotherapy has a place in aiding engagement, understanding, and relationship dynamics. One was also concerned about equity, and that psychoanalytic psychotherapy needs to be available to young people in both the private and public sectors.

Four directors declared psychoanalytic psychotherapy had a place as part of a multiple treatment approach. One argued that psychoanalytic treatment and training is valued as part of a range of programs, and another that it is important to encourage debate concerning different models to help in the understanding of complex behaviour. It was also noted that CAMHS had never been only psychoanalytic, but that there needs to be a place for all interventions, that a variety or broad range of treatments is required to meet a plethora of needs. The adage commonly used by the directors in relation to treatment of adolescents, was 'one size does not fit all' Two directors specified that psychoanalytic psychotherapy has

a place with seriously disturbed young people who needed longer treatment. One thought that psychoanalytic psychotherapy had a place with vulnerable people with complex problems and trauma, where short term work is insufficient. The other disputed the allegedly common view that someone could be too disturbed to benefit from psychoanalytic psychotherapy, and considered fears that psychoanalytic psychotherapy could make adolescents worse are unfounded, and concluded that if good systems and case management are in place, then:

"in the worse-case scenario, it may not necessarily be helping people improve .... but, ... it's hard to think how it would be actually making people worse. Unless you got people [clinicians] who were very poorly trained and acting out in therapy in some way. But ... it's hard to think how providing, a very respectful, supportive psychological intervention could be harmful."

9.3 Findings 4: Integrative summary

A thematic content analysis was used to analyse the transcript data of the narrative interviews conducted with seven directors of the CAMHS regions in the State of Victoria. All of these had initially agreed to actively supporting the TFFP clinical research. These interviews described the CAMHS context between 2002 and 2012. This was the decade during which adolescents referred to the TFFP participated in psychoanalytic psychotherapy, and of whom ten were subsequently interviewed for the present study. Six domains of enquiry were embodied in the directors' interview protocol, and hence were explored in the analysis of the interviews.

In the first domain of enquiry, the directors talked about their expectations of the TFFP. Receiving additional clinical resources for long-term treatment with adolescents who were found to be serious mentally ill, delivered by trained and supervised clinicians, was considered an attractive proposition. Whilst some directors had reservations about the suitability of psychoanalytic psychotherapy treatment for adolescents with serious mental illness, others thought that some adolescents would benefit. All directors endorsed the benefits of research in general, and supported research investigating the effectiveness of psychoanalytic psychotherapy with disturbed adolescents.

The second domain of enquiry was the socio-cultural context of adolescents in the region. The youth in the regions were seen as typical adolescents, but those referred to CAMHS were described by the directors generally being from lower socio-economic backgrounds, extremely high-risk, vulnerable, deprived and exhibiting at-risk behaviours such as alcohol and drug-use and self-harm. Particular challenges were described for adolescents in country regions or metropolitan growth corridors, where there was always a lack of infrastructure and services.

The third domain of enquiry was the CAMHS context from 2002-2012, and three subdomains of themes emerged in the analysis. One was a description of service functioning, programs, staff, and client groups. The CAMHS were mandated to deal with the most vulnerable high-risk groups, and according to the directors they provided a multiplicity of approaches and programmes across all age strata emphasising development, assessment, and formulation to inform treatment and management. Some services covered a large geographical area and struggled to provide beyond crisis assessment and had difficulties in recruitment and

retention of clinicians in small outpost teams. Rural teams were noted by the directors as relatively disadvantaged. They struggled with travel times for long distances, and lack of privacy and stigma in small communities was an obstacle for some adolescents in accessing CAMHS.

The second subdomain related to growth and change over the decade from 2002 to 2012. Multiple demands, from both external and internal sources for CAMHS to change, was the theme that emerged most strongly among the responses in this subdomain. The complexity of these multiple demands was emphasised. In particular, demand to meet the needs of at-risk and suicidal adolescents became the more obvious, and this required a major refocussing of service structures and operations.

The third subdomain related to challenges, resources, and debates across the same decade. The challenge of providing service delivery with insufficient resources to meet an ever-increasing demand was described by all directors. Resource differences between rural and metropolitan regions, which clinicians managed by finding creative solutions, were also discussed. Three topical debates within CAMHS in 2012 were stressed by the directors. These were around the use of medication, increased emphasis on evidence-based interventions, and extending CAMHS to service zero to young people twenty-five years of age. In regard to the latter, there were concerns regarding the planning process, fears about insufficient resourcing involving the depletion of resources to younger age groups, preserving a developmental perspective across all stages of childhood and adolescence, and retaining the CAMHS skills base.

The fourth domain of enquiry concerned the directors' views on working with adolescents with serious mental illness. Five major themes were raised with most directors commenting on the need for models of care to be supported by research findings, and the need for increased collaboration with other services. The issue of flexibility was a common theme, and some were critical of the lack of flexibility of assessment processes in the past. All discussed the need for large, multi-disciplinary, highly trained, and well supported staff groups who used multiple treatment approaches. Directors particularly emphasised the importance of having a developmental understanding of adolescents. Supervision and support were themes that emerged under a number of domains and was considered a strong part of the CAMHS culture at the time. Finally, in considering adolescents with serious mental illness, some directors spoke about building a therapeutic alliance, and the need for clinicians to be able to sit with risk and adversity.

The fifth domain of enquiry addressed by directors was what clinicians needed to work with severely disturbed adolescents. Ongoing training, education, supervision, and specific knowledge were raised as important, as was the ability to work with systems. However, all directors raised the theme of particular personality characteristics and abilities in the clinician as being important, for example liking to work with adolescents, listening skills, flexibility, creativity, reflectiveness, experience, and self-awareness. Yet again the directors focussed on the ability to engage and develop rapport with adolescents, and the critical importance of the therapeutic relationship.

The final domain of enquiry concerned the place of psychoanalytic theory and practice in CAMHS. All directors considered that psychoanalytic theories and concepts have a place in CAMHS, with many of the concepts in every-day language. Psychoanalytic theory was

further seen as a useful framework for understanding and formulating a treatment plan. Psychoanalytic training was seen as valuable for CAMHS clinicians, as were reflective sessions with external psychoanalytically trained consultants. Psychoanalytic psychotherapy was seen as having a limited place due to reduction in resources, loss of trained staff and the need for further research on its effectiveness. However, there was a strong advocacy that psychoanalytic psychotherapy should be an option amongst a suite of treatment models, and particularly for seriously disturbed adolescents who also need longer-term treatment.

CHAPTER 10: DISCUSSION OF FINDINGS

Findings are discussed in terms of the aims and research questions of the study, with reference to previously published in-depth qualitative research in the area of adolescent and psychotherapist experiences of psychoanalytic psychotherapy as outlined in section 2.5.8 of Chapter 2. This discussion is preceded by consideration of the methodological limitations and strengths of the study.

10.1 Limitations and strengths of the research

10.1.1 Limitations

Potential bias in data collection and analysis derived from the fact that the researcher trained in psychoanalytic psychotherapy, supervised psychoanalytic psychotherapy trainees within the MCPP and had previously worked in CAMHS. Given the qualitative nature of the study, labelling of themes was interpretative and hence subjective, and in their successive distillation to arrive at the higher order themes bias was also possible. However, possible bias was offset by the likelihood that deep knowledge of psychoanalytic psychotherapy and the CAMHS system allowed for more in-depth engagement with both data collection and analysis, as intended by qualitative research and that the researcher maintained a reflexive position. Indeed, other researchers reported that they either had psychoanalytic psychotherapy training or interest, and/or had worked in CAMHS (Binder et al., 2011; Bury et al., 2007; Midgley et al., 2005; Midgley et al., 2006; Sagen et al., 2013).

Given the nature of the study there were also issues related to replicability. Firstly, there was a unique researcher relationship with the participants developed over years in the TFFP, which is not easily replicable. Secondly, government funded CAMHS in Victoria no longer or rarely offer psychoanalytic psychotherapy as a treatment to adolescents, so it would be difficult to repeat such a study at this point in time. However, the research has taken place in a clinical (CAMHS) setting with participants who have complex and comorbid diagnoses, and comparisons potentially can be made with other CAMHS clinical settings that have similar populations. Others have argued for assessment of levels of validity of qualitative research, as discussed in Chapter 5 (Guba, 1981; Maxwell, 1992; Leichsenring, 2004; Rolfe, 2004).

A further limitation was that the interviews were retrospective, (3.6 years to 9.3 years with a mean of 6 years since cessation of psychotherapy). Memories may not always have accurately represented what occurred, as they become subjective over time, but it is the perceived meaning of the experience that is of import, in relation to psychoanalytic psychotherapy, change, memory, and time (Bollas, 2011; Nunn, 2006).

Again, retrospective interviews are common in this research field. Bury et al. (2007) interviewed retrospectively but closer to the time of the adolescent's therapy, ranging between 3 months and 18 months from end of psychotherapy. It is noted that Midgely and Target, (2005) and Midgley et al. (2006) interviewed adults who had been children and adolescents in psychoanalysis, and it was an average of 27 years from referral rather than cessation of treatment (range 18 to 42 years); it was not stated whether those patients continued to be in psychoanalysis post that time or were in psychoanalysis at the time of interview.

In contrast, Binder et al. (2011) and Sagen et al. (2013) did not interview retrospectively but interviewed people at various stages of treatment (three sessions to years). For some, however, more than one psychotherapist had been involved, presenting its own set of limitations and implications.

The patient sample available to the present study was representative of the patient group studied in the TFFP in terms of gender. However, it must be remembered that the latter was heavily biased toward female participation (see Appendix II). To what extent this gender bias was representative of seriously ill mentally ill adolescents in Victoria at the time of the TFFP is unknown. In Chapter 2, Section 2.1.7 the findings of adolescent females with depression as more likely to seek out talking therapies could also be a factor (Lawrence et al., 2015). All efforts were made to contact and interview the entire group of young adults who participated in psychoanalytic psychotherapy in the TFFP apart from exclusion criteria (see Chapter 5, Section 5.3.3, p. 96) and the impact on the findings of not having the whole group it is not known.

As is common with qualitative studies, a large amount of data was gathered that could not be analysed within the timelines of the thesis, such as the parent/carer interviews that were conducted. The researcher's records of observations, transference and countertransference across all interviews were not included except for Chapter 6 section 6.4.1 with reference to the impact of the break in the adolescent interview.

There was potential to make cross comparisons between psychotherapists and patients but given the emphasis on preserving anonymity enhanced through aggregated group data

analysis, this had to be finessed carefully to avoid identification of adolescent, psychotherapist or both and was thus limited.

Whilst limitations must be considered, several strengths of the present research enhanced confidence in the findings.

10.1.2 Strengths

A number of such strengths have been displayed in previous comparative studies. All of the adolescents in this study had had serious mental health difficulties with a range of comorbid diagnoses. They were adolescent patients of public Child and Adolescent Mental Health Services who referred them to the TFFP for psychotherapy, as in several other qualitative studies in the UK and Norway respectively, (Binder et al., 2011; Bury et al., 2007; Sagen et al., 2013).

As in other studies too, it was one researcher who conducted all the qualitative interviews with each participant, so that the interviews were conducted in a standardised way leading to a more uniform and consistent gathering of information. It appeared that Bury et al. (2007) also had one researcher that conducted the interviews, and whilst Midgley et al. (2006, 2005) reported on a qualitative part of a larger retrospective research project with multiple researchers and approaches, the qualitative interviews appeared to have been conducted by one interviewer.

Further, the interview questions were broad and open-ended promoting as little as possible influence over the participant's recollections (Appendix D), as described similarly in other studies (Binder et al., 2011; Bury et al., 2007; Sagen et al., 2013).

The retrospectivity of the research meant it was possible to reflect and evaluate the experience of psychoanalytic psychotherapy in adolescence from the position of a different developmental stage of young adulthood. This also gave the opportunity to see how patients' reflective capacity had changed or not. Similarly, for psychotherapists and directors, all had developed further through their own study, and professional and personal experiences. Therapeutic actions and pivotal points could not be easily recalled but these aspects were offset by the processing of meaning over time, which enabled a more holistic contextual view of past experiences to be articulated. Indeed, retrospective reflection on their experience of psychoanalytic psychotherapy may have enhanced capturing the complexity of therapeutic change.

Further, like other studies (Bury et al. 2007; Binder et al., 2011; Midgley et al., 2006; Midgley & Target, 2005), this research used the interpretative phenomenological analysis recommended by Smith (2004, 2007) and this allowed for complex data analysis of the adolescents' lived experience of psychoanalytic psychotherapy.

All available participants were interviewed, and the qualitative method of analysis used (Miles & Huberman, 1994) was both systematic and comprehensive, noting every single emergent theme that was expressed in each narrative. Smith, Flowers, and Larkin (2009, pp.83-4) have claimed that transparent and systematic data analysis enhance research validity and credibility, allowing different levels of independent audit, including that by a research supervisor. In this research, the thematic analysis was audited, principally by the main supervisor, but also the secondary supervisor, both having considerable experience in qualitative research methods. Similar methods of auditing have been used, for example by Binder et al. (2011) and Sagen et al. (2013), who used different researchers to audit the

interviews, and by Bury et al. (2007) who used an independent audit of the analysis of two complete transcripts.

That the researcher was familiar to the adolescent and psychotherapist participants strengthened their ready responsiveness. The researcher had interviewed them periodically in the TFFP for research follow up and re-assessments over a 14-year period. There was associated trust and good will. Wood (2010) hypothesised that research can have a triangulation function in relation to psychotherapy and psychoanalytic thinking. It is hypothesised that the TFFP clinical research provided a containing function for the psychotherapy and for thinking psychoanalytically about CAMHS and other systems. This aspect of the research relationship seemed less evident in the previously mentioned qualitative studies as the researchers did not appear to be involved in an ongoing longitudinal study, but rather in a cross-sectional research project, albeit reflecting on the experience of psychotherapy treatment (Binder, Moltu, Hummelsund, Sagen, & Holgersen, 2011; Bury, Raval, & Lyon, 2007; Sagen, Hummelsund, & Binder, 2013; Midgley, Target, & Smith, 2006; Midgley & Target, 2005).

In the present study, the psychotherapists were all trained in the same training programme (MCPP) supervised weekly by clinical supervisors also providing supervision in the MCPP, reinforcing a consistency of approach. No other qualitative research project on adolescent psychotherapy appears to have applied such rigor to the homogeneity of the training and psychoanalytic psychotherapy offered: indeed, some other research in this area (notably that of Binder et al. 2011) included a range of psychotherapy orientations, of which psychoanalytic psychotherapy was only one. It is likely that analysts in the Anna Freud Centre study of Midgley et al. (2005, 2006) had the same training at that time, but their

training and practice would have developed during that 28 years. Given the analyses were placed between 1952 and 1980 there are possibly major historical and cultural differences compared to a cohort in the 21st century.

Binder et al. (2011) and Sagen et al. (2013) studied adolescent psychotherapies received in the course of usual CAMHS treatment, and the psychotherapists had different psychotherapy orientations including psychodynamic, cognitive-behavioural, systemic, and eclectic; the type of psychotherapy each adolescent subject received was not distinguished. Patients in this study however, received psychoanalytic psychotherapy in addition to CAMHS TAU from psychotherapists who were all psychoanalytic psychotherapists trained in the MCPP, and they were not necessarily employed within the CAMHS system. Bury et al. (2007) focussed on a specific treatment and common training of clinicians employed in CAMHS, which was Individual Psychoanalytic Psychotherapy (IPP as described by Baruch (2001) which did not appear to be manualised. Sensitivity to the experience of the adolescents feeling like outsiders may have been paralleled, as the therapists in this study were from outside CAMHS.

Another feature enhancing internal validity was that all directors of CAMHS in the State of Victoria during the decade (2002-2012) were interviewed, so that a clear understanding of the service context for the public adolescent mental health system in which the psychotherapy was delivered was obtained. The engagement responsiveness, and passion for the work displayed in their interviews by the Directors, the psychotherapists and the young people alike also attested to the internal validity of the study.

From a different point of view, the principal focus of the study was on what the adolescents' lived experience of psychoanalytic psychotherapy was, and what it meant or symbolised for them and the perspective of the psychotherapists meant there was verifiable data from more than one perspective, as well as the cross-sectional data gathered in the TFFP project. The voices of the adolescents and their psychotherapists were genuine, as evidenced by their commitment to the study, and reflecting on a time in their lives that had been one of great emotional suffering.

Similarly, contextual issues relating to the adolescent patients' comorbidities, psychosocial complexities and development were highlighted. Again, this contextual sensitivity is not commonly evident in reported research in this field. Sensitivity to context is a feature of this study's validity. It became evident that different geographical locations highlighted unique challenges according to whether an adolescent lived in a regional country town, outer metropolitan, semi-rural or metropolitan/urban environment in terms of infrastructure and availability of public transport, services and supports catering to adolescent needs and interests. Other studies tended to be at one clinic (Bury et al., 2007; Midgley et al., (2005, 2006), and whilst adolescents were selected from two clinics in the study written about by Sagen (2013) and Binder (2011), geographical impact upon the context of care was not discernible as a feature from their publications.

10.2 Consideration of the aims of the study

As stated in Chapter 4 the two aims were:

- to explore how these young people, and their psychotherapists perceived and experienced the psychoanalytic psychotherapy process and its outcomes.

- to describe the overall context of care as perceived by the directors of CAMHS, by the now young adults, and by their psychotherapists.

In this discussion of the aims it is considered more meaningful to address the second aim first, as it then sets the scene for description of the context in which the psychoanalytic psychotherapy occurred.

10.2.1 The context of care surrounding the treatment: The directors' perspectives

A major focus of the directors' reflections were detailed in-depth descriptions of the context of care provided by CAMHS between 2002-2012 thus addressing the second aim of the study.

In a decade of increasing demands for CAMHS to respond to adolescent crisis presentations, featuring high risk behaviours such as self-harm, suicidality, and increased substance use (particularly the rise of crystal methamphetamine use), the need for evidence-based, crisis response, assessment and short-term treatments were seen as paramount by the directors, with tertiary level services CAMHS mandated to treat those with serious mental illness. Directors described their adolescent population as typically from lower socio-economic groups suffering social disruption, disorganisation, deprivation, and violence. They spoke of vulnerable groups that included traumatised children in out-of-home care, many having experienced extreme levels of abuse and trauma, often manifesting high-risk behaviours such

as non-attendance at school, risk of homelessness, alcohol and substance use, deliberate self-harm, and suicide attempts.

Directors described the organisational procedures and processes in CAMHS within their urban, metropolitan, and regional communities, and the challenges that had been faced across the decade with respect to staff recruitment, retention, support and need for further training such as in alcohol and drugs, cultural sensitivity and trauma work related to refugee and indigenous populations (Basu & Isaacs, 2019), changes with respect to work practices, and the nature of the adolescent client population within the CAMHS context.

Directors identified the disparity of resources between urban, metropolitan services and semi-rural growth corridors and regional areas. Particular organisational challenges in regional and metropolitan semi-rural growth areas were the support of clinicians in isolated areas, travel distances, difficulties in recruitment and retention, levels of experience and capacity to develop specialist clinical interests in teams that lacked critical mass.

The young adults and their therapists' descriptions of the difficulties they experienced during adolescence fitted the cohort of vulnerable young people with complex difficulties as described by the directors, and there was representation of participants from urban, metropolitan growth corridors and regional areas. As noted in Chapters 6, 7 and 8, referral to psychotherapy at between 13 to 18 years of age, the adolescents were highly distressed, often suicidal with a recent hospitalisation, and had complex difficulties in all areas of life and with comorbid diagnoses.

Both the adolescent and the psychotherapist interviews highlighted that the majority of the adolescents seen in psychotherapy were isolated and disconnected from peers and family. Previous research has found an association between difficulties in attachment and serious psychological disturbance in adolescence (Allen, Hauser, & Borman-Spurrel, 1996; Main, 1996; Rosenstein & Howrowitz, 1996).

Challenges that directors saw for adolescents and their families in rural regions included lack of anonymity and privacy with potential stigma in being seen to attend a mental health service, lack of resources, large geographical areas to be travelled, lack of infrastructure and services for adolescents which could lead to boredom and offending. Planning of services showed awareness of shortfall of services in regional areas for adolescents (AICAFMHA, (2011, 2003); Department of Health and Community Services, 1996)

Both the young people and psychotherapists, too, emphasised the impact of lack of infrastructure in regional and outer metropolitan/semi-rural areas, and described not only how that led to risk-taking behaviours by the adolescents. They also conveyed how these issues impacted upon the capacity to attend therapy or not, as the further therapy was away from where the adolescent lived the more difficult it was to maintain attendance, particularly if there was a lack of public transport, so that a parent/carer needed to drive them, and on occasion, there was not enough money to afford petrol.

10.2.2 Psychoanalytic psychotherapy treatment

The second aim of this study also achieved, was to explore the adolescents' and psychotherapists' perceptions and experiences of psychoanalytic psychotherapy, its processes, and outcomes.

Whilst the young people initially spoke in their interview of concern that they might not remember much, what unfolded was a rich tapestry of their lived experience of having entered psychoanalytic psychotherapy as adolescents. At times they struggled to think about what the key ingredients of the psychoanalytic psychotherapy experience were and described different components embedded in the dynamics of the therapeutic relationship that evolved. All comparable qualitative studies demonstrated the importance of the therapeutic relationship as well as common facilitating skills on the part of the psychotherapist (Binder et al., 2011; Bury et al., 2007; Midgley et al., 2006; Midgley & Target, 2005; Sagen et al., 2013).

Emphasis on what was helpful and what was unhelpful in the experience varied according to the stage of the therapy - beginning, middle, or ending. Variations were also evident according to the contribution of the adolescent, the psychotherapist, the dynamic of their therapeutic relationship, the frame of psychotherapy, the developmental stage of adolescence, the changes that had already occurred within the adolescent, the pace of these changes, and the interaction of these changes in relation to the external world. Bury et al. (2007) also found overarching themes that highlighted the different stages of the psychotherapy when adolescents reflected upon their experience.

In this study psychotherapists were asked to comment on the process of psychotherapy with specific adolescent patients. Comparisons with other studies is at times difficult because in other studies, psychotherapists were interviewed about a body of adolescent psychotherapy treatments.

10.3 Addressing the research questions

The significance of the findings is discussed in terms of their relation to the research questions set out in Section 4.3 of Chapter 4. The relation of those findings to those of previous studies is often difficult to determine because the description of the context of these studies is frequently sparsely mentioned. Wherever corroboration with previous relevant research is evident, this is noted in the discussion that follows.

10.3.1 How did adolescents who have had serious mental health difficulties experience psychoanalytic psychotherapy?

10.3.1.1 The adolescent perspectives

There was an enigmatic quality to psychotherapy which became evident as the young adults tried to understand the role psychoanalytic psychotherapy played when they were adolescents: they contemplated layered facets to its operation, for instance what was about skills and attitudes, what was about the setting, their personality and attachment style in the context of adolescent developmental needs, what was required to establish a therapeutic relationship in terms of time to build trust, for those who may have had little experience of

trustworthy relationships, and what was about desperation, commitment, hope and the need to survive and find a different way.

Overall, psychoanalytic psychotherapy was identified by the young adults as being a positive experience, the only exception being when a negative transference emerged at the onset. Midgley et al. (2006) found almost half their respondents saw analysis having a positive impact in their adult lives, and 2/3 identified analysis as having helped at the time, with children tending to be more favourable than adolescents. However, in this study, the positive impact of psychoanalytic psychotherapy during adolescence was 90%. Midgley & Target (2005) found that a small number of females who commenced analysis in latency or adolescence had hated their therapists and felt misunderstood and interrogated, and resented the distance and unresponsiveness of the analyst, leading to early termination. Certainly, in this study, a perceived lack of reciprocity and rejection of interpretations (thus a sense of being misunderstood) were identified when there was a negative transference from the outset, but unlike the Midgely and Target participants, the adolescent continued in psychoanalytic psychotherapy hoping things would change. Sagen et al. (2013) also found some adolescents needed a more '*transactional*' relationship with their therapist to not feel like they were '*talking to a wall*'.

As the research interview progressed, the participants were able to reflect and unpack a more deeply layered and nuanced understanding and thinking about the components of their experience of psychoanalytic psychotherapy.

In beginning to think back on their experience of psychoanalytic psychotherapy, feeling states were remembered more than content, but specific activities were also recalled, like

drawing, and talking in general about family, school, thinking and difficulties. In various ways, the frame of psychotherapy and the stance of the psychotherapist were described. Some were surprised to find that after several years, they still remembered the time and day of their psychotherapy session, and recounted detailed descriptions of the room and its view. These specific aspects of the frame were not highlighted by other studies, but boundaries and the testing of boundaries were discussed (Binder et al., 2011; Midgley and Target, 2005). The establishment of clear boundaries was argued as important for a clear definition of roles and the development of autonomy for the adolescent by Binder et al. (2011). In-depth talking and reflection on feelings and situations that were difficult to talk about elsewhere were also highlighted by other studies (Binder et al., 2011; Bury et al., 2007; Midgley et al., 2006; Midgely and Target, 2005; Sagen et al., 2013).

A therapeutic frame, initial engagement, and development of a mutual commitment of adolescent and psychotherapist were found as necessary for the work of psychotherapy. The young adults identified specific skills and traits within the psychotherapists and themselves that contributed to and enhanced the work. This study had similar findings to others in relation to the therapists skills, notably the importance of liking the therapist and being liked by the therapist (Bury et al 2007), the therapist stance of acceptance, non-judgment, respect, undivided attention towards the adolescent, calm, flexibility, warmth, caring, deep listening, understanding, and not having to take care of the therapist's feelings which encouraged trust and collaboration (Binder et al., 2011; Bury et al., 2007; Midgley et al., 2006; Midgely & Target, 2005; Sagen et al., 2013). All are key components in meta-analysis of therapeutic alliance in treatment studies with youth, and in therapeutic alliance research with adults as well (DiGiuseppe, Linscott, & Jilton, 1995; Karver, Handelsman, Fields, & Bickman, 2006; Shirk and Karver, 2011).

Consistent with previous research, it was important for the adolescents in this study that a connection or engagement was made at the beginning of psychotherapy, and that the personality and skills of the therapist in promoting such engagement were identified as helpful (Binder et al., 2011, Bury et al., 2007, Sagen et al., 2013). As in other studies, some adolescents in this study confirmed that it was helpful for the therapist to give a description of psychotherapy at the start (Bury et al., 2007).

The difficulties of engaging adolescents in individual psychotherapy and building a rapport has been well documented, along with the association between therapeutic alliance and positive outcomes (Hawley & Garland, 2008; Oetzel & Scherer, 2003;). In this research, the adolescents initially saw psychotherapy as an unknown, which has been remarked on by other studies (Bury et al., 2007). Adolescents reported feeling ambivalence, fear, and vulnerability, and it took time for many to develop trust and to move towards a therapeutic alliance based on mutual qualities and their collaboration. The studies of Binder et al. (2011), Bury et al. (2007) and Sagen et al. (2013) focussed on initial engagement and described similar findings. Binder et al. (2011) emphasised that adolescents often did not instigate their referral, and Midgley and Target (2005) mentioned some not understanding why they were referred to analysis, feeling stigmatised and damaged by an experience that was different from their peers. In this study, only one adolescent was not sure by whom and why the referral had been made but nevertheless, felt committed to engage in psychoanalytic psychotherapy.

In this study it was also found that those who had previously unsuccessful experiences of seeking therapeutic help had to overcome their sense of hopelessness that anything else could work. Binder et al. (2011) and Bury et al. (2007) focussed on the ambivalence and fear that

can accompany starting psychotherapy but did not explore the impact of previous unsuccessful treatment.

Other studies that focussed on engagement had more of an emphasis on what the psychotherapist did to facilitate the therapeutic alliance, and the adolescent's contribution to facilitating engagement was not a feature (Binder et al., 2011; Bury et al., 2007; Midgley, Target, & Smith, 2006; Midgley & Target, 2005; Sagen et al., 2013). In this research, some adolescents also identified that their own capacities and skills contributed to engagement from the outset, highlighting their motivation, hope, need for help, and capacity to reflect, talk, work, and explore. Perhaps this point of emphasis came about as there was no expectation that just because they were adolescents, they would automatically be ambivalent; this stance contrasted with a frequent view that adolescent engagement in individual psychoanalytic psychotherapy with an adult psychotherapist can be antithetical to adolescent developmental demands for separation and individuation (Erikson, 1977, 1971; Blos, 1978). However, some of the adolescents in this study, particularly having experienced early trauma as evident from their descriptions and difficulties, struggled to cope with the developmental demands of adolescence and needed help to achieve the normal developmental trajectory of adolescence by forming an attachment with a therapist from whom they could later separate (Perl, 2008).

Most patients in this study reported a positive, and collaborative therapeutic alliance, and the issue of a power differential between therapist and adolescent was not a commonly expressed concern but could become one when an adolescent felt misinterpreted. Bury et al. (2007) found that in the process of therapy some adolescents felt that a power differential meant that adolescents were unable to question decisions about their treatment or to challenge their therapist.

Half the group remembered the process and ending of therapy. Emerging was a theme expressing a sense of guilt over missing sessions, and that guilt remained for years with some adolescents who drifted away from their therapy without closure. Whilst some had felt ready to finish and move on with their lives, others felt their problems had not changed and questioned the helpfulness of therapy. Some sought further help when problems arose after psychotherapy had ended, and expressed the view that psychotherapy was not a cure. This research corroborated the importance of termination in psychotherapy, which triggers issues around separation, loss, and moving forward, and arouses feelings of ambivalence (Bury et al., 2007). The way psychotherapy ended had an impact on the overall experience of psychoanalytic psychotherapy, and unprocessed premature endings, whether instigated by the therapist or the adolescent, were even more difficult. The adolescent could feel worried about the therapist, and experience a sense of abandonment sensitised by former losses in their life in the first scenario, and guilt about not saying goodbye in the latter. These added difficulties of premature termination were not prominently considered in other studies.

Contributing to the adolescents' early cessation of therapy was the build-up of mixed feelings of guilt for non-attendance, or hostility about expected attendance, or feeling stuck and frustrated about there being no solutions to their problems. It is noted that a study with young adults looking at the notion of cure was a predictor of premature termination and the need to discuss and negotiate ideas of cure in the initial assessment was recommended (Phillps, Wennberg, & Werbart, 2007). Further contributory factors to cessation of psychotherapy were geographical inaccessibility, as where an adolescent did not have independent means of transport to sessions, or where the adolescent struggled to protect their post-therapy space on the car ride home with their parent. These factors were not featured in the other in-depth qualitative adolescent studies.

10.3.1.2 The psychotherapists' perspective

A confluence of thinking between adolescents and psychotherapists emerged around the beginning of psychotherapy, with the recognition that a prior negative experience of treatment could be an initial barrier but not insurmountable. This point was not a particular feature of the comparable qualitative studies under discussion.

Like the adolescents, the psychotherapists also commented upon the adolescents' contribution in the beginning stages of psychotherapy. The psychotherapists described variation in presentation and engagement style from those adolescents who engaged readily, were committed to work, and were invested, to those who were awkward, ambivalent, distrustful, and silent. The psychotherapists described the intense emotions of fear, anger, and sadness that adolescents brought to the room. The psychotherapists identified their need to be finely attuned to the adolescent, and the adolescent's potential unconscious transferences from the outset. Binder et al. (2008a) interviewed psychotherapists with mixed trainings with a view to elucidate the challenges and practical strategies they used in engaging with adolescents who were often ambivalent. Thus, the ease of therapeutic engagement varied according to whether the adolescents connected easily or whether more work and time was required to establish the therapeutic alliance. Jones et al. (2020) found experienced therapists recognised how they needed to adapt their techniques to the individual adolescent.

10.3.2 What did participants perceive were important influences on their mental health during psychoanalytic psychotherapy?

During adolescence, a variety of significant influences mitigate psychological distress. Adolescent participants identified the probable role of maturation and experience, music, exercise, creativity such as writing, blogging, and art and their positive impact upon their mood. Others additionally identified the support of their parents, family, and friends was of critical importance. Religious readings, faith and community support were important for a minority, for some it was having subsequent treatment, and another having a pet dog. Medication was raised by less than half with a mixed response from "helping a lot", to ambivalence about effects such as a decrease in creativity, motivation, and weight gain, with limited voiced concern as to long term consequences from long-term use of medication. Some of these influences were talked about in combination with psychoanalytic psychotherapy during adolescence.

10.3.2.1 The adolescents' perspectives

Midgley and Target (2005) also reported on the difficulty for participants in adolescent analysis to look back and discriminate what changes were due to psychoanalysis, and the same was found in this study regarding psychoanalytic psychotherapy.

Helpfulness of psychotherapy was identified in relation to outcome and change in the adolescent some of which were identified as internal, and some could be seen in external relationships and behavioural changes. Seventy percent of adolescents in this study

highlighted specific positive outcomes such as internal changes in mood, awareness, and understanding as well as skill acquisition.

Only a few, regarded psychoanalytic psychotherapy as having a minimal impact on their psychological distress and those participants did not have a lengthy therapy, or had terminated prematurely, (either because the therapist became ill or the adolescent withdrew from treatment) but nevertheless it was seen as a helpful place to vent and talk about problems. This feature has been confirmed by other studies (Binder et al., 2011; Midgley & Target, 2005; and Sagen et al., 2013).

Binder et al. (2011) and Midgley and Target (2005) found internal changes were predominantly identified, such as improved coping, self-confidence and self-understanding, and emotional regulation, which all emerged in this study as well.

Lack of friends and difficult relationships particularly with mothers were reported prior to therapy, by less than half of the group, and different views emerged as to how psychotherapy impacted upon their relationships with only two saying it had no influence. Sixty percent saw psychotherapy as having a positive impact on family and peer relationships. Important changes were reconnecting and learning to talk more with parents and family, and improved quality in relationships. Some learned to initiate and make friends, and for some this was a unique experience for them. Changes in the young person meant they were less withdrawn, more relaxed and this in turn helped their relationships as well as their increased awareness, ability to assert their needs, consideration for the perspective of the other, and taking things less personally. Such growth was related to a sense of symptom relief, but also can be seen

as demonstrating considerable internal restructuring illustrative of the working model of attachment as described by Bowlby (1978).

Some participants attributed psychotherapy with helping their own individual development, sense of empowerment, increased self-confidence, self-awareness, and self-esteem and in turn this had improved their capacity to think, accept, understand, and trust themselves and others. Just under half were able to identify that it was the processes in psychotherapy which were important in achieving these changes in the self. These involved validation of their feelings in a separate space where they could speak freely, the therapist being able to withstand testing out behaviours without rejecting or giving up on them, and the adolescent being able to introject positive qualities (such as calmness, patience, understanding and non-judgement) that they saw in their therapist. Such findings are corroborated in comparable studies (Binder et al. 2011; Midgley & Target, 2005; Midgley et al. 2006; and Sagen et al. 2013). In addition, some in this study described a process of internalisation of aspects of their psychotherapist as helping them sort out differences in their external relationships.

Whilst all the young adults observed having ongoing internal and external difficulties, they were nonetheless also able to specify changes which they attributed directly to their experience of psychoanalytic psychotherapy. The majority identified that psychoanalytic psychotherapy had played an important role in helping them to develop coping and social skills, thinking capacity (or as described by some, "*learn to think*"), hold hope, increase self-expression, improve reality testing, decrease mental health symptoms, identify their emotions, learn to manage their emotions, develop greater self-awareness and understanding, achieve individuation, and to achieve a greater sense of well-being.

Significantly, for those that recognised that through the course of their lives there might be times of challenge and difficulties they were confident they could recognise when they needed further help and feel comfortable to seek help. A number of young adults had in fact sought help at particular crisis points in their life post psychoanalytic psychotherapy. Future help seeking did not appear as a focal point of comparable studies.

The most compelling outcome of this study was the young adults stating psychoanalytic psychotherapy enabled them as adolescents to remain alive and develop a capacity for self-protection and self-care. Whilst this was not a study that had a primary focus on suicidality and self-harm in adolescence, and nor was this the focus of the four other in-depth qualitative studies, many of these disturbed adolescents did have histories of self-harm and suicidal behaviours as also mentioned by Binder et al (2011) when referred to psychotherapy. The clinical and theoretical implications of this finding will be discussed further in the conclusion chapter.

10.3.2.2 The psychotherapists' perspectives

The psychotherapists used their theoretical framework to articulate a complex understanding of each adolescent and their mental health difficulties which reflected an interactive matrix of personality, attachment style, the interplay of defences, stage of development, mixed hypotheses as to onset and aetiology such as genetic pre-disposition, early attachment disruptions, and trauma. The psychotherapists described psychotherapy outcome changes in terms of behaviours, internal changes in processing and symptoms. The psychotherapists traced particular psychoanalytic concepts and dynamics, such as their role in holding and

containing projections, the therapeutic frame, psychotherapeutic skills, and the therapeutic relationship as contributing to these changes.

Comparisons on outcome are difficult with the three qualitative papers focussed on the psychotherapist's experience of psychoanalytic psychotherapy with adolescents as they did not focus on outcome related to a discrete psychoanalytic psychotherapy treatment. The TFFP psychotherapists observed the following outcomes from the adolescent psychotherapies: symptom reduction, development of capacity for hope, improvement in social, coping, and protective skills, cessation, or reduction in self-destructive acts, becoming on track with adolescent developmental tasks, and strengthened ego capacity in terms of the adolescent's ability to process and manage their feeling states, to have more insight, self-awareness, and reality-testing. Their observations match closely to the adolescent reports, but also reflect the therapists' theoretical understanding of ego development and developmental theory.

Palmstierna and Werbart (2013), found some similar findings in their study of successful psychoanalytic psychotherapies with young adults, especially the similarity of views between the therapists and the young adults of the outcomes.

A positive impact upon relationships was hypothesised by the TFFP psychotherapists as due to an improved relationship towards the self, increased self-awareness, acceptance, and insight with a better capacity to process their feelings. This was confirmed by the adolescents. Psychotherapists believed that the experience of an intimate therapeutic relationship would generalise to other relationships, and the capacity to form intimate relationships with a partner, and this too was confirmed by the adolescents. It was thought that providing a space for the adolescent to express and process their intense emotions could

result in less volatility at home, but conversely, they may be more argumentative as they attempted to individuate or outgrow peer relationships. Again, such impacts were confirmed by the adolescent participants. The importance of establishing a strong therapeutic relationship or bond was confirmed in the three adolescent qualitative studies by (Binder et al. (2008a, 2008b), and Jones et al (2020). The strength of the bond is seen as important for initial engagement, developing a working collaboration (Binder et al., 2011) and associated with better outcomes (Bury et al., 2007; Goldfried & Davila, 2005; Shirk, Karver & Brown, 2011b)

10.3.3 What difference did the experience of psychoanalytic psychotherapy make?

This study explored the phenomenological processes underlying what was found to be the effectiveness in psychoanalytic psychotherapy as compared to TAU in the TFFP results which found improved mental health of adolescents involved. The participants in the present study commented on potential differences in their mental health from having experienced psychoanalytic psychotherapy in their adolescence.

10.3.3.1 The adolescents' perspectives

The structure and the frame of psychotherapy were valued, whilst initially tested and resented at the time by some, the young adults were retrospectively appreciative and saw it as helpful. This experience of aspects of psychotherapy being seen as helpful more in retrospect by some was also reflected in the findings of Midgley et al. (2006), as was the differentiation between what was experienced as helpful at the time of treatment and what was seen as

helpful in retrospect. Flexibility was also seen as important, particularly when the adolescent was in crisis; however, this was not a prominent feature described by adolescents in comparable qualitative studies, and in one, the adolescents emphasised the importance of boundaries for them (Binder et al. 2011)

Whilst a private and safe space was valued by the adolescents, the young adults further explained that as part of the process of psychotherapy it was helpful to have a separate space where they could speak freely with an independent, robust person and learn to express and identify emotions which had overwhelmed their capacity to think, and these findings concurred with those of Binder et al. (2011) and of Midgley and Target (2005).

The capacity for the therapist to advocate, link and liaise with the adolescent's school or family/care systems was also valued by the adolescents in this study, with the psychotherapist being seen as an ally or advocate for the adolescent's position and needs. Reports of other studies did not feature this issue in their findings.

Specific traits and skills of the therapist were deemed vital in the enhancement of the work such as responsive listening, non-judgmental attitude, an independent perspective, dependability, respectfulness, caring, being held in mind, being fun, and giving a welcoming smile. These were similar findings to those of other studies (Binder et al., 2011; Bury et al., 2007; Midgley & Target, 2005; Sagen et al., 2013).

Binder et al. (2011) detailed the initial engagement with the adolescent with similar findings to this study, and they commented on the adolescent need to protect their autonomy which was facilitated by an adult outside the family and school system. In the present study the

young adults spoke specifically about the importance of the therapist being independent from their family, not only as an adult that would keep their confidentiality, but also it meant they could express their feelings and thoughts freely without worrying about the reaction of the other, and the emotional impact it might have upon them.

The centrality of the therapeutic relationship emerged as of great importance a finding that was reflected in all the four comparative qualitative studies in view. The young people reflected how important it was to them that the therapist thought well of them, liked them, thought they were intrinsically good, separated their behaviours from them as a person, and carried hope for them. As adolescents they had also been keenly observant of the therapist's non-verbal communications, sensitive to the psychotherapist's tone of voice, and made deductions about their meaning. Some such specific findings were also highlighted by Sagen et al. (2013).

10.3.3.2 The psychotherapists' perspectives

The importance of the therapeutic frame was discussed along with the need for flexibility, and whilst the classic form of weekly psychotherapy in the same room and at the same time and day was maintained, there were times when this was altered but done so in a thoughtful way. Sometimes changes were made to preserve a somewhat fragile connection by seeing an adolescent when they were admitted to an inpatient setting or communicating by text or phone between sessions when there had been discontinuity in attendance, or the adolescent had been in crisis. Maintenance of connection and containment within the frame was described as a delicate balance and process. Reports of qualitative studies have not addressed these particular issues, as their focus was more on the specific adolescent psychotherapist

relationship rather than the frame of that relationship, although Binder et al. (2008a) in discussing engaging adolescents talked about the variation of the use of authority in the therapist role, a consideration of how the therapeutic frame was held.

The capacity for the therapist to be flexible was something that arose as important for the adolescents, and also for the CAMHS directors when they spoke of what was needed to work with disturbed adolescents. Contemporary literature has explored the changing therapeutic frame particularly in the context of child and adolescent psychotherapy (Anagnostaki et al., 2017; Gold & Cherry, 1994; Gregson & Lane, 2000; Laor, 2007).

TFFP psychotherapists also identified critical therapeutic skills as attentive listening, commitment and care, thoughtfulness, being non-judgmental, attempting to understand, availability, not setting too high expectations, and the timing of making interpretations. The capacity was needed to sit with intense and uncomfortable feelings without being reactive, to keep the therapeutic frame and sometimes just to survive and to be able to think under provocation. That the psychotherapist needed to present as a positive, stable, and reliable figure providing containment for the adolescent was discussed. These themes expressed as central to their work the concepts of holding and containment (Bion,1959, 1957; Hinshelwood, 2018; Winnicott, 1955) and the provision of a secure base (Bowlby, 1988). Binder et al. (2008a) found all their therapists considered the establishment of a therapeutic bond was imperative, no matter what their theoretical stance.

Containment was considered extremely important by psychotherapists in the present study, as their patients often had early trauma backgrounds, and at times presented in crisis. The therapists' thought being a calm and containing presence and sitting with their patient's pain

was what was needed. Jones et al. (2020), who had experienced psychoanalytic psychotherapists compare the pros and cons of using Transference Intervention (TI) or not with depressed adolescents, found that for particularly vulnerable adolescents and those who have experienced relational trauma such as early abuse, or have difficulties with mentalizing and communication skills, the use of TI had to be considered very carefully by the therapist.

The psychotherapists agreed with the adolescents that liaison with the adolescent and their systems was important, and particularly naming the parent/carer, CAMHS, child protection, school pupil welfare coordinator and adult psychiatry teams for those who had turned 18. The psychotherapists expressed compassion and understanding for the parents and the multiple influences on their parenting, in addition to the struggle of managing adolescent development with appropriate emotional distance when their child had engaged in self-harm or at-risk behaviours. The relationship of the psychotherapist with the adolescent's parents was not a feature of the comparison qualitative papers.

Whilst it was not in the psychotherapist's brief to work with the parents, as CAMHS was involved with the adolescents and their families, the level of contact with parents varied. Some parents solicited contact with the psychotherapist in a non-intrusive way, as they were concerned about the suicidality of their child or wanted direct feedback on progress in psychotherapy.

The TFFP psychotherapists observed that the adolescent's attitude towards the psychotherapy relationship varied from positive regard through to strong negative transference of mixed projections. Some psychotherapists reflected that for some adolescents there was disappointment when the transference desire for a close maternal relationship in an informal

setting could not be fulfilled, and how boundaries in the therapeutic relationship could elicit different reactions such as understanding, confusion, and frustration. Binder et al. (2008b) discussed how therapists reflected upon their own feeling states with regard to ruptures in the therapeutic relationship, and that therapists varied in how they worked with such ruptures depending upon their theoretical focus on the interpersonal dynamics of the therapeutic relationship, as opposed to the adolescent's individual characteristics.

The significance of the therapeutic relationship, and what the psychotherapist was till holding from the therapeutic experience, was evident upon meeting them at the research interviews. All were curious to know how the young person was and some therapists had carried a concern for the young person and their well-being for years after the psychotherapy had finished. Just as the adolescents had carried feelings about the therapist, and the relationship, so did the therapist for the adolescent, and there appeared to be relief and pleasure to know that the adolescent was alive and getting on with their life.

The importance of the psychotherapeutic relationship was identified by the TFFP psychotherapists which was comparable to other studies (Binder et al. 2008a; Jones et al. 2020). The TFFP psychotherapists commented on their observations of the therapeutic relationship as being dynamic within sessions and over time. They discussed how the adolescent viewed the relationship in those moments was influenced by their capacity to use the relationship, their early history, associated transference and projections, developmental stage, and temporal needs. Binder et al. (2008b) noted fluctuating emotional instability as common in the adolescent group, with ruptures in the therapeutic alliance occurring within and between sessions. In the present study the TFFP psychotherapists commented that such variability in the adolescents meant they needed to be finely attuned to when there was a

difference between and within sessions, and to be adept at recognising and adapting to changing projections.

A theme of the psychotherapists and the young adults having exceptionally close views of the experience was found. Binder et al. (2008a) discussed a variation in their therapists on a symmetrical – asymmetrical dimension, and it would appear that that the psychoanalytic psychotherapists from the TFFP took up a position that was inclined towards a symmetrical position to engage and build the therapeutic alliance.

10.3.4 What impact, if any, did the research have on the psychotherapy?

Responses to participating in research was a special focus of the present study, not usually reported in this field. The experience of the repeated follow up re-assessments of the TFFP longitudinal study were explored with both the adolescents and their psychotherapists, and not a feature of any of the other qualitative studies discussed in this chapter. However, it was thought to be relevant to what implications the research had for the treatment of psychoanalytic psychotherapy.

10.3.4.1 The adolescents' perspectives

Contrary to fears of some psychoanalytic psychotherapists that research might interfere with the psychotherapeutic process, the majority of the young adults reported that participating in TFFP data gathering during the course of their psychotherapy had no discernible impact upon the progress of their therapy. As the completion of forms had been part of the process prior to commencement of psychotherapy, it was routinely accepted at follow up. At a minimum

the research was seen as irrelevant or having no impact on what happened in the room between them and the psychotherapist. However, at best, the research was seen as enhancing their psychotherapeutic work with their therapist. The research as separate from the psychotherapy treatment evoked curiosity in the present from a few young adults who were interested to see how their responses had changed over time.

Different experiences of the TFFP research follow up re-assessments were reported: feeling like an object who was being analysed, finding them emotionally intense, or like therapy rather than research. Finally, there was a valuing of the ongoing research relationship over time which had for some outlasted the length of their respective psychotherapies. There appeared to be not only a positive experience of the therapy for the young adult, but also an experience of feeling held in mind by the research project over time.

The TFFP research was seen in the present study to positively complement the psychotherapy by almost all the participants, with half saying it had helped them to reflect, remember and think about changes in their psychotherapy over time and at each follow up this reflection often helped them in their therapy as they thought about their thoughts and feelings. Just under half were motivated by altruism to help other young people through their participation in the research.

Only a couple remembered or associated the research project with the source of funding for their psychotherapy and were immensely grateful for having had the opportunity to experience psychotherapy at a critical time of need during their adolescence. The gratitude of these participants indicated the development of their emotional maturity and that they had a good experience of psychotherapy (Klein, 1957).

10.3.4.2 The psychotherapists' perspectives

Similarly, to the adolescents, the psychotherapists did not believe there had been any negative impact from the research project upon the psychoanalytic psychotherapy, viewing the two processes as separate. Like the young adults, they had observed that if there was any impact it had been positive, in that the research provided a structure and support for lone psychotherapists who were not employed within CAMHS. As mentioned in Chapter 3 as part of the set-up of the TFFP the philanthropic trust had provided funds not only for adolescent psychotherapy but also for weekly supervision of the psychotherapists.

It was also noted that there was an independent value in the research as another form of care for some, as the ongoing connection with the TFFP research continued after the psychotherapy had ended.

10.3.5 Can there be a place for psychoanalytic psychotherapy with adolescents within public child and adolescent mental health services (CAMHS)?

This research question was addressed only in the interview with the CAMHS directors. All had supported the TFFP as it provided a free, additional treatment in the form of psychoanalytic psychotherapy, and whilst some might not have seen this form of psychotherapy as the treatment of choice, there was confidence in the standard of care through the MCPP specialised training of the psychotherapists, and thus these directors thought it would do no harm.

Some directors considered that psychoanalytic psychotherapy within CAMHS had a limited place as clinical treatment for seriously disturbed, vulnerable adolescents with complex problems and trauma, where short-term work had been insufficient and long-term work was needed. Value was also placed on equity between private and public systems, and the benefits of a variety of treatment modalities to meet different needs.

Indeed, it was found in the TFFP (unpublished research data), that a number of the adolescents from CAMHS were referred to psychotherapy after other methods of treatment had not worked. In reviewing the field, Gabbard et al. (2002) mentioned that psychoanalytic treatments in psychiatry may be needed under such circumstances.

Other directors did not view psychoanalytic psychotherapy treatment in CAMHS as a practical option due to a loss of psychoanalytically trained staff, diminished training opportunities for CAMHS clinicians, the reduction of resources, the cost of long-term work, and the increased systemic demand for a crisis response which meant an appointment-based model was difficult to maintain, and the overall difficulty of justifying long-term work. Binder et al. (2008a) commented on the Norwegian health system and required empirically supported treatment possibly led to a loss in flexibility in treatment provided. Jones et al. (2020) also suggest the use of TI would not be advisable in public health care considering that short-term treatment frames are required.

Psychoanalytic theories and concepts were seen, by directors to have historical relevance in psychiatry, and as helpful in providing a framework for assessment and formulation, and useful in understanding complex interactions and dynamics. It was lamented that external psychoanalytic consultants for team reflective practice had become less available in CAMHS.

At the same time, directors considered that further research was necessary to link neuroscience and psychoanalytic theories, to operationalise psychoanalytic concepts such as projection to determine mechanisms, to evaluate treatment effectiveness, and to compare psychoanalytic psychotherapy with other treatments to evaluate effectiveness for particular diagnostic groups of adolescents. It is noted that considerable thinking and research around these areas and the challenge for increased research on the effectiveness and efficacy of psychoanalytic psychotherapy with adolescents have increasingly been conducted (Abbass et al., 2013; Fonagy & Target, 1997; Fonagy, 2003; Fonagy, Roth, &Target, 2005; Fonagy et al., 2015; Midgley, Target, &,Smith, 2006; Midgley, 2009; Midgley et al., 2009; Midgley & Kennedy, 2011; Solms, 2018; Yovell at al., 2015).

The directors all supported the value of research and were positive about investigation into the effectiveness of psychoanalytic psychotherapy with adolescence, as this mode of treatment was not seen by them to have a sufficient evidence base to justify its use in CAMHS. All directors desired multiple evidence-based treatments dovetailed to the particular needs of adolescents and their families within CAMHS.

10.4 Summary

Consideration of the limitations and strengths with respect to the validity of this study have been delineated. Some of the findings in Chapters 6, 7, 8 and 9 have been highlighted with comparisons made to the few qualitative studies on adolescent and psychotherapist experiences of psychoanalytic psychotherapy within CAMHS. This discussion has provided the foundation for conclusions to be drawn from this study. Implications for theory, clinical practice and further research endeavour are outlined in the final chapter.

CHAPTER 11

CONCLUSION

The two aims of this research study were addressed. It explored how seriously mentally ill adolescents and their psychotherapists perceived and experienced the psychoanalytic psychotherapy process and its outcomes. Secondly, it described the overall context of care as perceived by the directors of CAMHS, by the now young adults, and by their psychotherapists.

Chapters 7, 8 and 9 are the heart of this study, distilling and condensing the group themes raised by the individual adolescents, psychotherapists and directors whilst still allowing their words to be heard, as discussed in Chapter 10. After noting the key findings of the study, this conclusion considers the implications of the findings, in terms of their relevance to theoretical, clinical and research issues.

11.1. Key findings

The present study demonstrated that open-ended and potentially long-term psychoanalytic psychotherapy was experienced as effective for a group of severely disturbed adolescents in Victoria, Australia. The findings were compared to those of the few reported qualitative studies on the experience of psychoanalysis or psychoanalytic psychotherapy with adolescents suffering mental health difficulties (Binder et al. 2011; Binder, et al. 2008a, 2008b; Bury et al. 2007; Jones et al. 2000; Midgley & Target, 2005; Midgley et al., 2006; Sagen et al. 2013) and some young adults (Palmstierna & Werbart, 2013; Werbart et al. 2017). Across all studies, conducted in Norway, UK, Sweden, and now Australia, consistent

themes were found for what factors help with engagement and the ongoing work of psychotherapy with adolescents, thus adding to the validity and robust reproducibility of all the studies' results. This study in Australia illuminated these factors in an integrated way.

Directors reported that, as a tertiary service, Victorian public CAMHS 2002-2012 was responsible for adolescents with a combination of the most severe mental illness, comorbid diagnoses, childhood trauma, and psychosocial complexities in the State. Adolescent self-descriptions and psychotherapist descriptions of the adolescents in this study were in accord with the cohort of adolescents described by CAMHS directors as the primary target group for their services. With regard to its second aim, the present study highlighted problematic mental health service provision. Directors described, with some pride, a valued culture of ongoing learning and supervision within CAMHS. However, it was difficult to recruit and maintain staffing in some regions, small teams lacked critical mass and the complexity and demand was ever increasing. CAMHS endeavoured to provide efficient, economic, and effective, evidence-based treatments, cutting their allocated piece of the pie into thinner slithers. Three years on, the second child and mental health survey found the demand for mental health treatment exceeded service resources (Lawrence et al., 2015). They recognised the usefulness psychoanalytic psychotherapy for severely disturbed adolescents whose needs for long-term treatment was evident. Nevertheless, at the commencement of this study, the role of psychoanalytic psychotherapy as a treatment within CAMHS in Victoria had diminished, and now, at the time of writing, it is virtually non-existent.

11.2 Theoretical implications

The findings highlighted certain critical aspects of psychoanalytic theory as it pertains to psychological development and change as a function of psychoanalytic psychotherapy.

11.2.1 The importance of developing a secure base for exploration and change

The importance of a consistent, and caring adult figure available over time is vital. The importance of the therapeutic relationship was strongly stated by psychotherapists and adolescents in this study and across all comparative qualitative studies. Adolescents who have had early relational trauma need more time to build trust, further supporting the need to develop an ongoing therapeutic relationship with the same person. The adolescents in this study, when they became unwell, and in their most regressed and distrusting state, needed an adult whom they had learned to trust, and this implies the need for the availability of a long-term psychotherapy on the adolescent's terms.

Bowlby (1978) proposed the therapist has four simultaneous, but conceptually distinct tasks. The primary task is to provide a secure base to explore the self and relations with others with whom there is a potential or existing emotional connection. The other tasks were to concentrate on real-life experiences, to hold back on transference interpretations whilst looking at object relations, and to be aware of the impact of interruptions to treatment.

It could be argued that an ongoing relationship with a supportive, caring adult figure does not necessarily have to be with a psychoanalytic psychotherapist. That may be true, but in this study the work was with adolescents who were not just experiencing transient fluctuations in

mood, but rather, extreme difficulties in ego functioning such as emotional dysregulation, impulsivity, fluctuating boundaries around reality and fantasy, as well as feeling at times quite persecuted as they struggled with anxiety, depression and sometimes psychosis. They needed someone with deep understanding of extreme distress and primitive states of mind.

What was important for these adolescents was their therapist's capacity to receive the intensity of their communications without being reactive and rejecting, to finely tune to fluctuations within and between sessions using deep contemplative listening and to show that they wanted to understand them. It is suggested that it was due to their training, theoretical framework, and work on their own self-awareness, accompanied by weekly supervision, that the psychotherapists were able to hold the adolescents, so they and the adolescents survived those difficult times.

11.2.2 The therapeutic stance and frame

The TFFP psychotherapists talked about the need to hold or maintain the therapeutic frame, creating a safe place bordered by time and space, to enhance the development of the transference relationship (Milner, 1952). However, the capacity to be flexible within that frame and be more active in psychotherapy was considered important by psychotherapists, adolescents, and directors alike. It was noted that whenever there were deviations from the frame, these deviations were carefully considered by the psychotherapists either individually, or in consultation with their supervisors.

In this study psychotherapists refrained from making interpretations when an adolescent was in a fragile state. Awareness of transference and countertransference was a central part of the

psychotherapists training, theoretical understanding, and making sense of what was happening in the dynamics in the room with the adolescent, but interpretations needed to be timely, when the adolescent was able to receive them (Bion, 1962, 1957). As mentioned by Jones et al. (2020), research is showing that for those who are having difficulty mentalizing, who have had relational trauma, or where a negative transference has developed, transference interpretations may not always be helpful. Klein emphasised the therapeutic attitude of respect for the patient (Blass, 2018), and this stance includes the need to respect the defensive structure of an individual.

11.2.3 Outcomes achieved from establishing a secure base

Some adolescents talked of having no sense of worth when they commenced psychotherapy, and others described being so overwhelmed by their emotions, sometimes linked to trauma, that they could not think. Through establishing a secure base within a therapeutic relationship, these adolescents started to change. They started to learn to think, and that led to developing a capacity to begin thinking about their own mind and the separate minds of others, with a growing capacity to process feelings and thoughts and growing self-confidence. These changes then translated into a more genuine and intimate capacity for relatedness and improved relations with family and peers in their lives, as their own self-esteem, self-care and self-identity grew.

As proposed by Bowlby (1978), the processes of psychoanalytic psychotherapy allow for an exploration of the adolescent's internal world in relation to situations, and relationships in their external world. Through the dynamics of their therapeutic relationship and a re-working of their internal objects and identifications (internal working models), a developing capacity

for reflective functioning and mentalization emerged (Fonagy, Gergely, Jurist & Target, 2002; Fonagy, 2001).

11.3 Clinical implications

11.3.1 The provision of weekly psychoanalytic psychotherapy for two years to the most disturbed and complex adolescents can promote long term mental health, quality of life and save their lives

It was reflected by the young adults that it was difficult to separate out various influences and their impact on how they had changed over time. However, definite and clear statements were made by some that it was their experience of psychoanalytic psychotherapy that had kept them alive and diminished their self-destructive behaviours and negative relationships.

Concerning resources, whilst funding was provided for twice weekly open-ended psychoanalytic psychotherapy to adolescents within CAMHS, it was found that weekly was the most common frequency that adolescents preferred, and that an average of about 2 years length of treatment was sufficient.

11.3.2 The centrality of the psychotherapeutic relationship

Both the young adults and the psychotherapists in this study carried strong feelings about the other for years after the psychotherapy had finished. The psychotherapists were eager to know not merely how the adolescents were, and how they had turned out, but if they were alive. Some psychotherapists had felt a deep concern and fear for the adolescent many years

after their finishing. The young adults exhibited a sense of mourning for the lost relationship, often carrying feelings of guilt for not having said goodbye or letting the psychotherapist know how they felt. The psychotherapists had also learned from the adolescents, and that learning informed their subsequent psychotherapies with adolescents. Whilst the relationship was in the past, it had ongoing significance for both parties and they both remembered and cared about the other.

The premature termination of psychoanalytic psychotherapy, whether by the psychotherapist or the adolescent, was seen as unhelpful by the adolescents. There are occasions when such events cannot be prevented such as the ill health of a psychotherapist, but clear communication about what had happened is important, so that the adolescent is not left in a state of ignorance, uncertainty, and anxiety about the therapist. The feelings about the ending could be worked through if the adolescent agrees to a transfer to another therapist, in the situation where the therapist becomes ill.

The implication clinically is that particular attention needs to be directed to how the psychotherapy ends, and a therapeutic letter, email or text may be considered useful if the adolescent is unable to say goodbye.

11.3.3 The holding of the psychotherapist by supervision and by the system

The TFFP psychotherapists talked about how hard and intense the work was and this has been echoed by other studies (Binder et al. 2008b; Werbart et al. 2017). When unpacking the difficulties of that work, the psychotherapists identified a complex process. This included sitting with the intensity of the patient's emotions and their own reactions and thinking about

their theoretical hypotheses about what was happening, their observations of interactional patterns over time with the adolescent, what was going on in the adolescent's life in the here and now, and their experience over time of what the adolescent most needed. The complexity of thinking, observing and self-monitoring that took place within and between sessions in trying to make sense of what was happening, and what the adolescent needed, was challenging and tiring. Again, the importance of getting to know the adolescent over time is underlined, as well as the role of training, theory, and support to hold the psychotherapist in this sometimes volatile and risky work.

Clinical supervision is essential to the wellbeing and effectiveness of psychotherapists delivering intricate, multi-faceted, attuned, and responsive psychotherapeutic treatment in the context of severe psychological disturbance. However, the service system also plays a part in this holding and facilitation of a space to think about complex patients, and current challenges are considered in the next section.

11.3.4 The service context of the psychoanalytic psychotherapy

The theoretical understanding, and language of psychoanalysis were seen as useful in understanding complex dynamics, but the place for psychoanalytic psychotherapy as a treatment was seen as limited by the directors. In the CAMHS system, the demand is greater than the resources (Lawrence et al. 2015), presentations are complex and acute, and quick responses and risk assessments are prime. CAMHS are challenged to find a space to think, to filter the differing demands, and to sit and be present with the vulnerable adolescent whose internal world is as fragmented and depleted as the external service that is trying to help

them. How can the psychotherapist be held in an overall sense, in order to be able to hold and contain the disturbed adolescent and their projections?

Herein lies the dilemma. Psychoanalytic psychotherapy is an effective treatment for adolescents with severe mental health difficulties, but can the public mental health system provide the necessary conditions to make it available, viable, and a safe space?

11.3.5 When is it time to finish?

Most psychotherapists thought the adolescent needed more therapeutic work, but the adolescents thought that what they had done was sufficient. The adolescents based their thinking on relief from symptoms and being ready to connect with peers and to move forward by asserting their identity and independence in terms of study, work, and relationships. The therapists were thinking of deeper structural changes which some adolescents were free to address or not at a later time. A collaborative agreement on the ending was not always achievable.

What was important for the adolescents was to be self-determining, the experience had helped them deal with their problems at the time and was 'good enough' (Winnicott, 1965). The adolescents talked about having better coping and problem-solving skills to deal with stressors and strains in their lives, but they also had developed an awareness of when they might need help again, and an acceptance that it was okay to seek further help. Some were quite direct in articulating that psychotherapy was not a cure.

Clinically, this is an important outcome, that adolescents no longer felt shame or stigma about future help seeking as needed.

11.4 Implications for further research

This study has contributed to the understanding of the adolescent and their psychotherapist's experience of psychoanalytic psychotherapy and has thus contributed to one area of the growing evidence-base for the effectiveness of psychoanalytic psychotherapy with adolescents with severe mental illness.

11.4.1 Research as an aid to reflection

This study found that participation in the TFFP had a recursive value for the psychoanalytic psychotherapy, in that follow-up assessments prompted a focus for both adolescents and their psychotherapists to review their work together, which was seen as helpful by both. Despite fears that the research could impinge in a negative way upon the work between the adolescent and their psychotherapist, this was not seen as an issue by anyone in the present study.

The inclusion of research in the training of psychotherapists is an advantage in which all psychotherapists in the present study participated. However, the MCPP training has become the Child Psychotherapy stream of the Master of Mental Health Science (MMHSc) which teaches the theoretical component of the child psychotherapy training, with the clinical training provided separately by the CPPAA. The requirement to submit a minor research thesis is not necessary if it is chosen to complete a Master degree by coursework. The present study affirmed the value of the psychotherapist understanding the role of research.

Findings here also confirmed that long-term clinical research can have a containing function for both the psychotherapist and the adolescent, in that participants are aware that their work is kept in mind by the researcher. The theoretical credentials of the researcher, being in tune with those of the psychotherapists involved, are probably important where qualitative research is being conducted.

11.4.2 Potential areas for further research

11.4.2.1 Investigation of the long-term cost-benefits of long-term psychoanalytic psychotherapy in adolescent mental health services

The findings justify the provision of long-term psychoanalytic psychotherapy as an evidence-based component of the treatment program offered by inpatient and follow-up public community adolescent mental health services. Further research to investigate the relative long-term cost-benefits of long-term psychoanalytic psychotherapy (LTPP) is necessary to convince governments to invest in its inclusion in the budgets of CAMHS.

The study demonstrated that open ended psychoanalytic psychotherapy was of benefit to adolescents with a complex range of serious mental health and adjustment problems, which is the usual presentation of youth requiring inpatient treatment. Further research directed at the relative effectiveness of open-ended psychotherapy for specific mental health disorders such as mood disorders or schizophrenia spectrum disorders is indicated, to determine whether open ended psychotherapy has a relatively more specific effectiveness on the complex components of mental illness in young people.

11.4.2.2 The parent's perspective

The young adults in this study consented to their parents being interviewed, and these interviews were conducted. These data have yet to be analysed. Such analysis would provide information about the parent's experience of having their adolescent receive psychoanalytic psychotherapy, which would contribute to an understanding of the wider family context and of family contributions to the youth mental health difficulties, their outcome and long-term adjustment.

11.4.2.3 The supervisor's perspective

In any similar study in the future, exploration of the supervisors' experience in combination with that of the psychotherapists and adolescents would provide a further opportunity to triangulate information and thus understand the overall experience for all concerned at a deeper level.

11.4.2.4 Further exploration of the impact of premature termination and termination processes in adolescence

The young adults nominated premature termination as the most unhelpful aspect of psychoanalytic psychotherapy, and it continued to carry emotional charge some years later. It would be useful in terms of clinical practice to explore the different conditions of termination and what might be mediating factors.

11.4.2.5 Exploration of what contributes to a negative experience of treatment

A negative previous treatment can increase reluctance and hopelessness about seeking further treatment, and this would also be an important area for further investigation.

11.5 In summary

The experience of psychoanalytic psychotherapy was reported retrospectively to be a positive one for the majority of the severely disturbed adolescents interviewed in this study. It was difficult for them to return to a time that was extremely painful, and it was because they wanted to help other adolescents that they shared their stories. These adolescents had seen themselves as outsiders, unworthy and unlovable. All they wanted was someone who was prepared to listen, respect, and value what they had to say - someone who would accept them, and like them even when they behaved in awful ways, and someone who would not give up on them, even when they had given up on themselves. Having a safe space and containment facilitated the development of self-valuing, help seeking capacities and self- protection.

This thesis demonstrated that open ended psychoanalytic psychotherapy provided within a CAMHS context, was an important and meaningful experience. The development of a positive and trusted therapeutic bond facilitated the process of therapeutic change, along with the skills and stance of the psychotherapist, and the motivation of the adolescent to form a working alliance. Improvement occurred in developing a sense of identity, capacity for reflection, awareness, management of feelings and behaviours and these changes in turn, benefited their interpersonal relationships. Most importantly it kept adolescents alive.

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APPENDIX I

28 January 2003

MONASH UNIVERSITY

Professor Bruce Tonge & Ms Jill Pullen
Centre for Developmental Psychiatry
Monash Medical Centre

Project 2002/645MC – A follow-up study of the recovery process of young people admitted to Southern Health CAMHS

Thank you for the information provided in relation to the above project. The items requiring attention have been resolved to the satisfaction of the Committee. Accordingly, this research is approved to proceed.

Terms of approval

The project is approved as submitted for a three year period from the date of this letter and this approval is only valid whilst you hold a position at Monash University. You should notify the Committee immediately of any serious or unexpected adverse effects on participants or unforeseen events that might affect continued ethical acceptability of the project. Any changes to the research protocol require the submission and approval of an amendment. Substantial variations may require a new application. Please quote the project number above in any further correspondence and include it in the complaints clause which must be included in the explanatory statement and may be expressed more formally if appropriate:

You can complain about the study if you don't like something about it. To complain about the study, you need to phone 9905 2052. You can then ask to speak to the secretary of the Human Ethics Committee and tell him or her that the number of the project is _____. You could also write to the Secretary. That person's address is:

The Secretary
The Standing Committee on Ethics in Research Involving Humans
Monash University, Victoria 3800
Telephone (03) 9905 2052 Fax (03) 9905 1420
Email: SCERH@adm.monash.edu.au

Progress reports

Continued approval of this project is dependent on the submission of annual progress reports and a termination report. Please ensure that the Committee is provided with an annual report by 20 December each year. A final report should be provided at the conclusion of the project. The Committee should be notified if the project is discontinued before the expected date of completion. The report form is available at http://www.monash.edu.au/resgrant/human-ethics/forms-reports/index.html.

Retention and storage of data

The Chief Investigators of approved projects are responsible for the storage and retention of original data pertaining to a project for a minimum period of five years. You are requested to comply with this requirement.

fav
Ann Michael
Human Ethics Officer
Standing Committee on Ethics in Research Involving Humans (SCERH)

RESEARCH GRANTS AND
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Time For A Future

APPENDIX II

WHO TO REFER

CAMHS Assessment Follow up Study & Youth Psychotherapy Program

We are conducting a study on the recovery process of emotionally disturbed young people referred to CAMHS in Victoria. This will involve an initial assessment and then follow-up assessments at 6, 12, and 24 months.

For the Assessment Follow Up Study, it is appropriate to refer:

- Any young person between the age of 13 and 17 years who has experienced serious emotional disturbance requiring admission to CAMHS services, and in particular, intensive treatment such as hospitalisation and day programmes.
- In particular, young people who have experienced psychotic symptomatology and may fall into the following diagnostic groups (or combination of)-: Mood Disorder – (eg. Depression with psychotic features, Bi Polar Disorder), Schizophrenia, Schizophreniform Disorder, Brief Psychotic Disorder, Delusional Disorder and severe Anxiety Disorders such as PTSD, which may be associated with Personality difficulties such as Schizotypal and Borderline states.
- Young adolescents who may not have a formal diagnosis, but have high levels of difficulty coping with daily life and relationships (eg. low functioning on GARF & GAF scores), and/or a family history of mental illness, symptoms of external family relationship difficulties (peer & adult), a history of childhood trauma, and/or a combination of the following symptoms -: sleep disturbance, eating disturbance, social isolation (avoidance), hypersensitivity, lack of motivation, confusion, depression, anxiety, irritability, poor concentration, difficulties coping with adolescent developmental tasks, such as study and so forth.
- Young people whom it is thought are using drugs to self-medicate/control symptoms related to an underlying mental illness, but this behaviour does not constitute their primary diagnosis.

To participate, both parent/carer and young person would need to be prepared to be involved in follow-up studies.

The Psychotherapy Treatment Program

In addition to the usual treatment provided by CAMHS, some funding has been made available for us to establish a psychotherapy program. This means a referral can be made to our program for long-term intensive psychoanalytic psychotherapy. Those referred for this type of treatment would be included as a subset of the above overall study, provided the patient and their family consent to participate in the research study. Young people who meet the above criteria and who may be interested/prepared to attend twice weekly psychotherapy sessions, may be referred. It would also facilitate the young person's attendance and treatment in psychotherapy if they have a supportive family/carer group, as they would be expected to be involved in the young person's treatment through parent, family or case management work

If you need further clarification about the CAMHS Assessment Follow Up Study or the Youth Psychotherapy Treatment Program, please ring Jill Pullen or Georgina Hughes on 9594 1300 at CAMHS Southern Health Reception, Clayton Campus and we can discuss the referral in detail.

APPENDIX III: TFFP HANDOUT ON MYTHS ABOUT PSYCHOANALYTIC PSYCHOTHERAPY

PSYCHOANALYTIC PSYCHOTHERAPY & PSYCHOTIC YOUNG PEOPLE

THE MYTHS/FEARS	THE REALITY
1. Psychotherapy promotes dependency	1. Psychotherapy is relationship based [in working with young people with early unmet emotional needs dependency often develops in the context of psychotherapy & this is necessary in order to develop a more consolidated sense of self and individual capacity]
2. Psychotherapy deals only with the past	2. In psychotherapy the past is relevant & worked with in so far as it impacts on the patient's current functioning [the past is dealt with when it's dynamics (Transference) are reflected in the 'here and now' of the relationship with the psychotherapist in the consulting room]
3. Psychotherapy is rigid & precious about times and rooms being kept the same	3. Psychotherapy aims to provide consistency & continuity which then allows sufficient trust & a sense of security to develop [trust is a key issue in the development of a sense of self and a capacity to do difficult emotional work] • Psychotherapy provides a containing & holding structure [e.g. the experience of the same environment & time is helpful for the client particularly when they may never have developed a sense of internal structure]
4. Psychotherapists break down defenses • Psychotherapists uncover & expose the individual's fragility leaving them more disturbed • Psychotherapy is dangerous & causes psychotic breakdown • Psychotherapists make interpretations to vulnerable patients when they are floridly psychotic • Psychotherapists escalate high emotion in patients which can cause them to decompensate	4. The Psychotherapist holds what the patient is maybe unable to know or bear (this could be over weeks, months or years) [the process of projective identification is a primitive communication of raw feelings that are normally heavily defended against but are encountered daily in our clinical population] • Psychotherapy is flexible & responsive to the client's needs & becomes supportive & holding when the client is in a state where they cannot work on issues. • For those patients who have developed a 'False Self' the 'True Self' or vulnerable inner core is well hidden & protected & whilst psychotherapy may aim to assist the young person with their authenticity this may take many years

APPENDIX III: TFFP HANDOUT ON MYTHS ABOUT PSYCHOANALYTIC PSYCHOTHERAPY

PSYCHOANALYTIC PSYCHOTHERAPY & PSYCHOTIC YOUNG PEOPLE

THE MYTHS/FEARS	THE REALITY
5. Psychotherapists only see their patient's point of view or side of the situation	5. The Psychotherapist explores the capacity of the patient to hold different points of view [when the patient is in a more disturbed state they may be unable to perceive other points of view, however the psychotherapist holds these views in mind]
6. Psychotherapists only deal with feelings & don't help with confused & distorted thinking	6. Psychotherapy provides a thinking space for the patient • Psychotherapy involves the integration of conscious & unconscious thoughts & feelings [with the aim of integrating aspects of functioning that the person is maybe disconnected from and to make them more accessible]
7. Psychotherapy is contraindicated for young people suffering with psychosis	7. Contemporary psychoanalytic psychotherapy is now used internationally with significant results with diagnostic groups previously considered untreatable e.g. personality disorders and psychosis.
8. Psychotherapists are unavailable for consultation	8. Psychotherapists are part of a treating team & whilst there is confidentiality between patient & therapist there is also an expectation that there is consultation & liaison [the treatment needs of the young person & the psychotherapist 's understanding of the meaning of the young person's behaviour in different contexts needs to be communicated] • The Psychotherapist is aware of dynamics that the patient can generate through parallel processes e.g. splitting, disruption and enactment amongst people who work with them
9. Psychotherapy can be a stand alone treatment for young people with psychosis	9. It is essential with this clinical population that psychotherapy is considered as one of a number of treatment approaches and that the treating team has close liaison & communication

APPENDIX IV List of Measures TFFP

<18 years	>18years
1. MEASURES OF ADOLESCENT FUNCTIONING:	**1.MEASURES OF YOUNG ADULT FUNCTIONING:**
i. Diagnostic status & clinical severity	**i. Diagnostic status & clinical severity**
K-SADS-1VR (Kiddie SADS – semi structured diagnostic I/V for DSM1V)	SCID-I (Adult semi structured diagnostic I/V for DSM1V)
GAF & GARF (CM,Px,Prt, Researcher)	GAF & GARF (Young Adult, CM,Px,Prt, Researcher)
ii. Self-reports	**ii. Self-reports**
Coping Questionnaire (SEQ-PA).	Coping Questionnaire (SEQ-P).
Reynolds Adolescent Depression Scale (RADS).	The Beck Depression Inventory-II
The Revised-Children's Manifest Anxiety Scale (R-CMAS).	The State-Trait Anxiety Inventory for Adults
YSR – Youth Self Report:	ASR - Adult Self Report
Clinical Interview including **Adolescent Background Q**	Clinical Interview including **Young Adult Background Q**
iii. Other Data on Adolescent Functioning:	**iii. Other Data on Young Adult Functioning:**
CBCL – Parent/Carer completes	ABCL- Adult Behaviour Checklist –Parent/Carer/Partner
CBCL - TRF – Teacher completes	
The Pitzner Negative Life Events Checklist for Adolescents (PNLEC-A)	The Pitzner Negative Life Events Checklist (PNLEC)
Child Temperament Survey (EAS) – parent/carer completes	Young Adult Temperament Survey (EAS) – parent/carer completes
	Dissociative Experiences Scale (DES)
Clinical Interview including **Parent/Carer Background Q**	Clinical Interview including **Parent/Carer/Partner Background Q**
Case Manager Questionnaire	**Case Manager Questionnaire**
Psychotherapist Questionnaire	**Psychotherapist Questionnaire**
Referral Information – CM/Px/other (Time 1)	
2. MEASURES OF PARENTAL MH & FAMILY FUNCTIONING.	**2. MEASURES OF PARENTAL MH & FAMILY FUNCTIONING**
The Brief Symptom Inventory (BSI).	The Brief Symptom Inventory (BSI).
The Personality Diagnostic Questionnaire (PDQ-4)	The Personality Diagnostic Questionnaire (PDQ-4)
The Dyadic Adjustment Scale (DAS)	The Dyadic Adjustment Scale (DAS)
Family Assessment Device (FAD) – completed by adol & parent	Family Assessment Device (FAD) – completed by young adult & parent

Assessment & Reassessment Intervals					
Time 1: pre-treatment	**Time 2: 6 months (only PP & stopped)**	**Time 3: 1 year**	**Time 4: 2 years**	**Time 5: 4 years**	**Time 6: 6 years**

1. Case Manager Questionnaires in follow up assessments only obtained if young person/young adult still in treatment within CAMHS or AMHS or another service.
2. Psychotherapist Questionnaires in reassessments only obtained if young person/young adult was still in Psychotherapy treatment.
3. At some reassessments the adolescent/young adult or parent/carer would only agree to a telephone interview & completion of measures by post.
4. At some reassessments information was only obtained from the adolescent or young adult
5. At some reassessments information was only obtained from the parents/carers
6. Assessments and reassessments were done by Research Staff in the TFF Project – minimum training was an Honours Degree in Psychology whilst completing a DPsych or PhD. Others had a Masters in Psychology or Psychoanalytic Psychotherapy; PhD in Social Work, and 1 x trainee Child & Adolescent Psychoanalytic Psychotherapist. Majority of Psychotherapy Group 'adolescent/young adult' assessments and reassessments were conducted by the Project Coordinator (Child Psychotherapist).
7. When no other researchers were available, the adolescent, young adult, parent/carer(s) assessments and reassessments were all done by one researcher, and in the last years of the project this was the Coordinator.

APPENDIX V

Research Project Title: A follow up study of young people admitted to a Victorian Child and Adolescent Mental Health Service (CAMHS) (Retrospective Experience of Psychoanalytic Psychotherapy Component)

YOUNG ADULT INTERVIEW PROTOCOL

***Introduction**:*

You may remember the first time we met, when you were first referred to the Time for a Future Project (TFFP). I last met with you, at the six year follow up of the Project.

Today, we have up to two hours together with a break in the middle, so you can have a rest, but first I want to check if there are any further questions you have regarding the explanatory statement and consent form you have signed, before we start.

I would like you to think back over the time you were in psychotherapy with ……..…… (*Therapist's name*). You began therapy on …….. (*Insert date).* I am interested to know as much of it as you recall; how you found it, your experience of it.

QUESTIONS to be asked

PART 1:

1. What can you tell me about your experience of psychotherapy?

2. What do you think your therapist's experience was of working with you?

3. What do you remember about your relationship with your therapist?

4. How do you think the therapist saw your relationship with them?

5. How did psychotherapy impact upon your relationships?

6. When you think back what sort of adolescent were you and what was happening?

BREAK

PART 2:

7. Having had a break is there anything you want to add to what you said earlier?

8. What part has psychotherapy played in your management and thinking about psychological distress now, compared to when you were an adolescent?

9. How do you think things would have gone if you hadn't had psychotherapy?

10. Thinking back what sort of influence if any do you think the Research Project had on your psychotherapy?

11. Thinking back to that period of time when you were in psychotherapy. What was it like being an adolescent growing up in …… (*Insert* name) region of Melbourne/Victoria at that time?

12. Is there anything else you would like to add?

Thank you for your participation and sharing your experiences of psychotherapy as an adolescent

APPENDIX VI

Method: Construction of semi-structured interview

Young Peoples' Domains x 10

Domains of enquiry: Interview questions

1. Overall experience of psychoanalytic psychotherapy
2. Young person's view of the psychotherapist's experience of psychoanalytic psychotherapy
3. Young person's view of their relationship with the psychotherapist
4. Young person's view of how the psychotherapist saw the relationship
5. Impact of psychotherapy on the young person's relationships
6. Explanation & understanding of the young person's difficulties
7. Change in management & thinking about psychological distress
8. What if there had been no psychotherapy?
9. Socio/cultural context of the young person
10. Impact of the research on the psychotherapy

APPENDIX VII

Research Project Title: A follow up study of young people admitted to a Victorian Child and Adolescent Mental Health Service (CAMHS) (Retrospective Experience of Psychoanalytic Psychotherapy Component)

Time For A Future

PSYCHOTHERAPIST INTERVIEW PROTOCOL

***Introduction**:*

It is …….. (*Insert length of time*) since ……. (Insert *name of Young Adult*) completed psychotherapy with you. She/he was first referred to psychotherapy on…….…… (*Insert date*).

Today, we have 1 to 1.5 hours together, but first I want to check if there are any further questions you have regarding the explanatory statement and consent form you have signed before we start.

I hope you have had a chance to review your process notes from that time, as they may assist in your recollections. I would like you to think back over the time you were the psychotherapist of ……..…… (*Insert Young Adult's name*). I am interested to know as much of it as you recall; how you think …….. (*Insert Young Adult's name*) found it, his/her experience, and your own experience, of therapy with him/her.

QUESTIONS to be asked

1. What can you tell me about the young person's experience of psychotherapy?

2. What was your experience of psychotherapy with this young person?

3. What do you remember about your relationship with the young person?

4. How do you think the young person saw your relationship with them?

5. What do you remember of the young person's parent/carer?

6. How did Psychotherapy impact upon the young person's relationships?

7. When you think back what sort of adolescent was the young adult and what was happening?

8. What part did psychotherapy play in his/ her management and thinking about psychological distress at completion of treatment compared to when he/she was an adolescent?

9. How do you think things would have gone if the young adult had not had psychotherapy?

10. Thinking back what sort of influence if any, do you think the Research Project had on the psychotherapy?

11. Thinking back to that period of time of the psychotherapy. What was it like being an adolescent growing up in …….. (*Insert* name) region of Melbourne/Victoria at that time? And what would it have been like to be a parent of an adolescent?

12. Is there anything else you would like to add?

Thank you for your participation and sharing your thoughts as the psychotherapist of an adolescent in psychotherapy

APPENDIX VIII

Research Project Title: A follow up study of young people admitted to a Victorian Child and Adolescent Mental Health Service (CAMHS) (Retrospective Experience of Psychoanalytic Psychotherapy Component)

Time For A Future

DIRECTOR INTERVIEW PROTOCOL

***Introduction*:**

You may recall that the *TFF: Assessment Follow up Study* was designed to explore treatment of young people with serious mental illness often they had been, or were inpatients. The project was funded by the Pratt Foundation to commence in early 2002. As a Director of a CAMHS, you were approached about your service participating in this study. The study was eventually extended to six year follow-up with participants. You will remember, as part of this clinical naturalistic follow up study, additional psychoanalytic psychotherapy treatment and weekly supervision for the psychotherapists was funded.

I have commenced a PhD study looking more closely at the young people who received psychoanalytic psychotherapy. This interview with you is to explore the organisational context within which the psychotherapy occurred. Directors of participating CAMHS when the study commenced are being contacted.

As always, of course, your participation is voluntary and your comments confidential. The material from CAMHS Directors will be pooled and analysed as a group. Illustrative quotations could be cited in the thesis, but these will be anonymous. As before, all data will be stored in a locked filing cabinet at Monash University, (Clayton), and transcripts kept electronically will have a code number only. The interview is expected to take about an hour of your time.

Do I have your verbal consent to audio-record today's interview, so that what you say is accurately recalled? Do I have your permission to contact you should I need to clarify anything from today's interview? What would be the best way to do so, by email or phone?

Now I would like to know your opinions about CAMHS and adolescents based on your experience.

QUESTIONS to be asked

1. Thinking back to when this project began in early 2002, what expectations, if any, did you have regarding the project in CAMHS?
2. Thinking back to 2002 again, what do you think it was like for adolescents growing up in the …….. (*Insert name*) region of Melbourne/Victoria?
3. What were CAMHS themselves like back in 2002?
4. What have been the important changes for adolescents in CAMHS since 2002?
5. Now for something different, what are your thoughts about working with young people with serious mental illness?
6. What do you think best equips clinicians to work with young people with serious mental illness?
7. Do you have any further comments?
8. Just one more thing, what place do you think psychoanalytic theories or psychotherapy treatment have in public mental health services with adolescents?

THANK YOU FOR YOUR TIME

APPENDIX IX

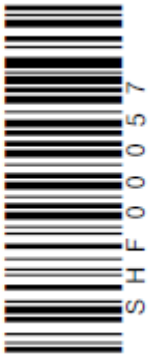
Time For A Future

Southern Health – CAMHS (Monash Medical Centre)
and
Centre for Developmental Psychiatry & Psychology
(Monash University)

YOUNG ADULT EXPLANATORY STATEMENT
31/10/11

You have been invited to participate in a research study entitled:

A follow-up study of young people admitted to a Victorian Child and Adolescent Mental Health Service (CAMHS: (Retrospective Experience of Psychoanalytic Psychotherapy Component)



Your Consent:
This two page Participant Explanatory Statement contains detailed information about the research project. Its purpose is to explain to you as openly and clearly as possible all the procedures involved in this project before you decide whether or not to take part in it.

Please read this sheet carefully. Feel free to ask questions about any information in the document. You may also wish to discuss the project with a relative or friend. Feel free to do this.

Once you understand what the project is about and if you agree to take part in it, you will be asked to sign the Consent Form. By signing the Consent Form, you indicate that you understand the information, and that you give your consent to participate in the research project.

Purpose of the Study:
You have been involved in our long-term follow-up study of young people and their family who have accessed Victorian CAMHS. It has now been some time since you first accessed CAMHS and you may have experienced an improvement to your mental health and wellbeing since then. As you were engaged in psychoanalytic psychotherapy, we are hoping that you are willing to be interviewed about your experience of this treatment. We also hope you are willing to give consent to your Parent/Carer and your then Psychotherapist to be interviewed.

Whilst a body of research in the area of psychoanalytic psychotherapy for adults has become more established, not a lot is understood about how psychoanalytic psychotherapy is experienced by young people who suffered mental health problems during their adolescence. Sharing your experience will make an important and valuable contribution to assessment and treatment for young people experiencing mental health problems.

Procedures involved in the Study:
We will seek your written consent to meet with you again to discuss in detail your experience of psychoanalytic psychotherapy as an adolescent. A researcher would meet with you at a convenient time and location, possibly at 18 Beddoe Avenue, Monash University, Clayton, or at your home, to interview you about your reflections on treatment.

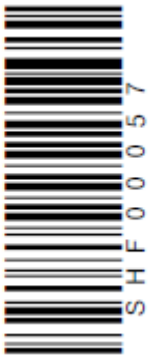
We will also seek your written consent to meeting with your Parent/Carer (if currently in contact with you), and your former Psychotherapist.

Demands on patients:
The interview would take up to 2 hours, with a break in the middle for you to have a rest.

Possible Benefits:
The purpose of this study is to explore your experience of the process of psychoanalytic psychotherapy as an adolescent and how it impacted upon you with regard to your mental health problems at the time. The study has scientific and social benefits in terms of providing information

relevant to psychoanalytic psychotherapy treatment of adolescents with mental health problems. This information could potentially lead to improvements in adolescent mental health treatment.

Possible risks:
Although unlikely, if you should become upset at the time you complete the interview, we will discuss whether you may require assistance from a support agency or service, and if so we can facilitate an appropriate referral for you.



Privacy, Confidentiality and Disclosure of Information:
You will be asked to give written consent for participation in the interview and for it to be audio-recorded so that an accurate account of what you say can be remembered.

Your personal information will be kept in the strictest confidence at all times. Your involvement in this study will in no way be identified. Results of the study will be reported on a group basis only in any publication. Your name will not appear in any such published reports.

Notes collected about you and your family during the study will be kept anonymously in a locked and secure filing cabinet at Monash University, Clayton. After more than five years all identifying information linking your name to ID codes will be destroyed.

Participation or withdrawal from the Study:
Your participation in this study is voluntary and you may withdraw at any time without loss of access to any health services.

Ethical Guidelines:
This study will be carried out in accordance with the *National Statement on Ethical Conduct In Research Involving Humans* (2007) produced by the National Health and Medical Research Council of Australia. The Ethics Committee of the Monash-Medical Centre, Southern Health has approved the ethical aspects of this research project.

Results of the Study:
A summary report of the outcome of the research will be mailed to all participants at the end of the study. A detailed report will be submitted for publication in a scientific journal. The study will be reported in a PhD Thesis available in Monash University Library.

Further information or Complaints:
Should you have a concern regarding the conduct of the project, or regarding your rights as a participant in this study please contact-: Malar Thiagarajan (Director - Research Services) on 9594 4611

Any further information or questions about the study can be discussed with Ms. Jill Pullen (Project Coordinator & Researcher) on 9905 1553; 0417 575 884 or jill.pullen@monash.edu.

You will receive a copy of this information sheet. Again, please feel free to contact us directly if you require any further information about this study.

Research Team:

Jill Pullen	(Project Coordinator, Co-Investigator & PhD Candidate) Tel: (03) 9905 1553 or Mobile: 0417 575 884
Emeritus Prof. Bruce Tonge	(Chief Investigator) Tel: (03) 9594 1477
Ms. Jeanette Beaufoy	(Co-Investigator)
Dr. Stanley Gold	(Co-Investigator)
Clinical Associate Professor Suzanne Dean	(Co-Investigator)

APPENDIX X

Time For A Future

Southern Health – CAMHS (Monash Medical Centre)
and
Centre for Developmental Psychiatry and Psychology
(Monash University)

INFORMED CONSENT to RESEARCH

Young Adult

Version No.2, dated 31/10/11

Full Project Title: A follow up study of young people admitted to a Victorian Child and Adolescent Mental Health Service (CAMHS) (Retrospective Experience of Psychoanalytic Psychotherapy Component).

Principal Investigator: Emeritus Professor Bruce Tonge

Co-Investigators: Ms. Jill Pullen, Ms. Jeanette Beaufoy, Dr. Stanley Gold and Adjunct Clinical Associate Professor Suzanne Dean

1. I have read and understood the Young Adult Explanatory Statement (version 2 dated 31/10/11) concerning the study that has been supplied to me.

2. I understand the purpose of this study is to reflect upon my experience of psychotherapy as an adolescent

3. This study will involve an interview asking about my experience of psychoanalytic psychotherapy when I was an adolescent and will take up to 2 hours, with a break in the middle so I can have a rest.

4. I consent to the interview being audio-recorded

5. I understand there will be an interview with my Parent/Carer (if we are currently in contact), and my former Psychotherapist regarding their reflections on the psychoanalytic psychotherapy experience, and I hereby consent to that.

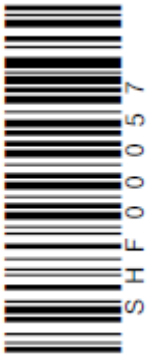
6. I understand there is not likely to be any risk of psychological harm in the study but if I become distressed, if I am no longer receiving treatment, then I can be offered referral options.

7. The details of the study and the purpose of the study have been fully explained to me by Jill Pullen

8. I have been given the opportunity to ask questions regarding the study and any questions that I have asked were answered to my satisfaction.

9. I have been given the opportunity to have a family member or a friend available while the project was explained to me.

10. I understand that data will be kept for at least 5 years in a locked filing cabinet at Monash University, Clayton and any identifying codes completely destroyed after that time.



11. I authorise the-researchers to preserve, use or publish the results of this study, provided my identity, Parent/Carer's identity and Psychotherapist's identity are not revealed to others.

12. My participation in the research study is voluntary, and I am free to withdraw at any time, without consequences for my receiving any health service.

13. I understand that I may not receive a direct benefit from the study.

14. I understand that the project has been approved by Southern Health Human Research Ethics Committee (HREC) and if I have any concerns about the conduct of the project I can contact the Chief Executive Officer of that Committee.

15. I have been given/offered a copy of this Consent Form.

I HAVE READ AND UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS 1-15

I HEREBY VOLUNTARILY CONSENT AND OFFER TO TAKE PART IN THIS STUDY.

Name: ……

Signature: …….. Date: /……/……

DECLARATION BY INVESTIGATOR RESEARCHER

I hereby declare that I have given the research participant all necessary information regarding his/her involvement in the study and believe he/she understood this information. He/she will also be informed of any changes in the study. I declare that the above named participant freely gave consent to participate in this study.

Researcher's Name (printed) ……

……. Date ….. / ….. / …..

Signature of RESEARCHER

Note: All parties signing the Consent Form must date their own signature.

Project Number: 01133B

Research Team:

Professor Bruce Tonge	Chief Research Investigator/Supervisor
Jill Pullen	Project Coordinator, Co-Investigator & PhD Candidate
Jeanette Beaufoy	Co-Investigator
Dr Stanley Gold	Co-Investigator
Clinical Associate Professor Suzanne Dean	Co-Investigator/Primary PhD Supervisor

Complaints:
Malar Thiagarajan (Director - Research Services) on 9594 4611

APPENDIX X1

Time For A Future

Southern Health (CAMHS) Monash Medical Centre
and
Centre for Developmental Psychiatry and Psychology,
Monash University

PSYCHOTHERAPIST EXPLANATORY STATEMENT
(Version 1: 31.10.11)

Dear .....

You have been invited to participate in a research study entitled:

A follow-up study of young people admitted to a Victorian Child and Adolescent Mental Health Service (CAMHS): (Retrospective Experience of Psychoanalytic Psychotherapy Component)

This two paper participant Explanatory Statement provides vital information about the research project. Its purpose is to explain the procedures involved in this project before you decide whether or not to take part in it.

Purpose of the Study:

Some time ago you provided psychoanalytic psychotherapy treatment to a young person admitted to CAMHS to help with his/her recovery from serious emotional difficulties as part of the Time for a Future Project (TFFP). We are interested to find out how young people with emotional problems who receive psychoanalytic psychotherapy recover and get on with their lives. As you provided psychoanalytic psychotherapy to a young person in the project, we are interested to speak with you about your experience of the process of psychoanalytic psychotherapy and its outcomes with young people with mental health problems during adolescence.

The findings of this study will be made available to psychotherapists, mental health professionals and others working with young people to help provide the best possible treatment.

Procedures involved in the Study:

We are seeking your written consent to participate in an in depth interview reflecting on your experience of providing psychoanalytic psychotherapy to a young person with mental health problems.

The interview will take between 1 and 1.5 hours of your time

We are happy to meet with you at a location and time that is convenient for you

We understand that the young person you saw for psychoanalytic psychotherapy has completed that treatment with you, and we have obtained his/her written consent to interview you about the process.

As well as your written consent to be interviewed, we will also ask that you consent to the interview being audio- recorded, so that your reflections are accurately remembered.

Demands on You as Psychotherapist:

To facilitate the process of reflection on the psychotherapy, it may be helpful to you, to review or read over your process notes before the interview.

The interview itself will take 1 to 1.5 hours of your time.

Potential Benefits:

The purpose of this study is to map the process and evaluate your patient's recovery from serious emotional difficulties. The study has scientific and social benefits in terms of providing information about the process and outcome of assessment and treatment of adolescents with serious emotional difficulties. This information could potentially lead to improvements in adolescent mental health treatment, and increase our understanding of the impact of psychoanalytic psychotherapy as a treatment.

Privacy, Confidentiality and Disclosure of Information:

Your involvement in this study will in no way be identified in that your name will not appear in any of the published reports of this study. Results will be presented in publication as group findings. Any brief illustrative quotes will be anonymous. The interview recordings and transcripts collected will be kept in a locked and secure filing cabinet at Monash University, Clayton. After more than five years all identifying codes will be destroyed.

Ethical Guidelines:

This study will be carried out in accordance with the *National Statement on Ethical Conduct in Research Involving Humans* (2007) produced by the National Health and Medical Research Council of Australia. The Human Research Ethics Committee of Southern Health has approved the ethical aspects of this research project.

If you have a complaint concerning the manner in which this research **[project number 01133B]** is being conducted, please contact: Malar Thiagarajan (Director - Research Services) on 9594 4611.

You will receive a copy of this information sheet. Please feel free to contact us directly if you require any further information about this study

Research Team:

Jill Pullen	(Project Coordinator, Research Fellow & PhD Candidate) Tel: (03) 9594 1726 9905 1553 (Mobile: 0417 575 884)
Emeritus Prof. Bruce Tonge	(Chief Investigator) Tel: (03) 9594 1477
Ms. Jeanette Beaufoy	(Co-Investigator)
Dr. Stanley Gold	(Co-Investigator)
Dr. Suzanne Dean	(Clinical Associate Professor, Co-Investigator)

APPENDIX XII

Southern Health CAMHS, Monash Medical Centre
and
Centre for Developmental Psychiatry and Psychology
Monash University

Time For A Future

INFORMED CONSENT to RESEARCH

Psychotherapist

Version No. 1, 31/10/11

Full Project Title: A follow-up study of young people admitted to a Victorian Child and Adolescent Mental Health Service (CAMHS): (Retrospective Experience of Psychoanalytic Psychotherapy Component)

Principal Investigator: Emeritus Professor Bruce Tonge

Co-Investigators: Ms Jill Pullen, Ms Jeanette Beaufoy, Dr Stanley Gold and Clinical Associate Professor Suzanne Dean

1. I understand the purpose of this study is to follow up my former patient's recovery process.
2. I understand there will be one interview of 1 to 1.5 hours.
3. The interview will be audio- recorded so there is an accurate account of my reflections on the experience of psychoanalytic psychotherapy with an adolescent who experienced mental health problems
4. I understand that written consent has been obtained from the Young Adult involved, for me to participate in an interview regarding his/her former psychotherapy treatment with me
5. I have read and understood the Explanatory Statement concerning the study that has been supplied to me. I have been given the opportunity to ask questions regarding the study if I am not completely satisfied with the information provided.
6. I understand that the project has been approved by Southern Health Human Research Ethics Committee (HREC) and if I have any concerns about the conduct of the project I can contact the Executive Officer of the Committee.
7. I authorise the researchers to preserve, use or publish the results of this study, provided my identity and my patient's identity are not revealed to others.
8. I understand that data will be kept for at least 5 years in a locked filing cabinet at Monash University, Clayton and any identifying codes completely destroyed after that time.
9. I have had the opportunity to take a copy of this Consent Form.
10. I HEREBY CONSENT TO TAKE PART IN THIS STUDY.

Name: …….

Signature: ……. **Date: /…. / …..**
(Psychotherapist)

DECLARATION BY RESEARCHER

I hereby declare that I have given the participant all necessary information regarding his/her involvement in the study and believe he/she understood this information. He/she will also be informed of any changes in the study. I declare that the above named participant freely gave consent to contribute to this study.

……. **Date**: / ….. / …..

Signature of RESEARCHER

Project Number: 01133B

Research Team:

Professor Bruce Tonge	Chief Research Investigator/Supervisor
Jill Pullen	Project Coordinator, Co-Investigator & PhD Candidate
Jeanette Beaufoy	Co-Investigator
Dr Stanley Gold	Co-Investigator
Dr Suzanne Dean	Clinical Associate Professor, Co-Investigator/Primary PhD Supervisor

Complaints:

Malar Thiagarajan (Director - Research Services) on 9594 4611

APPENDIX XIII

Time For A Future

Date ---/---/----

To …….
Director of ……CAMHS (2002)
Current Address …….
…….

Dear ……

We are writing to you in regard to the *Time for a Future: Assessment Follow up Study*, funded by the Pratt Foundation. You were approached in late 2001 or 2002, as the Director of ……CAMHS to request your service's participation in this study. The study was later extended to include 4 and 6 year follow up data collection.

You will remember that as part of this clinical naturalistic follow up study, additional psychoanalytic psychotherapy treatment and weekly supervision for the psychotherapists was also funded.

In an amendment to the above project, Jill Pullen, as a PhD candidate, will look more closely at the group who received psychoanalytic psychotherapy in addition to treatment as usual. Jill would like to meet with you to discuss the project outcomes and the service context at the time psychotherapy treatment was delivered.

Only participating CAMHS Directors at the time the project was conducted are being contacted. Your comments will be confidential and material from CAMHS Directors will be pooled and analysed as a group. Any illustrative quotations will be anonymous.

The interview is expected to take about one hour of your time. Your consent will be sought for the interview to be audio-recorded so that what you say is accurately recalled.

You will be contacted by telephone after you have received this letter, to arrange an interview at a time and location convenient to you, should you agree to participate.

Yours sincerely,

Bruce Tonge
Emeritus Professor & Chief Investigator

Jill Pullen
Project Co-ordinator/Researcher
PhD Candidate

Research Team:

Jeanette Beaufoy	Co-Investigator
Dr Stanley Gold	Co-Investigator
Dr Suzanne Dean	Adjunct Clinical Associate Professor, Co-Investigator, Primary PhD Supervisor

APPENDIX XIV: STEPS IN THEMATIC CONTENT ANALYSIS: FOR EACH DOMAIN OF ENQUIRY

(Successive, display and distillation of themes across aggregated data set)

STEPS 1-6 for each individual participant's treatment

STEP 1: Matrix 1 created in 2 columns- raw data inserted on RH side, and punctuated into emergent themes (EH) at same time - typical quotes in transcript page number, and *

STEP 2: Matrix 1 - on LH side, write Level 1 (ET1s), slightly abbreviated (distilled)

STEP 3: Matrix 2 - created in 2 columns - ET1s on RH side, and group like with like (keep quote stars)

STEP 4: Matrix 2 - identify Level 2 ETs (ET2s) on LH side, being briefer labels for ET1 groups

STEP 5: Matrix 3 created in 2 columns - insert ET2x on RH side, considering overlaps between Domains, and shifting ET2s appropriately (keep quote stars)

STEP 6: Matrix 3 - Identify Higher Order Themes Level 1 (HO1s) on LH side

- -

STEPS 6-12 combine group participant themes

STEP 7: Matrix 4 - created in 2 columns - ET2 of all participants aggregated on RH side (stars remaining) with HO1s on LH side

STEP 8: Matrix 4 - re-group HO1s, collapsing/distilling/combining themes and re-labelling

STEP 9: Matrix 5 created in 4 columns

- Col 1 (LH) HO2s (still subject to distillation, using ET2s)
- Col 2 HO1s - grouped in HO2 sections
- Col 3 ET2s
- Col 4 participants mentioning (place quote stars here)

STEP 10: Matrix 6 created in 4 columns, now construct hierarchy of themes:

- Col 1 (LH) HO2s (still subject to distillation, using HO1s)
- Col 2 HO1s - grouped in HO2 sections
- Col 3 participants mentioning (quote stars here)
- Col 4 number of participants mentioning

STEP 11: If Matrix 6 is longer than one page, split Domains into further matrices - i.e. Sub Domains, or HO3s, distilled from HO2s

STEP 12: Matrix 7 created in 2 columns - HO2s on LH side, and on RH side, participants mentioning (with quote stars). Based on method by Miles and Huberman, 1994.

APPENDIX XV Step 1. Matrix 1: Domain 1 – Young Adult

Matrix 1: **Analysis of Domain 1:** Experience of psychoanalytic psychotherapy **Participant:** … **Interview:** Young Adult **In response to question 1:** "What can you tell me about your experience of Psychotherapy?"	
Emergent Themes Level 1	**Interview Narrative (raw data)**
Would show up at the office, we would sit there, and she would sit there and wait for me to talk. Very different to any other sort of therapy had before as they would ask questions. I would start talking about what was on my mind. She sometimes would question or draw out information about my thinking, if I realised I thought that way, to prompt me about why I held my beliefs or thoughts. It was more than me exploring what was going around in my head, as speaking it out helped me to understand my thinking more.*[p.1] Makes you more aware and gets it out in the open	Um basically I just remember sh, showing up at …….office and we would sit there and she would um, she would just sort of sit there and wait for me to talk/ um which was very different to any other sort of therapy I'd had normally they would ask questions/. And I would just sort of start talking about what was on my mind,/ and umm she would sort of, when I came out with statements and things that sort of she would sometimes question them and try and like draw out more information about maybe why I thought that way or had I realised I was thinking that way just to kind of prompt me to think about why I held the beliefs or the thoughts I had/. Umm. So it was more just me exploring what was in, going around in my head/ but actually being able to speak it out helped me sort of realise. Helps you sort of understand what you're thinking more/. Umm. *It's sort of like everyday things go round and round in your head but when you actually have to articulate them then you sort of, it makes you realise more what you, what you're thinking or the beliefs why you're acting and things like that*.*[p.1] Does that make any sense? **So it makes you more aware?** Makes you more aware and it sort of gets it out in the open/. Mmm. **Okay**

APPENDIX XV Step 4. Matrix 2: Domain 7 – Young adult

Analysis of Domain 7: Internal changes associated with psychotherapy
Participant:…
Interview: Young Adult
In response to question 7: "What part has psychotherapy played in your management and thinking about psychological distress now, compared to when you were an adolescent?"

Emergent Themes Level 2	**Emergent Themes Level 1**
Think how to behave appropriately.	I think about how I'm going to proceed in the appropriate manner.
If frustrated can ask for help or use distraction.	If I'm frustrated to tell someone and they can help, or I'll watch TV, or find a solution and do that.
Able to tell someone I don't like what they've said and find a solution with them.	If frustrated with someone I tell them that I don't like what they said to me and try and find a solution with them.
Helped to think about and manage difficulties in relationships.	So helped to think about difficulties in relationships and how to manage them.
As adolescent withdrew from relationship difficulties and said nothing.	When I was an adolescent I wouldn't have told someone I was having a problem with them and kept it to myself.
Increased frustration with another resulted in self-harm	If I got too frustrated with someone I would've hurt myself.

APPENDIX XV Step 6: Matrix 3: Domain 3 – Young adult

Analysis of Domain 3: Young person's view of their relationship with the Psychotherapist **Participant:**… **Interview:** Young Adult **In response to question 3:** "What do you remember about your relationship with your therapist?"	
Higher Order Themes Level 1	**Emergent Themes Level 2**
Can't remember long time ago	Can't remember, long time ago.
She mostly listened and that was what I needed	She mostly listened which was all I needed then. The listening was huge.
Took time to build a relationship and trust	Took time to trust the therapist. Same now it takes time to build a relationship[*p.8] Experience of holding back and talking about trivial things in relationships as needed time to talk about the real stuff.
Therapist non-judgmental, independent and kept privacy.	Couldn't talk to mother as experienced her as judgmental and still is. Couldn't talk to siblings as would tell mother. It was an independent outlet to talk.
Remember brief conversations, and not therapist's response to what said.	Not sure can describe what happened as can't really remember what the sessions were like. Remember brief conversations Remember telling her that had a job, but can't remember what she replied.
Then would not of thought of her as a friend [FD2]	At time maybe wouldn't have said therapist was a friend, [FD2]
Now see enabled to talk as she was like a friend [FD2]	but looking back she was like a friend and maybe why could talk. [FD2]

FD2 – from domain 2

APPENDIX XV Step 7: Matrix 4: Domain 1 – Combined data of all young adults and retain * and page number for quotations

Combined Young People Matrix 4:
Domain**: Experience of Psychoanalytic Psychotherapy**
Higher Order Themes

Higher Order Theme **Level 1**	**Participants (1-10)**			
Good experience	**8** It was a good experience She was a fantastic therapist. Therapy was the best thing I ever did for myself	**1** Think it was good.	**6**** Some people might think you were crazy if you spoke your mind.[*p.3] Very relaxed, sit on a bean bag, talk, use metaphors and reflect.[*p.5] We didn't have coffee together. Talked about life and meaning behind behaviour. It wasn't a bad experience.	**10** Good, enjoyed Remember being ready every time to go to my appointments.
Didn't know what therapy was and what to expect	**5** Not sure what psychotherapy is Didn't know what to expect, a bit of a shock	**6** Wasn't sure of therapist's role.	**9** When started given an explanation of psychotherapy. Don't feel understand even now what psychotherapy is Don't know what current psychotherapy is supposed to do. Didn't understand her role.	

APPENDIX XVI

C

Research Directorate
Southern Health
Monash Medical Centre
246 Clayton Road
Clayton Victoria 3168
Australia

Postal address:
Locked Bag 29
Clayton South Vic 3169
Australia

Tel (03) 9594 4611
Fax (03) 9594 6306

02 December 2011

Prof Bruce Tonge
Centre for Developmental Psychology & Psychiatry (MMC)
Psychological Medicine - Centre for Developmental Psychiatry & Psychology (CDPP)
Monash Medical Centre
246 Clayton Road
Clayton Vic 3168

Dear Researcher,

Research Project Application No. 01133B: A follow up study of young people admitted to a Victorian Child and Adolescent Mental Health Services (CAHMS)

We thank you for Ms Jill Pullen's and your letter of 01 December 2011. We advise that the involvement of Dr Suzanne Dean as a Co-Investigator and Ms Jill Pullen as a Project Coordinator have been noted. We take the opportunity to remind you that as the Principal Investigator of this study it is your responsibility to ensure that all staff conducting the study are adequately trained in and are familiar with the requirements of the protocol. It is requested that Dr Suzanne Dean and Ms Jill Pullen sign the declaration at the bottom of this page and send back a file copy for our records. The change in title has been noted and amended accordingly.

We advise that the following documents:

(i) HREC Amendment Form;
(ii) Young Adult Explanatory Statement version dated 31 October 2011;
(iii) Informed Consent to Research – Young Adult version no. 2 dated 31 October 2011;
(iv) Parent/Carer Explanatory Statement version dated 01 November 2011;
(v) Informed Consent to Research – Parent/Carers version no. 2 dated 01 November 2011;
(vi) Psychotherapist Explanatory Statement version no. 1 dated 31 October 2011;
(vii) Informed Consent Form to Research – Psychotherapist dated 31 October 2011;
(viii) Young Adult Interview Protocol dated 11 November 2011;
(ix) Psychotherapist Interview Protocol dated 11 November 2011;
(x) Parent/Carer Interview Protocol dated 11 November 2011;

in respect of this study have been reviewed and approved, subject to updating Ms Malar Thiagarajan's details on all the consent forms:

"Director – Research Services
Phone No. 9594 4611"

Research Directorate
Southern Health
Monash Medical Centre
246 Clayton Road
Clayton Victoria 3168
Australia

Postal address:
Locked Bag 29
Clayton South Vic 3169
Australia

Tel (03) 9594 4611
Fax (03) 9594 6306

We request a clean copy of the entire revised Information Sheets & Consent Forms to be emailed to Heather.Jackson@southernhealth.org.au so that the barcode for scanned medical records may be inserted.

Should you have any queries please contact me on 9594 4605.

Yours sincerely,

JULIE GEPHART
HREC Coordinator
Research Directorate

"I accept responsibility for the conduct of this research project according to the principles of the National Statement on Ethical Conduct in Human Research published by the National Health & Medical Research Council (2007)."

Name: Dr Suzanne Dean [Signature]_____Date _____

"I accept responsibility for the conduct of this research project according to the principles of the National Statement on Ethical Conduct in Human Research published by the National Health & Medical Research Council (2007)."

Name: Ms Jill Pullen [Signature]_____Date _____

Cc: Ms Jill Pullen

Please Note: All responses/correspondence must be submitted in hard copy with the project number and title

APPENDIX XV11

Domains of enquiry: Interview questions for psychotherapists

1. What can you tell me about the young person's experience of psychotherapy?

2. What was your experience of psychotherapy with this young person?

3. What do you remember about your relationship with the young person?

4. How do you think the young person saw your relationship with them?

5. What do you remember of the young person's parent/carer?

6. How did psychotherapy impact upon the young person's relationships?

7. When you think back what sort of adolescent was the young adult and what was happening?

8. What part did psychotherapy play in his/ her management and thinking about psychological distress at completion of treatment compared to when he/she was an adolescent?

9. How do you think things would have gone if the young adult had not had psychotherapy?

10. Thinking back to that period of time of the psychotherapy. What was it like being an adolescent growing up in …….. (*Insert* name) region of Melbourne/Victoria at that time? And what would it have been like to be a parent of an adolescent?

11. Thinking back what sort of influence if any, do you think the Research Project had on the psychotherapy?

Therapists' Final Matrices:

1. Psychotherapist's view of the young person's experience of psychotherapy-

   A: Reflections on their expectations & beginning therapy

   B: Structure

   C: What the psychotherapist views the young person experienced as helpful

   D: What the psychotherapist views the young person experienced as unhelpful

   E: Reflections on the young person's experience of the processes & ending of therapy
2. Psychotherapist's experience of the psychotherapy with the young person
3. Psychotherapist's view of their relationship with the young person
4. Psychotherapist's view of how the young person saw the psychotherapy relationship
5. Psychotherapist's view of their relationship with the parent/carer
6. Psychotherapist's view of the impact of psychotherapy on the young person's relationships
7. Explanation & understanding of the young person's difficulties as an adolescent

   A: Description of difficulties when referred to psychotherapy

   B: Reflections on their difficulties
8. Changes related to psychotherapy or other influences
9. The difference having psychotherapy mad
10. The sociocultural context of the young person

    A: Family, school & neighbourhood

    B: Peer culture, behaviours & belonging

    C: Interests & behaviours
11. The impact of the research on the psychotherapy

Total of 18 tables