Exploring How a Trainee Child and Adolescent Psychoanalytic Psychotherapist Generates Clinical Formulations When Undertaking Assessment Work. A Qualitative Study.

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Contents

Abstract

Research Thesis Title
Exploring how a Trainee Child and Adolescent Psychoanalytic Psychotherapist Generates Clinical Formulations When Undertaking Assessment Work. A Qualitative Study.

Background information
Assessment forms a significant and important component of a child psychotherapist's work. Petit and Midgley's (2008) small-scale, qualitative study found that assessment equated to 45% of their work within a five-year period. Despite this, child psychotherapy assessment continues to be relatively neglected in the research literature.

Focus of the study
The research study explores how a trainee child psychotherapist generates formulations within their psychotherapy assessment work. This will involve the systematic analysis of the assessment encounter, incorporating an understanding of the unfolding transference and countertransference relationship and the technical approach of the assessing psychotherapist.

Gap
This research study is the first to use template analysis in order to examine how clinical formulations arise as a result of child psychotherapy assessments.

Methodology
A qualitative approach was used. Detailed descriptive commentaries of assessment sessions for three different case studies form the data to be analysed. This was facilitated using the hierarchical coding structure of Template Analysis.

Conclusion
The application of template analysis enabled a systematic exploration of assessment data. Coding of the session data allowed for the fine detail of the communications between the child and assessing psychotherapist to be illustrated and tracked. The research demonstrates how close and detailed observation of a child can facilitate an expression of their inner world. This allowed the origin and validity of the trainee child psychotherapists formulations to be captured and evaluated. This included evidence of clinical understanding in relation to the unfolding transference-countertransference relationship. It has also provided evidence of the technical approach to undertaking assessment work.

Introduction

> 'The opportunity to undertake initial exploratory work with a child can be a very special one. The freshness of the child's first communications make assessment work a privilege and a source of extraordinary interest for the clinician. The anxiety of facing the unknown is balanced by the delight of discovery and the opportunity of a new beginning. A good assessment can be a crucial creative experience for a child in trouble'.

(Rustin & Quagliata, 2000 p.7)

Assessment forms a significant and important component of a child psychotherapist's work. Petit and Midgley's (2008) small-scale, qualitative study of five child psychotherapists within a single CAHMHS service found that assessment equated to 45% of their work within a five-year period. Despite this, the findings detailed within the literature review indicate child psychotherapy assessment continues to be relatively neglected in the research literature. Berkowitz (1998) stated there appeared to be limited number of either adult or child psychotherapy papers dedicated to the process of assessment when she completed an overview of the psychoanalytic assessment literature (p.7). She goes on to speculate that 'the whole area of assessment rather than becoming clearer has, in some way, become more blurred' (*ibid*. p. 8). Midgely et al. (2017) provide a helpful updated narrative review of the current child psychotherapy research, although within that there is a striking absence of child psychotherapy assessment empirical research published in recent years.

As a Trainee Child and Adolescent Psychoanalytic Psychotherapist completing the new Professional Doctorate in Child and Adolescent Psychoanalytic Psychotherapy, my first experience of completing a child psychotherapy assessment was striking. It occurred in the first few months of a National Health Service (NHS) Child and Adolescent Mental Health Service (CAMHS) clinical placement and immediately connected me with the importance of this aspect of child psychotherapy work. As Rustin and Quagliata so beautifully describe; assessment work is both a privilege and a source of extraordinary interest.

Initially there was a feeling of being woefully ill-equipped to undertake child psychotherapy assessment work. The sense of the assessment's importance for the child and network supporting them added to the pressure for something to be *understood* by the assessment encounter – and in turn for there to be evidence to support this understanding. I quickly realised that throughout the process of assessment my feelings and responses were in many ways the primary assessment tool (Sternberg, 2006). The lack of a standardised model seemed to be a consequence of differing assessment purposes and will be explored further as part of the research thesis.

The initial response to the anxiety undertaking assessments produced was to utilise the much needed and valued support of a service supervisor. This was followed by an immersion in the available assessment literature. I was surprised by the apparent lack of contemporary empirical research relating to the process of assessment. One exception to this was Petit and Midgley's (2008) exploratory study in psychotherapy assessments in CAMHS settings. Within the study Petit and Midgley detail one of the research participants describing the use of an instrument designed to assess quality of attachment (See Barth et al., 2005). Petit and Midgely describe this as:

> 'An effort by Child Psychotherapists to find some common ground with those who are not familiar with psychoanalysis; it can also be understood as a way of securing more credibility for subtle details of their clinical judgment which cannot be explained easily because they are a matter of intuition and unconscious knowledge'
>
> (p.153)

This observation sparked a seed of thought in my mind that has grown into the form of the current research thesis. It suggested there was an opportunity to find 'common ground' in a way that could make child psychotherapy assessments more accessible, meaningful and credible to patients, multidisciplinary colleagues and child psychotherapy colleagues. Alongside this, there is an opportunity to develop a systematic method of analysis that would

more effectively evidence and elucidate the subtle details that inform clinical judgement without impinging of the process of assessment in its current form.

The Relevance of the Research to Child Psychotherapy Practitioners

Various authors have identified that further study of the way in which assessment is actually carried out and made use of in an NHS setting is clearly needed (Rustin & Quagliata 2000; Sternberg 2006; Mees 2017; Bradley 2019). A clear evidence base for the importance of such understanding is essential in a multidisciplinary CAMHS context.

As Kam and Midgley (2006) point out, most evidence-based guidelines are for particular treatment modalities designed for specific psychiatric diagnoses. Often within CAMHS, and certainly within the author's experience, there is a much more 'complex interplay between the specific difficulties that the child exhibits, which would not necessarily be captured by a broad diagnostic term' (p.40). This research thesis provides an initial attempt at developing a clear and accessible method for evaluating and evidencing the data that informed a trainee child psychotherapists clinical formulations during three distinct and different psychotherapy assessments. This systematic exploration of the data will allow further development of an evidence base for the nuanced way in which child psychotherapists conceptualise meaning within an assessment.

The systematic analysis of the assessment encounter, incorporating an understanding of the unfolding transference and countertransference relationship and the technical approach of the assessing psychotherapist, was thought to be a useful addition for the field of child psychotherapy as assessment forms an increasingly important aspect of our workload within CAMHS. This will add to the existing research evidence base and to the resources which psychotherapists can draw from while undertaking assessment work. While the current research is limited to one trainee child psychotherapist, working in a particular NHS, CAMHS clinic setting, there is an acknowledgement that child psychotherapy assessments take place in a wide range of contexts and frequently with varied and multiple functions in mind. Holding

in mind the reality that child psychotherapy assessment is not a neatly homogenous activity, the question whether the data analysed in this research produces findings that have transferable merit to the varied contexts and multiple functions of psychotherapy assessments remains open. The research does however aim to demonstrate how close and detailed observation of a child within a small-scale study can facilitate an expression of their inner world. This I hope will allow the origin and validity of a trainee child psychotherapists formulations to be captured and evaluated through the systematic analysis of the their clinical understanding in relation to the unfolding transference-countertransference relationship within the data presented.

Main Aim and Objectives of the Research Thesis

The overarching aim of the research thesis is:

1. To understand and evidence how psychoanalytic clinical formulations are generated within my child psychotherapy assessments.

This aim will be met by focusing on the following objectives:

1. Examine clinical process notes from three different psychotherapy assessments in order to assess how an understanding of the child's internal world was developed.
2. Undertake a systematic qualitative analysis of detailed process notes using a Template Analysis research methodology.
3. Identify how consideration of transference and countertransference communications within an assessment are used as a tool to inform clinical formulation.

Overview of the Research Thesis

The following is a brief summary of the structure and content of the research thesis. The literature review evaluates all existing child psychotherapy assessment literature. Various different types of psychoanalytic assessments will be identified within the literature and their differing functions considered. There will be a critical appraisal of the current evidence that outlines the process and psychoanalytic technique used in assessment work. Consideration

will also be given to literature that outlines the process by which formulations are developed within child psychotherapy assessment work. Space will also be given to consider the contribution completing a thorough literature review had towards informing the content and structure of the coding template used to analyse the research data.

The methodology section will give an overview of the qualitative research method of Template Analysis (TA). It will also include details of the study design and the process of participant selection. The data collection process will be described in detail, along with a comprehensive outline of the data analysis procedure.

In the presentation and discussion of findings section the author will illustrate the systematic method by which information gathered during an assessment is synthesised and understood in order to arrive at the clinical formulations presented. The main body of the results is presented as three assessment case studies. Vignettes of clinical material will illustrate the application of the coding template and a commentary of the rationale for the coding will be given. This will provide a clear process for identifying evidence within the assessment that contributed to the development of the clinical formulations.

The discussion section will link the current available child psychotherapy assessment literature with my own research findings, to either confirm the findings, disagree or contribute something new. This will include a summary of what contribution the research offers to child psychotherapy practice and the empirical research evidence base.

Finally, the conclusion will consider implications for future clinical practice along with a recommendation for the systematic analysis of assessment work. Suggestions for future research in child psychotherapy assessment will be considered. Strengths and weaknesses will be identified within the study design and application.

Narrative Literature Review

Introduction

Accessing the Taylor and Francis online database in October 2018 provided access to 1,296 articles published in the Journal of Child Psychotherapy. A search for 'Assessment[1]' in the title of those articles returned 19 results (1.5% of the total articles available). A further search of the articles with 'Assessment' in the title and 'Formulation' located anywhere in the body of the text produced 8 results (0.6%). A final search of 'Assessment' and 'Formulation' in the title produced no results. This initial search exercise suggested there continues to be some disparity between the perceived importance of assessment within the minds of a child and adolescent psychotherapists and what has been produced in the literature.

This literature review [2]aims to evaluate existing child psychotherapy assessment literature. An overview of the development of assessment within the psychoanalytic literature will be given in order to give context to current assessment work within child psychotherapy. The different types of psychoanalytic assessments will be identified within the literature and their purpose considered. This will be followed by a critical appraisal of the current evidence that outlines the process and psychoanalytic technique used in assessment work. Finally, literature discussing the development and use of clinical formulations will be examined.

Rationale for Narrative Review Design

A narrative literature review (NLR) method (Ferrari, 2015; Green, et al., 2006) has been selected to summarise and synthesise the current body of literature relating to psychotherapy assessment. It enables consideration to be given to the significance of new research, along with identifying gaps or inconsistencies in the current body of knowledge.

[1] assess* truncation used in search parameters.
[2] Although the Northern School of Child and Adolescent Psychotherapy training is rooted in Kleinian theory, this narrative review aims to consider the wider child psychotherapy theory and research literature.

Coughlan et al. (2007) suggest NLR's can be helpful in developing conceptual or theoretical frameworks, while Green et al. (2006) state they offer the opportunity to pull many pieces of information together into one accessible format. Ferrari (2015) highlights one of the limitations of NLR's: 'subjectivity in study selection is the main weakness ascribed to narrative reviews that potentially leads to biases' (p.231). The author has attempted to complete the literature search in a systematic way and has included supporting documentation to evidence its high levels of methodological rigour. This pragmatic approach to the NLR will help to limit this risk of bias, whilst at the same time allowing a wide enough scope to include all relevant sources of literature (Hek & Langton, 2000; Timmins & McCabe, 2005; Newall & Burnard, 2006; Timlin et al., 2014).

Method

The literature review was conducted utilising the databases and search methods outlined in Table 1.

Table 1 – Databases and Additional Searches

	Databases Used
1.	PsycINFO (via EBSCOhost)
2.	The Pep Archive (via EBSCOhost)
3.	Psychology and Behavioural Sciences Collection (via EBSCOhost)
4.	PsycArticles (via EBSCOhost)
5.	PsycBOOKS (via EBSCOhost)
6.	Medline (via EBSCOhost)
7.	PubMed
8.	The Cochrane Library

	Additional Searches
1.	Citation Search
2.	Manual search of reference lists from retrieved articles.
3.	Handsearching a number of specified journals and books.

Search terms were developed and tested through scoping searches in order to ensure that relevant articles were included and reflected the study objective[3]. The search terms are presented in Table 2:

Table 2: Guided Search Terms[4]

How do Psychoanalytic [C1] Clinical Formulations [C2] and Recommendations [C5] Arise from Child and Adolescent[C3] Psychotherapy [C1] Assessments [C4]?

Concept 1	Concept 2	Concept 3	Concept 4	Concept 5
Psychoanalytic	**Formulations**	**Child**	**Assessment**	**Recommendations**
Psychotherapy	Understanding	Children	Assessing	Intervention
Psychotherapist	Conceptualisation	Adolescent	Appraisal	Allocation
Psychotherapeutic	Formation	Young Person	Judgement	Indication
Psychological	Conception	Teenage	Consultation	
		Youth	Evaluation	
		Juvenile		
		Kid		
		Youngster		

In addition to the database search additional papers were added through article reference lists, along with hand searching relevant journals and books.

Eligibility Criteria

Studies were excluded if their primary focus was not psychoanalytic assessment. Papers that did not meet the inclusion criteria generally considered assessment in a context outside the scope of the paper. For example: assessment of parental function for a court report and the

[3] See Appendix One – Notes on Procedures

[4] A more detailed summary of the search strategy used, including the application of search parameters can be found in Appendix Two - Literature Review Database Search Activity.

assessment of change using pre and post treatment measures. Abstracts were reviewed and the reason for inclusion/exclusion recorded for each. Once themes had been identified a more coherent set of eligibility criteria was established[5]. This was then applied to a second screening of all abstracts as a means of ensuring consistent application of the criteria. Once this was the case the author progressed to reading full texts.

Quality Assessment Criteria

Steps were taken to standardise the critical review process in order to reduce bias in the selection of articles and increase the overall rigour of assessing the quality of the literature. The author used a combination of Sirriyeh et. al's, (2012) QATSDD tool, along with creating a bespoke Critical Appraisal Rating Scale (CARS)[6] that is a modified version of Green's (2006) Narrative Overview Rating Scale. The literature included in the review had both the QATSDD and CARS tools applied to it as a way of systematically assessing the quality of each paper. The validity of each papers findings were considered using these tools as part of their overall critical appraisal. Studies were not excluded based on the quality evaluation. A limitation of this process is the absence of independent verification by a third party as this would further reduce the risk of bias.

Identifying and Tracking Themes

Results were recorded as each paper was read, initially on a summary cover sheet. The main themes of each paper were identified and recorded, along with a brief critique of the paper and supporting details about the literature such as; the population studied, research aim, methods, strengths and limitations. Key themes from each of the summary sheets were then collated and common themes within the overall literature identified.

[5] Refer to Appendix One for detailed summary of exclusion criteria.
[6] See Appendix Three

Narrative Literature Review Findings

The first part of the findings section gives an overview of the type of assessment literature currently available. This will highlight the limited number and scope of child psychotherapy papers at this time. The second part of the findings, which represents the main body of the review, will attempt to map some of the common themes identified within the current literature and to consider why assessment has been described as one of the most complex, demanding and rewarding activities a psychotherapist can undertake (Mace, 1995).

An overview of the development of psychoanalytic assessment literature will be given, along with the three main themes identified within the literature:

1. The purpose of psychoanalytic assessment.
2. The process and technique of assessment.
3. Clinical formulations within assessment.

Literature was drawn from a variety of settings, which are summarised in Table 3:

Table 3: Summary of the setting where psychoanalytic assessments were taking place.

Setting for work described within each paper	Number of papers written about this setting
CAMHS	15
Tier 4 Unit/Hospital Setting	3
School	1
Private Practice	2
Adult NHS Setting	8
Non-UK Setting	17

The search of databases detailed in the methods section above produced 47 papers that met the specified inclusion criteria. Table 4 gives an overview of the types of papers identified in the literature search. Case study research had by far the highest prevalence within the

literature, accounting for 72% of the literature identified. Binder et al. (2013) is an example of a qualitative study design that used a thematic analysis based on a reflexive phenomenological epistemology. The study analysed primary data from fourteen semi-structured interviews with adolescents to consider their experiences of the assessment processes[7]. Bradley (2019) is the only empirical study that used the analysis of primary data to develop a finely detailed understanding of the child's emotional state of mind within an assessment. The study used Grounded Theory to categorise primary data of assessment sessions descriptive commentaries into themes or patterns of increasing abstraction. Whilst it was not possible to assess the quality of the study as the publication is an overview of the research, it does point to the potential future focus of assessment research.

Table 4: Summary of papers identified.

Total papers that met eligibility criteria	**47**
Focus on assessment of children and young people	32
Focus on assessment of adults	15
Study Type	
Case Study	34
Qualitative study	6
Quantitative study	4
Conceptual/procedural outline (No case study material or qualitative data included)	3
Summary of Case Studies	
Mode average number of cases used per paper	n=2
Range	n=5
Studies using selected vignettes of sessions	28
Studies using descriptive commentaries of at least one full assessment session.	4

[7] This paper will be discussed in more detail in the Purpose of Psychoanalytic Assessment section on p.24

Only clinical material presented an overview of patients presenting problem at referral	2
Summary of Qualitative Studies	
Semi-structured interviews	3
Questionnaire (patient)	1
Questionnaire (clinician)	1
Lowest number of participants	5
Highest number of participants	14
Summary of Quantitative Studies	
Assessment questionnaire (clinician)	1
Psychological test data	2
Analysis of assessment attendance	1
Lowest number of participants	32
Highest number of participants	2,106

In summary, the current child and adolescent psychoanalytic assessment literature is limited. Papers that are relevant to this review offer a diverse range of study design and focus. They range from conceptual outlines, not including any clinical material to a large-scale quantitative, retrospective analysis. Significantly, only 15 papers were identified from a CAMHS setting. Therefore, literature from wider settings, including adult and non-UK work has been included. In what follows, an overview of the development of psychoanalytic literature and the three main themes within the literature will be discussed.

The Development of Psychoanalytic Assessment Literature

This section will first discuss the history of assessment in adult psychoanalysis and then go on to discuss how child psychotherapy assessment developed out of the foundation of adult psychoanalysis.

Freud (1904a, 1905a, 1912e, 1937e) was the first to consider the whole personality of a prospective patient, rather than their particular diagnosis or illness. By outlining his understanding of the presenting problem in the context of the symptoms, indications and contraindications he was able to communicate the importance of the idea that careful consideration needed to be given before analytic treatment could begin. Jones (1920) developed what would perhaps now be thought of as screening criteria, listing certain diagnoses as appropriate for referral to psychoanalysis.

There is evidence of emerging themes and developments in assessment technique throughout the literature. For example; Stone (1954), Rosen (1954) and Busch (1986) suggest that a more active enquiry is required as part of the assessment process in order to judge the suitability of someone for psychoanalytic psychotherapy. This is contrary to the exclusively free associative stance suggested by Freud, but perhaps a reflection of the increasing volume of literature considering the type of data necessary to consider a patient's ability to make use of psychotherapy (Huxter et al., 1975; Lazar, 1976; Lower et al., 1972; Waldhorn 1960).

Tyson and Sandler (1971) are perhaps the first example within the literature of an active consideration towards methodological issues with previously published case studies in their critical review; 'Problems in the selection of patients for psychoanalysis'. Methodological deficiencies pertaining to the identification of key factors in assessment have been highlighted by authors such as Bachrach and Leaff (1978), Bloch (1979), and Erle and Goldberg (1979), although their focus is specifically on work with adults. Bachrach and Leaff (1978) offer one of the few examples of a systematic review of available literature at the time. Garelick (1994) points out their study identified 390 separate prognostic factors in the 24 studies

reviewed (p.103). All point to the increased need for evidence of triangulation within the data presented and the inconsistent way in which psychoanalytic assessments are conducted.

The debate in relation to a prospective patient's suitability for treatment was a component in discord between Anna Freud and Melanie Klein. King and Steiner (1992) describe how this related to differing viewpoints on how appropriate child psychoanalysis was for presentations outside of the more traditional neurotic disturbances, and at what age it was appropriate to offer psychoanalysis to a child. There was also the issue of interpretation with children, and whether analysis with children should include analysing the deeper anxieties. Anna Freud's work at the Hampstead Clinic and the publication of her 1965 Diagnostic Profile established a comprehensive form of assessment in order to obtain a picture of the child's total personality. As Chase (2011) observes, the diagnostic profile has since been applied to work with infants, adolescents, adults and psychotic children over a period of fifty years and remains relevant to the assessment of child mental health today.

Malberg and Pretorius (2017) point out that, outside of the Hamsptead Clinic, the developmental profile was not widely used among psychoanalysts of adults or children. They speculate this was due to the perception that the process resulted in the patient being conceptualised in 'mental bits' (Yorke, 1996a, p. 12) rather than a coherent whole. This is contrary to the original intention of providing a holding conceptual frame that could help inform theoretical and clinical understanding (Michaels & Pierce Stiver 1965; Young-Bruehl 1988; Yorke 1996a; Chase 2011; Malberg & Pretorius 2017).

The revised Diagnostic Profile, published in 2017, includes contemporary developmental psychology and attachment research (Davids, et al. 2017). Malberg and Pretorius (2017) write:

> 'The diagnostic profile is intended to draw the diagnostician's attention away from the child's pathology and to return it instead to an assessment of his developmental

> status and the picture of his total personality. The present attempt at classifying the symptomatology of childhood may serve to amend and amplify this procedure by returning to the symptoms themselves a measure of diagnostic significance'
>
> (p. 127).

Referring to the earlier iteration of the diagnostic profile Green (1994) describes how the diagnostic aim of the assessment is to create an understanding of the subjective, internal world of the child with a view of the child from the 'outside', including wider understanding about their developmental processes. The development of the Psychodynamic Diagnostic Manual (Lingiardi et al. 2015), is rooted in Anna Freud's work around the diagnostic profile and is perhaps an indication of increasing awareness in the psychoanalytic community of the need to develop tools that show the value of integrating psychoanalytic clinical data with current multidisciplinary practice.

Mace (1995) made the observation that the research contribution to assessment had been 'disappointing at best' (p.2). During this time there was an increasing prevalence of questions within the literature regarding how the process of assessment could be most effective. For example; writing at a similar time, Miller et al., (1993) reported a growth in the contribution of research to clinical practice, citing the increasing external pressures for psychotherapists to provide an evidence base for their clinical effectiveness. Whilst there are recent examples of research that provides evidence relating the process of psychotherapy to outcome (See Goodyer, et al., 2017), clinical research focusing specifically to the psychoanalytic assessment of children and young people is extremely limited.

The focus of the available assessment literature may give an indication of a contributory factor for the lack of assessment research literature. Current assessment literature seemed to be focused on the concepts of understanding the child's internal world and consideration of their potential analysability. This suggests something of an overlap with the wider child psychotherapy literature. For example; Sternberg (2006) writes that 'Child psychotherapy has

a fundamental tenet. It is the belief that childrens' play has symbolic meaning and gives the psychoanalytically trained observer the opportunity to understand something of the child's internal world; that is their 'unconscious'…' (p.12). This fundamental tenet is written about extensively within psychoanalytic literature and is relevant to both assessment and ongoing clinical work. The delineation of psychoanalytic literature that explicitly refers to psychotherapy assessment as the only available literature relevant to child psychotherapy assessment risks being reductionist. The perceived overlap between the 'fundamental tenet' to use Sternberg's description and the resultant similarities in technical approach between an assessment and ongoing clinical work may have resulted in assessment has not consistently been conceptualised as a distinct and separate topic of enquiry within psychoanalytic literature. Findings from clinical research in child psychotherapy could be argued as just a s relevant to child psychotherapy assessment.

Another factor potentially contributing to the lack of assessment literature is the apparent lack of consensus in relation to a standardised definition of psychoanalytic assessment, and in turn its purpose. Although there are many examples of assessment case studies and conceptual frameworks within the literature, Walker (2009) is one of the few authors (Green, 2009, Petit & Midgley, 2008; Mees, 2017; Rustin & Quagliata, 2000) to offer a comprehensive description of the purpose of psychoanalytic assessment within CAMHS. She writes:

> 'Clinicians try to understand the nature of a child's difficulties and to weigh up those assets that will facilitate the development of individual potential and those which may hinder good mental health, resulting in regression and symptomatic behaviour. This will include an evaluation of the internal resources of the child and the external environment around him. Such an assessment leads to a formulation about the child's difficulties and a recommendation of appropriate therapeutic intervention'
>
> (Walker, 2009, p.9)

I would also suggest that Milton's (1997) assertion that more clarity around the purpose and function of assessment within the child psychotherapy profession also contributes to the lack of assessment focused literature as it has presented a barrier for research to have a clear focus on this particular area of enquiry. This is discussed in more detail in the Purpose of Psychoanalytic Assessment section that follows along with some of the more contemporary child psychotherapy assessment papers. They include; Rustin (2000a) who provides a helpful summary of the broad aims of child and adolescent psychoanalytic assessment[8]. Wittenberg (1982), proposes a list of questions for the assessing psychotherapist to hold in mind during the assessment[9]. Rustin and Quagliata (2000) attempted to address the lack of research literature in this area and lay out what Petit and Midgley (2008) describe as some of the 'key components of a psychoanalytic approach' to assessment (p. 142). Their paper also helpfully begins with a short review of the assessment literature.

Parsons (1999) and Mees (2017) consider two different functions of psychoanalytic assessment, with Parsons outlining the processes involved in an assessment for psychotherapy, while Mees gives a useful description of the process and function of Psychoanalytic State of Mind Assessments (PSOMAs)[10]. They both build on earlier papers such as those by Dyke (1985) and Rustin (1982) with a focus on what Wittenberg (1982) describes as an interactional model based on the 'interaction between internal and external factors' (p. 131).

The Purpose of Psychoanalytic Assessment

The quality of a formulation and the recommendations that follow are dependent in a large part on the quality of the assessment and the information derived from it (Johnstone Et al., 2011). Having a clearly defined purpose in mind for an assessment therefore helps clinicians to arrive at their formulation and recommendations. This section of the review will outline the different functions of psychoanalytic assessment that are identified in the literature.

[8] Outlined in the Purpose of Assessment in the Findings section.
[9] Wittenberg's paper discussed in the Process and Technique of Assessment section on p.27
[10] More detail given within the Purpose of Psychoanalytic Assessment section on p.18

Whilst many of the papers within search results refer to the purpose of assessment, this section will focus analysis on the main papers that contribute to this area of understanding.

The complexity of assessment has been discussed by several authors (Stone, 1954; Malan 1979; Wittenberg 1982; Coltart 1986; Mace 1995; Tantam 1995; Rustin & Quagliata 2000; Cooper and Alfillè 2011). There seems to be a general consensus among these authors, which is perhaps best summarised by Malan (1979) when she describes assessment as 'the most complex, subtle and highly skilled procedure in the whole field' (p. 210). Although referring to her work with adult patients Milton (1997) opens her paper with questions that are equally as relevant within child and adolescent psychotherapy:

> 'Before the question of the title 'why assess?' there is another question — what is a so-called 'assessment' — what do we as psychoanalytic psychotherapists in the NHS mean by assessment?'
>
> (p.47).

Milton's opening questions set the tone for this important paper, as an attempt to address the need for more clarity within psychoanalytic literature around the purpose and function of assessment. The posing of such questions by authors at the time seemed to drive further development within the assessment literature as it placed emphasis on the importance of how best to define psychoanalytic assessment. Such questions had not been clearly presented in the literature before Tantam (1995) asked the same *why assess* question as the title of his paper. He examines the grounds for distinguishing assessment from other aspects of psychoanalytic psychotherapy and considers the range of distinct activities that are involved in the work of assessment. Tantam expands upon Wolberg's (1977) idea of primary goals within assessment, summarised in Table 5. They are discussed in detail within the paper, which includes reference to the assessment of the prospective patient's psychological mindedness and to the quality of interaction between the patient and the assessor.

Tantam describes part of the purpose of assessment is to consider selection criteria for a range of possible treatments. This includes efficacy, available resources and the conceptual framework of the psychotherapist. On this last point the paper includes reference to research by Pearson and Girling (1990), which concludes that the patient's attitude to treatment, along with the therapist's recommendations were significantly correlated to outcome. Tantam states that 'only a small amount of the information available will be used to make a judgement about treatment' (*ibid*. p. 23). The paper concludes by calling for further research and consideration to the assessment process, stating that, at the time of writing, a full answer to the 'why assess' question could not be given. It suggests that 'gathering information may well have a lower priority than most therapists currently believe'. This statement, along with the outline of different assessment goals, helpfully looks at the purpose of assessment from a different perspective to previous papers and highlights its complexity, both for clinicians and the patients.

Table 5: Assessment goals (Tantam 1995 – adapted from Wolberg 1977)

1. Establishing rapport with patient
2. Obtaining pertinent information
    a) Making a clinical diagnosis
    b) Assessing the strengths and weaknesses of the patient
    c) Determining aetiology
    d) Evaluating dynamics. For Example; inner conflicts, mechanisms of defence.
3. Giving information
4. Enabling the patient to feel understood - giving hope.
5. Providing a therapeutic account.
6. Giving the patient a taste of the treatment.
7. Motivating the patient to pursue treatment
8. Arranging for any further assessments.
9. Selecting patients for treatment
10. Selecting treatments for the patient.
11. Making practical arrangements for therapy.

Perhaps the 'why assess' question had previously never been adequately addressed in the literature because, as Wittenberg (1982) observes in the opening line of her paper; 'Assessment is a big subject'. More recent writers have attempted to address this gap in the literature despite the scale of the task and the complexity of the work. Rustin and Quagliata's (2000) 'Assessment in Child Psychotherapy', published just three years after Milton had raised her 'Why Assess?' question offers a significant contribution to the assessment literature. The following is a summarised version of the 'aims of assessment' they detail in their introduction:

1. To establish whether there is someone who can reliably support the treatment of the child.
2. To describe the child's state of mind, and to provide a preliminary formulation of the state of internal object relations, taking into account both developmental difficulties and internal conflicts and defence systems.
3. To describe the contribution of internal and external factors and to link with other workers to define priorities.
4. To clarify and make recommendations about action needed from other agencies to meet the mental health needs of the child.
5. To describe the child's likely capacity to make use of psychoanalytic psychotherapy and to make a judgement about the appropriateness of such intervention.
6. To recommend the mode, intensity and optimal timing of the treatment required.
7. To establish a clear baseline of clinical description against which it will be possible to note changes over time.
8. To offer a therapeutic experience which provides containment of psychic pain and sustains hope, and which does not re-traumatise unwittingly through repetition of earlier environmental failure.
9. To ensure the timeframe of the assessment has been adequate to allow for a process of working through what is being proposed.

(Summarised from; Rustin & Quagliata, 2000 pp. 6-7)

Cooper and Alfillè (2011) bring together clinical vignettes and conceptual ideas from different theoretical frameworks within adult psychotherapy in a well-structured and accessible way. They summarise the purpose of assessment as making a judgement about the nature of the patients distress and their suitability for psychoanalytic treatment. This includes a discussion in relation to what an assessment can offer and the need for prospective patient's expectations and fantasies of what therapy may offer to be thought about. There is an informative examination of issues such as the setting, the analytic position and different conceptual frameworks clinicians may utilise, whilst at the same time noting what appears to be an overarching common purpose. They quote Bolognini (2006) who states that the purpose of assessment is 'clarifying the patients suffering, needs, ways and levels of functioning, difficulties, fears, motivations, expectations and real possibilities for change' (p.25). Klauber (1971) had also previously emphasised the importance of establishing the patient's motivation to get better during the assessment. She comments that motivation must be seen in terms of whether 'a life situation has the possibility of fundamental change' (p.154). This seems to build on Stone's (1954) earlier comments where he considered it important to derive information from the longitudinal history relating to the character and pattern of the patient's relationships with people in general and to his or her life-situation.

Another version of the *why assess* question in the literature considers the clinical value of undertaking assessment. Truant (1999) picks up this point by asking 'Why should therapists take the time and effort to do such assessments, rather than proceeding with every patient who is referred?' (p.18). He helpfully highlights the risk that assessments could have a reductionist or limiting effect on the complexity of presenting problems that are considered for psychotherapy and points out the increasing importance that psychotherapists work with a broad range of patients.

Spurling (2003) considers the purpose of assessment from a similar perspective and draws attention to what he describes as 'need to manage a role conflict between acting as a therapist or gatekeeper' (p.1). There is limited consideration given to the 'conflict' between these positions for the assessing psychotherapist within the literature. Although some

authors do allude to this with references to the 'scarce resource' (Green, 2009, Petit & Midgley, 2008; Mees, 2017; Rustin & Quagliata, 2000; Schachter, 1997; Truant 1999). Perhaps as Spurling goes on to say, there is 'a sense of guilt in the assessor about depriving the patient of a valuable commodity, psychotherapy' (*ibid.* p.1) that makes this difficult to consider within the literature.

Mace (1995) pulls together several different papers that consider the more specialised functions of assessment within adult work. This includes areas such as assessment for in-patient psychotherapy, which is also referred to by Flynn (1988). There are some examples of papers within the literature with a specific focus on the purpose of assessing adolescents (Alfillé-Cook, 2009; Anderson, 2000; Binder, et al. 2013; Laufer, 1992; Waddell, 2000, 2002). Binder et al's. (2013) qualitative study, which considers adolescents' experiences of the assessment process, does not explicitly outline the purpose of assessment. However, the qualitative data derived from the semi-structured interviews, conducted with fourteen adolescents, offers a unique insight into what the adolescent patient themselves view as the purpose of the assessment. The authors of the research conclude that the adolescents interviewed considered the assessment an opportunity to establish emotional contact with the psychotherapist, to give meaning to one's own experiences in one's own terms. To receive encouragement and the fostering of hope. They go on to say:

> 'When these needs were met, and were balanced with curiosity about and affirmation of the unique aspects of their lives, the assessment process could be experienced as constructive and engaging, fostering hope, structure and facilitating trust in the therapist'
>
> (p. 116)

The results of this study, and previous ones such as Chadwick et al. (2003) and Horowitz (1997) seem to add further evidence to Winnicott's (1971) suggestion that assessments should be considered as a brief intervention with its own therapeutic potential.

There were some limitations to the Binder et al. (2013) study, such as pre-selection of potential interviewees rather than the use of randomisation and or blinding. Another interesting aspect of the participant recruitment was that some of the interviewees had only recently undergone their assessments, whilst others were providing data retrospectively. Some had been in therapy for several years and the authors' correctly question if this considerable time factor influences how the experience of assessment is remembered and described. Despite the small sample size, the authors' note high degree of heterogeneity in terms of presenting problem, therapeutic approach and treatment length. The presence of shared themes across the adolescent cohort within the study suggest the possibility of common characteristics that need to be considered when undertaking assessment with the adolescent population. A more systematic analysis and larger sample size would be required before there was enough evidence to generalise their conclusions to different clinical populations.

Some consideration is given to the more specialised functions of assessment within child and adolescent work, such as Mees (2017) paper discussing Psychoanalytic State of Mind Assessments (PSOMA's). She defines the purpose of the PSOMA as '…to have a therapeutic and consultative component as well as offering an assessment and formulation of a child or young person's difficulties' (p.380). This is set in the context of a 'package' of assessment offered to the referring clinician, parents and the child or young person with the aim of 'furthering understanding of the internal and external world of that of the child or young person' (ibid.: p.380). With the exception of papers such as Mees (2017, Walker (2009) and Rustin (2000b) this specialist area of assessment has very little written about it in the psychoanalytic literature.

Mees refers to Rustin (2000b) highlighting the potential for PSOMA's to contribute towards broader assessments to help inform thinking about educational issues, self-harm, violent behaviour or advice about placements (p.381). This is an important observation by both authors, yet it is not expanded upon in either paper. In order to properly capture the purpose

and function of PSOMA's additional studies to understand more completely this area of assessment are required. This would include more focus on their use and importance in informing the professional network around the child or young person. All three of the papers that outline the purpose of PSOMA's (Mees, 2017; Walker, 2009; Rustin 2000b) give some reference to the potential for understanding they offer the child and their parents along with multidisciplinary colleagues and the wider supporting network.

Cregeen et al's. (2017) Treatment Manual for Short-Term Psychoanalytic Psychotherapy for Adolescents with Depression (STPP) is an example of psychoanalytic literature that gives some consideration to assessment within a specific model of psychoanalytic treatment. Interestingly, the authors state that the psychoanalytic assessment for STPP can either be offered as a separate assessment, prior to the commencement of the 28-week session model, or the assessment can be incorporated into the first three sessions of the 28-week model followed by what the authors' describe as 'an agreement to proceed' (p.87). The reader is left to infer the reasons for this ambiguity in the assessment process and there is no discussion around the possible implications of the two different approaches to the outcome of the assessment. The treatment manual does provide a useful summary of elements to be considered within a psychoanalytic assessment for STPP:

1. Establishing the framework and setting for assessment and treatment.
2. Balancing information gathering with reflection on internal experience.
3. Examining transferential elements and monitoring countertransference.
4. Exploring the young person's capacity for curiosity and reflection.
5. Confirming the appropriateness and scope of time-limited work.
6. Establishing the therapeutic alliance.
7. Articulating the therapists understanding of the nature of the young person's difficulties (the psychoanalytic formulation).

(*Ibid.:* p.87)

The authors' also draw attention to young person's motivation or willingness to engage in treatment being an important consideration during the assessment of adolescents for STPP, or as Cregeen et al state 'the therapist will be looking out for what may be needed technically to elicit meaningful emotional engagement from the young person' (p.88).

There are other examples within the assessment literature that focus on a particular patient group. For example; Miller (2000) and Robson's (2009) papers focus on assessment within an under-five's service. Miller refers to 'a kind of assessment that never moves towards long-term treatment' (p.108) and references Winnicott's (1971) description of the initial encounter with a child as a 'therapeutic consultation'. The purpose of assessment within the under-fives service therefore seems to have more emphasis on providing support for parents who are 'engulfed in uncontained infantile anxiety and who have lost faith in their power to use their minds in a fruitful, problem-solving way' (p. 109). There are clinical examples within the paper that clearly illustrate the therapeutic value of this type of intervention. Whilst some of the cases described in this paper remain in the realm of a 'therapeutic consultation' Miller does go on to give a further clinical example where there is 'a more formal recognition of disturbance and future treatment for an individual child is recommended' (p.115).

To summarise, current literature with a focus on the purpose of psychoanalytic assessment gives a useful overview of the complexity involved in psychoanalytic assessment. Various authors give insight into elements they feel should be held in mind when conducting assessments. This serves as a useful framework for those undertaking assessments, particularly for assessments taking place within a particular context, such as an assessment for psychotherapy. The elements identified within the literature have been used to form the basis of the template to analyse the data in this study and will be discussed in more detail in the following chapters. With the exception of Binder et al. (2013) and Bradley (2019), the current available literature relating to the purpose of assessment almost exclusively focuses on case study material and the outlining of conceptual frameworks. There are key aspects of assessment that are only beginning to be addressed by the literature, such as offering

evidence of assessment efficacy through the provision of evidenced based empirical research. Or, the use of psychoanalytically informed formulations to act as a baseline prior to the intervention from which an evidence base for treatment efficacy could be measured. As a result, the current body of research can only be considered a first step towards a more profound understanding around the purpose of psychoanalytic assessment.

The Process and Technique of Assessment

Relatively few child psychotherapy studies in the literature focus specifically on aspects of psychoanalytic process or technique through the lens of assessment (Rustin, 1982; Wittenberg, 1982; Dyke, 1985; Parsons, 1999; Waddell, 2002; Rustin & Quagliata 2004; Petit & Midgley 2008). Those that do describe the close and detailed observation of a child during the course of the assessment as one of the fundamental aspects of technique that informs their clinical understanding. This section of the review will evaluate the process of assessment along with some of the different technical approaches identified within the literature. Consideration will be given to the reason behind such variations in process and technique and how this might affect the formulations and recommendations the assessment produces.

Parsons (1999) provides a clear step-by-step outline of the assessment process. She details the different stages within the process, explaining the clinical value of each. This includes; initial set-up meetings with the child and their family/carers, the assessment sessions themselves and an assessment review. Parsons emphasises the effectiveness of this process and its ability to 'facilitate the expression of [the child's] inner world' (p.221). Parsons' technical approach to assessment in the paper is more implied than explicitly stated, but the use of brief clinical vignettes suggest an exploring the child's inner world through unstructured sessions. It would be helpful to have more detailed description of the technical aspects of assessment within the paper, although Parsons does helpfully emphasise the importance of approaching an assessment encounter with the context of the child's defences in mind: 'It is important to recognise that the child's defences need to be kept intact or reinstated in order to help him to contain his anxiety and reduce the possibility of harmful acting-out' (Parsons, 1999 p. 222).

Wittenberg (1982) considers how to gain sufficient information within the assessment to arrive at a decision as to whether treatment is indicated and feasible. She outlines questions to hold in mind:

1. Who has the pain?
2. What is the attitude to the emotional pain?
3. What is the attitude to getting help?

(Wittenberg, 1982 p. 133)

This informative paper uses clinical material from two cases to demonstrate how the technique of careful attention to the interaction between the prospective patient and the psychotherapist can generate the evidence needed to address the three fundamental questions she brings to assessment work. This evidence can then be used to assess whether 'psychotherapy is necessary, wanted, and likely to be of any use' (*ibid.* p. 134).

Garelick (1994) describes a key technical issue as being 'the degree of the assessor's activity' within the assessment encounter (p.102). There is an evaluation of the degree to which a psychotherapist should call on active enquiry to gain information within an assessment. Garelick also considers the wider role and responsibilities of the assessing psychotherapist. There is a discussion within the paper in relation to the appropriateness of recommending treatment whilst trying to reconcile this with the nature of psychoanalysis and its aim to empower patients in their own decision making. This helpful questioning within the discussion draws attention to some of the conceptual differences inherent in psychoanalysis.

More recent studies suggest a trend towards a greater activity in the assessment process, which could perhaps best be summarised as the active searching-out of information, such as what Rustin and Quagliata (2000) describe as the character and pattern of the child's

relationships with people in general and their external life-situation. This shift in focus away from a more classical approach seems to first appear within the literature when Stone (1954) described the importance of actively deriving information in his paper titled 'The widening scope of indications for psychoanalysis'. Glover's (1954) paper, published in the same year, helps to illuminate the rationale behind this shift as he emphasises the link between the person, their symptoms and the developmental stage the symptoms may be routed in.

Rustin (2000a) suggests that responses to interpretations made within the assessment should be closely observed and consideration given to whether they produce an 'opening out and deepening of communication' or a 'freezing and defensive drying up' or turning away (p.5). Thinking about the origin and meaning of these different responses will help to elucidate some understanding about the child's view of the present and how it is filtered through the lens of their internal world and its ongoing internal dramas (Oelsner 2011). Similarly, Anderson (2000) recommends that assessment takes place through an exploration of the relationship that develops between the assessing therapist and the patient to allow something of a topography of the child's internal landscape to be mapped out. This is achieved through the active exploration of the child's suspicion or indifference towards the assessing psychotherapist, or indeed their ability to make use of the psychotherapist's interest in them in a helpful way. This enables the clinician to consider the child's internal capacity to make use of any help offered going forward.

Implications for technique in relation to the use of transference features prominently within the literature. Schachter (1997) suggests that engaging the patient in a transference relationship is not a central aim of the assessment, particularly if the assessing psychotherapist will not be the ongoing therapist. This is followed by a discussion, with clinical examples of when negative transference can function as a resistance to any exploration in the assessment. In such situations Schachter (ibid) suggests 'transference has to be interpreted to prevent an impasse (p.2). Hinshelwood (1991) suggests that the use of transference interpretations can 'correct primitive aspects of the patient's relationship to the therapist', which in turn can help them to form a more balanced frame of mind (p.165). This is perhaps

to counter concern that transference interpretations will create dependence during what is a time limited piece of assessment work. Hinshelwood (1991), Steiner (1993), Garelick (1994), Truant (1999) and Crick (2013) all suggest that creating dependence or deepening the transference interpretations should not lead to avoidance of interpretation in an assessment as such interpretations can facilitate the process of exploration.

Literature considering the role of psychotherapists in clinical training undertaking different forms of assessment remains extremely limited. Truant (1999), refers to this briefly, where he comments on the selection of cases being particularly important for trainees and warns that 'poorly selected cases can have a large and broad impact' (p.19). Langenbach's (1994) beautifully descriptive 'Hidden Flower' paper is the only example within the literature of assessment from the perspective of a trainee, in this case, a psychiatric registrar. The session-by-session accounts of the assessment, combined with a clinical commentary by the author, demonstrate the unfolding of the transference relationship and an emerging understanding of how the patient's non-verbal responses and behaviours helped the clinician to build up an understanding of the child's internal world. What is clear throughout the paper is the important function clinical supervision plays in the development of formulations and recommendations within the assessment. Langenbach speaks to this in detail during the discussion, describing how clinical supervision had acted as a container of anxieties and 'taught me that her playing and running away were as important as words are' (*ibid* p. 190). It also drew attention to the role of the clinical supervisor in helping a trainee to focus on their own feelings during the assessment encounter and to understand them as 'important for therapeutic understanding and progress'. (p.190). There is also some thought given to the wider discussion within assessment technique in relation to making initial interpretations and carefully assessing the child's response to them.

Rustin and Quagliata (2000) offer a clear and accessible introduction to some of the key considerations around issues of process and technique in the introduction to their Assessment in Child Psychotherapy book. They describe the 'fundamental convictions that underly the particular techniques employed in these first contacts with patients' (p.3). As with

other authors, they also point to the importance of close and detailed observation as the basis for clinical understanding. They emphasise the complexity of the process and point out the subjective nature of clinical understanding. Supervision is described as 'a crucial protective factor in helping us to ensure that our observations are properly rounded, not distorted by our own prejudices, limitations, special professional interests etc' (p. 4). Whilst supervision is described as a 'prime requirement' within assessment as part of their introduction, there is no further detailed discussion of this in the chapters of the book that follow.

Writing in 1986, Busch observed that little attention had been given to the assessment process itself within the literature. Although significant contributions have been made by authors in the years that have followed, the results of this literature review suggest information in relation to the process and technique of assessment is still insufficiently explored.

Clinical Formulations Within Assessment

This section will explore the contribution of the assessment literature in understanding how clinical formulations are developed.

Butler (1998) describes a formulation as 'The tool used by clinicians to relate theory to practice… It is the lynchpin that holds theory and practice together… Formulations can best be understood as hypotheses to be tested' (p.2). This concise definition feels like a useful starting point when beginning to think about the function of formulations but lacks a clear delineation of the process and objectives of formulation. Ingram (2006) goes further by stating that formulation is a way of 'Summarising diverse information about a client in a brief, coherent manner for the purpose of better understanding and treating of the client'. This still offers little in terms of understanding how formulations arise in assessments.

Eells (1997) describes a psychotherapy case formulation as 'a hypothesis about the causes, precipitants, and maintaining influences of a person's psychological, interpersonal and

behavioural problems' (p.2). Part of this process involves organising information about a person, which in the context of CAMHS work can frequently include information that contains contradictions or inconsistencies in their state of mind. Ideally, it contains structures that allow the assessing clinician to understand those contradictions in terms of their unconscious mental processes and conflicts (Perry et al. 1987) to categorise important aspects of that information within a sufficiently encompassing view of the patient. A case formulation also serves as a baseline of understanding from which recommendations for treatment can be made and as marker for future change.

Hinshelwood (1991) further developed thinking in relation to psychoanalytic formulations and states the importance of this function within assessment. There is reference to three levels of object-relationships within the paper that is used as a useful framework for thinking about the synthesis of information within formulations:

1. The current life situation.
2. The infantile object-relationship as described in the patient's history or hypothesised from what is known.
3. The relationship with the assessor …the beginning of a transference.

(p. 168)

Hinshelwood helpfully goes on to use case examples to illustrate the presence of these three levels of object relations in order to pick out a common theme that will have some 'approximation to an internal object-relationship' in the patient (p.170). This is referred to as a baseline hypothesis, which represents the nature of formulations in assessment as 'a baseline on which the future work can be guided and grounded' (p. 170). This is an important distinction as it allows other aspects of the assessment to be considered, such as the patient's motivation to engage in psychotherapy. Hinshelwood also uses development of a formulation as a basis for potential transference interpretations within an assessment. As previously stated, there is a discussion in relation to the advantages and disadvantages of making transference interpretations during an assessment. Hinshelwood helpfully frames this as the testing of a baseline hypothesis within a formulation. He suggests the individual patient's response to the interpretation is the best indication of the appropriateness of their use within

the assessment. In terms of arriving at a formulation it can be considered an indication of the suitability of the patient for psychotherapy, as well as giving them an experience that will help the patient to make a more informed decision about entering into psychotherapy should it be indicated.

There is evidence within the literature to suggest that the nature and nuances of a hypothesis within a case formulation will be influenced by the psychopathology of the patient, along with the theoretical viewpoint of the assessing clinician. Haynes et al. (1993) advocate perusing what they describe as rigorous causal connections between a psychopathological condition and its determinants, whereas Spence (1982) suggest more of an explanatory narrative that may not have a factual basis in historical truth but is more focused on the internal landscape of the child under assessment.

Rustin and Quagliata's reference to a reliable information base is perhaps an acknowledgement of past criticisms of psychoanalytic assessment (Gill et al. 1954; Pasnau, 1987; Wilson 1993). Such criticism raised a question in the authors mind in relation to how case formulation can be used as a tool for scientific study, whilst at the same time developing an understanding of how information is organised and then synthesised by an assessing clinician. When thinking about psychoanalytic case formulation there must be space for the subjective nature of the assessment process, whilst at the same time allowing psychoanalytic case formulation to become a useful conceptual tool and a source of scientific study that can develop a recognised evidence base (Schlessinger & Robbins 1974; Mallinckrodt & Nelson 1991; Stein & Lambert 1995; Huppert et al. 2001; Petit & Midgley 2008, Powell et al. 2010; Binder et al. 2013; Gastaud et al. 2014).

The available literature provides a useful outline of clinical formulations within assessment. There is an important distinction made by Herbert (2005) between the differing functions of a formulation. For example, for individual treatment intervention or as a tool for conceptualising a child's presenting difficulties in order to support the decision making of the

network around the child. Hinshelwood (1991) and Eells (1998) utilise clinical case material to demonstrate the iterative process of understanding a patient's relationship with their objects through the transference relationship. This is particularly helpful in understanding how the formulations were generated within their respective papers. Similar additional studies using case material are required to understand more completely the key tenets of how clinical formulations arise. This is particularly important in the contemporary setting of a CAMHS and in the context of the differing functions of psychoanalytic assessment.

Discussion and Conclusions

The literature review includes the main papers that contribute to the understanding of how clinical formulations arise from a psychoanalytic assessment. Whilst there was variation in the purpose and process of assessment within the literature, there is agreement that close and detailed observation of a child during the course of the assessment is one of the fundamental aspects of technique that informs clinical understanding. Only one paper considered the role of psychotherapists in clinical training undertaking assessment work and the important function of clinical supervision in developing and refining clinical formulations.

The literature as a whole was of a variable quality. It included case studies, qualitative research study designs and conceptual outlines of assessment. Many of the papers acknowledge what Hinshelwood (1991) describes as the high level of theoretical and technical ability required in order to arrive at a psychoanalytic formulation. None of the studies provided enough detailed evidence of the process by which clinical material within an assessment was understood by the assessing clinician in order to arrive at a formulation. Appelbaum's (1990) development of a working formulation and conceptual framework is an example of this. The paper gives a general overview of presenting problems. This leaves the reader in a position of being unable to gain a deep enough understanding of the patient's relationship with the clinician during the assessment in order to adequately appraise the formulation made by the author.

Those studies that did provide clinical material presented selected vignettes of session commentaries (Elfant, 1985; Flynn, 1988; Garelick, 1994; Green, 2009; Hinshelwood, 1991; Mees, 2016; Milton 1997; Schachter, 1997; Schlessinger & Robbins). This opens up the possibility of selection bias within the data. This presents the problem of how to reduce such a large volume of complex data into something that can be accessible. This is of course, one of the fundamental challenges in writing assessment reports, as well as within qualitative research literature. As Wallerstein and Samson (1971) highlight, there is a need for psychotherapists to provide succinct but sufficient data as evidence of their clinical understanding.

The current research study attempts to fill a gap in the research literature and build on the work of Binder et al. (2013) and Bradley (2019) in developing a qualitative research evidence base within psychotherapy assessment. This study is the first of its kind to apply the qualitative research methodology of Template Analysis (TA) to child psychotherapy assessments and to create a template to analyse the data using key themes identified within the current child psychotherapy assessment literature.

The Role of the Literature Review in Creating the Coding Template

Completing a thorough literature review has significantly contributed towards informing the content and structure of the coding template used to analyse the research data. Identifying key aspects relating to the purpose and function of the assessment within the literature helped to shape the overall structure to the coding template. The literature emphasised the central process of close and detailed observation of a child within the assessment to facilitate an expression of their internal world. The psychoanalytic tool of tracking the transference and countertransference within the assessment encounter therefore forms one of the primary higher order codes within the Template Analysis and will be discussed further in the following chapters. Literature relating specifically to clinical formulation was also of particular importance as it helped to clarify the function of the formulation within the assessment. Undertaking the literature review allowed the development of codes that related an understanding of relevant psychoanalytic theory to the practice of undertaking an

assessment. This allowed coding within the template to be developed in a structured and systematic way that linked the trainee psychotherapists understanding of psychoanalytic theory to their clinical practice. The literature therefore helped to inform the framework, in the form of the coding template, by which hypothesis about the nature and structure of the child's internal world can be generated and then systematically tested and evidenced.

Literature Review Limitations

There are a number of study limitations. The number of NHS based studies informing the discussion was low. The literature varied markedly in terms of design, methods, and sample sizes. It was therefore difficult to compare or generalise findings. Some of the studies identified were from the assessment of adults, which may mean that results are more applicable to that context. As detailed in the results section the papers also varied in their quality and results should be read in relation to this limitation.

Research Methodology

Study Design

The study adopted a qualitative approach. Detailed descriptive commentaries of assessment sessions for three different case studies formed the data to be analysed. This was done using the hierarchical coding structure of Template Analysis (TA).

The Process of Participant Selection

The child psychotherapy assessments took place in a large city centre NHS CAMHS. Three different types of assessment were identified. This was in order to reflect the different types of psychotherapy assessment typically undertaken within a contemporary CAMHS. The three different assessment types used in the research were:

1. Assessment for Psychoanalytic Psychotherapy
2. Psychoanalytic State of Mind Assessment
3. Assessment for Short-Term Psychoanalytic Psychotherapy

Within these three distinct types of assessment a convenience sample was taken (Morrow-Bradley & Elliott 1986). This non-probability, non-random sampling approach was taken for pragmatic reasons due to time and resource limitations. Participants who met certain practical criteria, such as the appropriateness of the referral, geographical proximity, availability at a given time, and the willingness to participate in the research study were all considered. Ethical guidelines (Bond, 2004) were followed to ensure the participants were not adversely affected by the research process. This included gaining ethical approval from the Tavistock and Portman Trust Research Ethics Committee and accessing approval and support from the clinical training placements Trust Research and Development Team. As a trainee child and adolescent psychotherapist I was also a member of the registered professional society The Association of Child Psychotherapists (ACP). The study was also competed in line with the ACP's clinical research codes and guidance.

Participant consent was obtained and detailed information provided through Participant Consent Forms and Participant Information Forms[11]. Both documents were created and tailored to be accessible to both parents and children at different developmental stages. Potential participants were identified through discussion with a supervising consultant child psychotherapist within the service. Inclusion criterion were children or adolescents who were actively engaged in the psychotherapy assessment process via internal referral. The assessing psychotherapist was the author of this paper. No specific clinical presentation was specified. Co-morbidity did not exclude participation in the study. Further participant detail will be given in their case studies within the results section as this is pertinent to the interpretation of the data.

Psychoanalytic Psychotherapy and the Qualitative Research Method of Template Analysis

Midgley (2004) highlights the important task of identifying an appropriate research focus and suitable methodology. Qualitative research methods are aligned with developing new understanding within psychotherapy as they capture the subjective experience of the child and the therapist (Levitt, Neimeyer, & Williams, 2005). This description of subjective experience within an interpersonal context lends itself to identifying the moments within the assessment sessions that generate the clinical understanding used to inform the formulation and recommendations. A qualitative research methodology can also examine the technical aspects of the psychoanalytic technique used within a particular encounter. This detailed systematic analysis of psychoanalytic assessment can reveal the technique of the assessing psychotherapist as well as offering insight into the process that underlies their clinical decision making —for example, deciding when to offer a transference interpretation and when to explore more (Williams & Levitt, 2007).

The TA research technique reflected the epistemological position of the author as outlined in the framing chapter. Other qualitative approaches were considered, such as Grounded

[11] See Appendix 4: The process of gaining consent involved meeting with participants and their families prior to the assessment taking place and discussing the research with them. Amongst other things they were advised of the right to withdraw from the study at any point, how all research data would be anonymised, how participation in study did not affect their ability to access an assessment or future treatment. Participants were also advised that the method in which the assessments were conducted was not affected by their inclusion in the research.

Theory (Anderson 2006) and Discourse Analysis as outlined by Stevenson (2004) and Traynor (2006) to analyse qualitative clinical data. King (1998; 2012) offered a research method that felt particularly relevant for the analysis of a psychotherapy assessment. It provides what Kidd (2008) describes as a 'contextual constructivist' position where the emphasis is on the reflexivity of the researcher. TA has been used widely in healthcare research (Kent, 2000; King et al., 2003) and is appropriate for data that is not fully transcribed (King, 2004). Articles such as King (2012) and Brooks et al. (2015) offer a detailed outline of the technique. Consideration was given to the possible limitations of the technique, such as the strong emphasis on the coding structure as a possible barrier to engaging with the descriptive commentaries in a more open and responsive way. Bassey and Melluish's (2012) focus study relating to IAPT and Perry et al's. (2013) template analysis of the experiences of male patients in secure hospital settings offer useful examples of research papers where TA has been effectively applied to a clinical data set.

TA is a form of thematic analysis that is applied to rich unstructured qualitative data following the primary data collection phase. The primary data in this piece of research was detailed descriptive commentaries of individual assessment sessions, written retrospectively by the assessing psychotherapist. This produced extensive and complex textual data. TA emphasises the use of hierarchical coding and balances a relatively high degree of structure in the process of analysing large amounts of textual data with the flexibility to adapt it to the needs of a particular study (Brooks et al., 2015). This is a particularly useful approach in the context of a child psychotherapy assessment as central to the technique is the development of a coding template, which can then be applied to the descriptive commentaries before being revised and refined as a result of interaction with the data.

Psychoanalytic Assessment and Data Collection Procedure

The assessment drew on a psychoanalytic frame of reference with three, weekly, individual fifty-minute sessions focusing on the immediacy of the transference dynamics. The assessment sessions took place in the same dedicated psychotherapy room. There were a

range of toys, equipment and art materials specifically provided for each child appropriate to their stage of development. Each participant attended their assessment sessions reliably.

An aim of the assessment was to gauge the quality and dynamics of the child's internal world in order to give an overview of their current state of mind from a psychoanalytic perspective. The material was tracked and recorded via the writing up of retrospective detailed descriptive commentaries for each assessment session. Typically, commentaries were written up immediately after the session. All were written up within twenty-four hours of the session taking place.

Development and Application of the Template

The main procedural steps in carrying out TA were followed as described in detail in King (2012). The first step was to read through all nine of the assessment descriptive commentaries in full a number of times. This consisted of three assessment sessions for each of the three patients. They were annotated with thoughts and free associations along with comments received in supervision[12].

The initial coding template was constructed *a priori* using annotations from the preliminary reading of the commentaries, and the identification of themes through the different forms of clinical supervision the assessment sessions were taken to. This was structured around, and enhanced by initial development of codes identified within the psychotherapy assessment literature. It included codes that were adapted from the assessment goals identified by Tantam (1995), the aims of assessment summarised from Rustin and Quagliata, 2000 and elements to be considered within a psychoanalytic assessment for STPP (Cregeen et al. 2017)[13]. The template was revised over the course of analysing the data. The final template

[12] It is beyond the scope of the current research study to systematically explore the function of clinical supervision within assessment. However, some further information relating to how the process of supervision contributed to the development of the coding template can be found in Appendix Ten.

[13] An example of how the different elements of supervision and an awareness of key themes within the literature contributed to the creation of the initial template is shown in Appendix Five.

was then used to recode all the descriptive commentaries. This served as an organising framework for the interpretation of the results[14].

The code template remained open to continuous revision throughout the analysis. The initial template was applied to the first assessment session in each of the three case studies. The codes were modified in response to emerging understanding of the data that arose as a result of the process of applying the initial template. For example; coding commentaries within the initial template raised the question of how to more effectively track the quality of my response to the child. This led to the development of a much more comprehensive set of lower-order codes within the 'Assessing Psychotherapists Countertransference Response' higher-order code. There was also the addition of a new 'Technical Approach of Assessing Psychotherapist' higher-order code with a number of lower-order codes underneath it. This more effectively captured the role of the assessing psychotherapist in the subsequent recoding of the data.

Four higher-order codes were identified in the final template to capture the data generated within the assessment that informed the formulations and recommendations. They were used to structure the more detailed analysis of the data:

1. Transference Relationship with Assessing Psychotherapist
2. Assessing Psychotherapists Countertransference Response
3. Technical Approach of Assessing Psychotherapist
4. Current Life Situation

Each higher-order code was divided into several descriptive lower-order codes. Once the final template was developed, the descriptive commentaries were coded by assigning higher-order codes to sequences of text. Subsequently, the sections of descriptive commentary were further reassigned to the more detailed lower-order codes. Within each lower-order code,

[14] Final template in Appendix Six

multiple assessment sub-themes emerged – such as the specific technical approach of the assessing psychotherapist and the more nuanced moment-to-moment understanding of the transference-countertransference relationship.

Application of the final template was repeated to ensure thorough assignment of coding. This was repeated until a point of saturation was felt to have been reached. The overarching higher-order codes assigned to the text were then used as a starting point to elaborate on the meaning within the data and to establish theoretical connections among codes that were consistent with the descriptive commentaries and the main research aims and objectives (Crabtree & Miller, 1999).

Data Analysis

Deedose, a Computer Assisted Qualitative Data Analysis Software (CAQDAS) package was applied to the descriptive commentary data[15]. The systematic application of the coding template described above allowed an emersion in the data that was supported by the CAQDAS. This emersion in the data until saturation was an essential part of the qualitative process of analysis. This enabled a move from the more concrete and data grounded analysis of the data to a more abstract and interpretative understanding – giving increased discrimination and clarity of thinking in relation to the data. As Brooks et al. (2015) describe, depth rather than breadth, of coding allows more refined distinctions to be made in key areas. A clear set of higher-level codes also allowed the assessing psychotherapist to draw together the analysis as a whole when presenting the results.

Data analysis took place once all of the assessments had been completed. This was in order to allow the initial template to be applied to subset of data that included all three assessments. The danger of losing sight of the original research aims and focusing on the constructed template as an end product, rather than a means to an end, was held in mind

[15] See Appendix Seven for examples of coding applied within Deedose.

(Brooks 2015). This ensured the on-going analysis remained focused on the data and was not unduly constrained by the initial template design.

Patterns across the data set were analysed using the CAQDAS. Codes were identified and prioritised in terms of giving the most valuable insights into how formulations and recommendations were generated for each assessment. In TA, as is common in other forms of qualitative data analysis, extracts of the written descriptive data were selected in order to illustrate and support my interpretation of the raw data (Waring and Wainwright, 2008; Perry et al., 2013). The frequency and pattern of coding (E.g. clusters of certain codes occurring together) within each assessment was also analysed.

Presentation of Findings

The main body of the results will be presented as three assessment case studies. First-level codes will be used to structure the analysis for each case study. Second, third and fourth level codes will then be used to illustrate how the analysis is grounded in the data.[16] Vignettes of clinical material will illustrate the application of the coding template and a commentary of the rationale for the coding will be given. This will provide a clear process of identifying evidence within the assessment that contributes to the development of the clinical formulations.

The four higher-order codes will be used to structure the more detailed analysis of each case study:

1. Transference Relationship with Assessing Psychotherapist
2. Assessing Psychotherapist's Countertransference Response
3. Technical Approach of Assessing Psychotherapist
4. Current Life Situation

These higher-order codes will also form the framework for the writing up of the clinical formulations and for each of the assessments. This will allow the link between the application of the coding and the resultant formulation to be clearly tracked by the reader.

[16] Codes will be denoted in **bold type** within the text to allow them to be more effectively tracked.

CASE STUDY ONE: Assessment for Psychoanalytic Psychotherapy – Aziz

Summary of Family and Developmental History

Aziz, not his real name, was a three-year-old boy at the time of referral. Parents spoke of Aziz as communicating his needs by crying and pulling on his mother's hand. He would make minimal eye contact and had a limited range of vocalisations. He demonstrated repetitive behaviours, such as repeatedly jumping on the spot or playing with toy cars. Parents were born outside of the UK and communicated their feeling of isolation due to the limited support network of family and friends around them.

Reason for Referral

Aziz was referred for a psychotherapy assessment by a Consultant Child and Adolescent Psychiatrist, due to ongoing concerns around his communication and social interaction skills. He had received an Autism Spectrum Disorder diagnosis from a Consultant Clinical Psychologist colleague within the team four months prior to the referral for a psychoanalytic psychotherapy assessment.

Transference Relationship with Assessing Psychotherapist

Significantly in the context of his ASD diagnosis, there were n=37 occurrences of feeling **worthy of attention** and n=21 occurrences of feeling/expecting that he **can be helped** in **response to a receptive and observant presence.**

<u>Aziz Assessment Session 1 Lines 54-62</u>

> He seems particularly interested in the fire truck and returns to this a number of times, repeating the phrase 'fire truck'. I say 'Yes, fire truck, nee naw nee naw'. Aziz seems interested in this and looks up at me, making eye contact with me briefly before looking back at the truck. He repeats 'Fire truck, nee naw'.

Sequence of transference coding applied to the above example of clinical material:

First Order Code: Transference Relationship with the Assessing Psychotherapist

Second Order Codes: Response to a receptive and observant presence, Response to what the therapists says

Third Order Codes: Positive experience/expectation, Opening out and deepening of communication

Fourth Order Codes: Worthy of attention, Can be helped, Worthy of Attention

This example of feeling **worthy of attention** was a familiar feature in the transference throughout the assessment data. Aziz demonstrated considerable functional capacity during the assessment through his striking **wish to communicate**.

In the following sequence Aziz demonstrates some of the social impairment that had been described in the referral.

Aziz Assessment Session 1 Lines 131 – 134

> He seems completely absorbed in the activity of repetitively looking at them, one after the other. There is a meaningless quality to this, and I feel less enthusiastic about matching his repetitive, almost robotic naming of the ambulance… fire truck… SUV…

Sequence of countertransference coding applied to the above example of clinical material:

First Order Code: Assessing Psychotherapists Countertransference Response

Second Order Code: Negative Response

Third Order Codes: Helpless/stuck, Distracted/disinterested and Shut out/rejected

The repetitive, meaningless feeling in this sequence – captured by the countertransference coding of **hopeless/stuck**, **distracted/disinterested** and **shut out/rejected** provided some evidence that in this particular moment Aziz was talking to what I began to think of as an *empty space* within the room. This was one of many occasions where there seemed to be an absence of object relations. I seemed completely out of Aziz's mind.

Alongside **defensive turning away** within the assessment the data analysis showed there were n=41 occasions where Aziz demonstrated a **wish to communicate** in **response to what the therapist says/does**. The following sequence occurred immediately after a sequence with **hopeless/stuck**, **distracted/disinterested** and **shut out/rejected** coding similar to the one above:

Aziz Assessment Session 1 Lines 113 – 127

I get the foam ball out of the box 'What's this Aziz? Oooh, look at the foam ball!' He looks at the ball and points at it making an 'Urgh' noise. I pass the ball to him and he looks at it briefly before throwing it across the floor. He makes an excited squeal noise and smiles in response to this. It feels much more playful than the 'throwing away' of the other items he wasn't interested in.

I retrieve the ball and return it to him. He makes brief eye contact with me and smiles warmly. There is a hint of real pleasure in his response. He throws the ball again and I return it to him. The ball is thrown for a third time. I collect it and sit opposite him on the floor, this time rolling the ball to him. He stops the ball with his hand and then rolls it back to me. I stop the ball and then clap my hands 'Yay! Aziz passed me the ball!' I roll the ball back to him and he glances up at me. This time much more briefly. He stands with the ball in his hand and then places it on the floor in front of him before kicking it to me. Before the ball has reached me, he has turned away and is looking at the cars again. He seems to have withdrawn into himself. Part of me wants to try and re-establish our brief connection but I stop myself, thinking Aziz was feeling that was enough for now.

Sequence of transference coding applied to the above example of clinical material:

First Order Code: Transference Relationship with Assessing Psychotherapist

Second Order Code: Continual movement between the following two codes: Opening out and deepening of communication ↔ Defensive turning away

This sequence suggests a capacity within Aziz to be object orientated, particularly with an attentive and lively other. It was however important for me to note the fragility of such moments and how quickly Aziz returned to a more withdrawn and isolated state of mind. While the **wish to communicate** occurrences were high within the coding, the depth, quality and duration of that **wish to communicate** also needed to be held in mind.

Another significant aspect of the transference relationship that support this formulation was his capacity to **become curious** with n=47 occurrences and his **responsiveness to my interest** in him with n=54 occurrences.

Aziz Assessment Session 2 Lines 131 – 143

> I select one of the cars from the house and follow him down the stairs with my car. He watches me do this and then repeats this himself. I follow him again and he seems pleased by this. We repeat this a few more times with Aziz allowing me to hold onto the car without taking it off me.
>
> Aziz drives the car on the roof of the doll's house. He taps it on the roof a few times. I say 'tap, tap tap!' and then comment that I think Aziz likes the tapping noise! I tap the car I'm holding in time with his taps. He lets me do this a few times before taking the car off me and taps them both together. I say 'tap tap tap' again as he looks at the cars with real interest.

Sequence of transference coding applied to the above example of clinical material:
First Order Code: Transference Relationship with Assessing Psychotherapist
Second Order Code: Response to what the therapist says
Third Order Code: Opening out and deepening of communication
Fourth Order Code: Became curious

Coding the data in this way helped me to think about the nature of Aziz's curiosity – something not done in the here-and-now of the session. One possibility was that Aziz had become interested in the difference between the two cars and the types of 'tap' they produced on the wooden roof. In turn, an awareness of this difference could then be thought of as a bridge to his awareness of the difference between himself and the assessing psychotherapist – an awareness that was necessary for his **wish to communicate** to emerge.

While there were 36 occurrences of **playfulness** compared with Katie n=3 and Ellis n=0 during the assessment, further analysis demonstrated the importance of considering the context of the play. For example; there were n=4 occasions where **playful** was coded along with **isolated/in own world** and three co-occurrences with **comment ignored**. Analysis of the co-

occurrence of coding within the data allowed for a more detailed understanding of the nuance behind Aziz's behaviour. It was possible to understand the moments of **playfulness** that were in the service of being object-orientated (n=30 in total over the whole assessment) and those that allowed Aziz to withdraw into himself.

Psychoanalytic Formulation of Transference Relationship with Assessing Psychotherapist Based on the Data Analysis Results[17]

Emotional engagement between Aziz and the people around him is critical for the development of his symbolic thinking and ability to communicate. Aziz's **response to a receptive and observant presence** within the assessment demonstrated a significant **wish to communicate** with the world around him. This felt significant in the context of his Autism Spectrum Disorder diagnosis and the original referral for psychotherapy that highlighted ongoing concerns around his communication and social interaction skills.

Aziz demonstrated considerable functional capacity during the assessment through his striking **wish to communicate**. There were occasions where there felt to be an absence of an object relation. However, he also demonstrated a capacity to be interested in the people around him, particularly with an attentive and lively other. Another significant aspect of his interaction with the psychotherapist during the assessment was his capacity to become curious in the world around him. This seemed to be in response to his experience of being held in someone's thoughts. Whilst there were occasions where Aziz retreated into much more isolated and withdrawn states of mind, he also showed some capacity to experience feelings of distress in a more ordinary way and to foster a secure attachment to make use of the containment available to him.

[17] For didactic purposes, First Level Codes will also be used as headings to structure the presentation of the clinical formulation. This will help to link the identification of patterns within the data coding to the creation of the clinical formulation. The author acknowledges that clinical formulations are typically written as continuous narrative that interweaves both internal and external aspects of the child's presentation.

Assessing Psychotherapists Countertransference Response

Analysis of the data clearly demonstrated a need to provide live company (Alvarez, 1992) in order to engage Aziz, the repeated countertransference experiences of feeling **shut out** and **rejected** in the coding resigned me to the feeling that interpreting this as a countertransference communication would not elicit any response.

The systematic method of coding the assessment was therefore essential in allowing me to avoid this dynamic taking hold and aspects of the transference-countertransference relationship being missed. This in turn helped to avoid the inevitable moment-to-moment experiences of such an impasse in the therapeutic encounter obscuring other more developmental aspects of the encounter. The template analysis of the assessment data could therefore be considered to have a containing function for me. Whilst not possible in the here-and-now of the assessment, this did allow me to retrospectively become more open to the *not knowing* aspect of the assessment encounter. I was able to adopt a third position in relation to the experience of being in the room with Aziz.

In the sequence below, the **hopeless/stuck** countertransference response to Aziz's play can be seen as a response to feeling **shut out** and **rejected** by him:

<u>Aziz Assessment Session 2 Lines 35-41</u>

> Aziz takes the toy off me, leaving me feeling as though I've had it confiscated for intruding into his fire truck world.
>
> I initially retreat from the play with a feeling of admonishment, but then gather myself and select the orange car, this time driving it in a more sedate manner with the idea of matching Aziz's pace.
>
> This seems to be tolerated by Aziz slightly longer before he again takes the car off me without making any eye contact or noise to acknowledge my presence. He pushes the orange car instead of returning to the fire truck.

I voice my interest in this 'Wow! Aziz has the orange car now! Beep beep!' He looks at me and says, 'orange car!' I say back 'Beep beep!' Aziz looks back down at the car and pushes it for a moment before repeating back 'beep beep'

Sequence of countertransference coding applied to the above example of clinical material:
First Order Code: Assessing Psychotherapists Countertransference Response
Second Order Code: Negative Response
Third Order Codes: Shut out and rejected, Hopeless/Stuck, Sadness

Aziz was able to elicit important bodily countertransference phenomena in me. This sequence included countertransference coding of **hopeless/stuck** and **feeling shut out/rejected**, as well as **sadness** and feeling **distracted/disinterested**. All of these responses were prominent features of the transference-countertransference dynamic within the assessment.

The formulation must outline what can be *known* from the transference-countertransference experience within the assessment, whilst at the same time holding in mind the need to account for *unknown* elements of the interaction – what is not said, felt or understood (Eells 1997). For example, while the countertransference feelings of projected **sadness** and **rejection** loomed large in my mind during the here-and-now of the assessment sessions, the subsequent coding of the session data allowed the recognition that **sadness** and **rejection** was not the whole story.

The frequency and intensity of the countertransference experiences of **hopeless**ness and of feeling **to be of no real interest** to Aziz in response to his more **isolated** and **withdrawn** states gave insight into the nature of this repeated pattern of non-relating. However, it did not adequately capture the *strength* of them in the moment, or the cumulative impact of repeated experiences of these feelings within the assessment sessions.

Equally, the moments of more hopeful contact also had a particular quality and strength to them. The sense of **hopefulness** was in fact significantly higher overall with n=18 occurrences compared to Katie n=3 and Ellis n=1. There was a powerful experience of **hopefulness** and

excitement in response to the *quality* of his **seeking contact** with an object he had suddenly become aware of and the *strength* of his **wish to communicate** during the sequences of contact and reciprocal play.

Psychoanalytic Formulation of the Assessing Psychotherapists Countertransference Response Based on Application of Template Coding

When Aziz became withdrawn in response to my actions or comments his attention seemed completely focused on an attachment towards hard, auto-sensuous objects, such as the toy cars. The sensations such objects provided, such as their sense of definition, had an addictive quality for him. Aziz could quickly become increasingly withdrawn and isolated in an activity such as spinning the wheels of a toy car, rather than seeking contact with someone in order to actively engage in a more developmentally appropriate and relational way. A number of times during the assessment this left me with an experience of feeling shut out and rejected, which resulted in a more hopeless and stuck feel to our interactions.

Close observation allowed the function of his play to be understood. At times this allowed him the space he needed to be in his own world as a way of regulating his emotions and preventing himself from becoming overwhelmed by too much contact with others around him. Sensitivity and responsiveness to Aziz's need for breaks in his level of contact with others allowed him to show more signs of curiosity. On occasions it allowed him to communicate his emerging sense of agency as he sought to master various tasks. His level of playfulness within the assessment was significant and also frequently demonstrated his desire for contact.

Technical Approach of Assessing Psychotherapist

I quickly became aware of Aziz's responsiveness to me. There were n=59 occasions of **adopted a lively presence** being coded during the assessment. In the following sequence it is possible to see how Aziz is able to make use of this:

Aziz Assessment Session 1 Lines 54-62

I make the 'nee naw' noise alongside him and then pick up the ambulance to drive it next to the fire truck he is holding. Aziz immediately takes it off me and begins to drive it. I give a disappointed 'Oh, no ambulance for Andrew!' He pushes the ambulance around for a moment longer and then returns to the fire truck before repeating the cycle of looking through each of the cars in turn.

I begin to make the 'nee naw' noise as he pushes the fire engine. He looks up and smiles before repeating back 'nee naw'. We then make the 'nee naw' noise together as he pushes the fire engine and I follow with the ambulance. He shakes his body from side-to-side and has a delighted expression on his face as we continue to do this together.

Sequence of Technical Approach coding applied to the above example of clinical material:
First Order Code: Technical Approach of Assessing Psychotherapist
Second Order Code: Adopt a lively presence

Adopting a lively presence with Aziz in the assessment allowed me to engage with him in such a way, that the possibility of reclaiming him from his more isolated states of being could be gauged. My subjectivity was crucial in the process of beckoning him into a more object orientated engagement. It required sensitivity to weak, delayed or underdeveloped signals of life that needed to be amplified. The formulation must therefore consider the aliveness in Aziz and his surroundings.

It was important within the assessment that I was careful not to impose any sophisticated meaning to Aziz's communications. This is perhaps best emphasised by the 'nee naw' language that spontaneously developed, as well as the absence of transference interpretations being offered to Aziz during the assessment. A function of the assessment formulation for Aziz therefore needed to address his potential for thinking and the role of sensation dominated states over his thinking.

Psychoanalytic Formulation of the Technical Approach of Assessing Psychotherapist Based on Application of Template Coding

Aziz repeatedly demonstrated an interest in my liveliness when I was able to be alongside him. This was not easily achieved and was typically only able to be maintained for brief periods within the session. It required careful and responsive work, such as emphasising the musicality of my voice and simplifying my language, along with accentuating my non-verbal responses. This frequently had the effect of reclaiming him back from his more detached states of mind. When this was possible, his response to my presence was one of excitement and curiosity.

Current Life Situation

I was not given any information directly relating to Aziz's current life situation during the assessment sessions. The information gathered regarding this was via parents and other clinicians involved in the case. This is a potential gap in the information obtained during the course of the assessment.

Psychoanalytic Formulation of Aziz's Current Life Situation Based on Application of Template Coding

While there was clear evidence of Aziz's wish to seek contact with others it is important to emphasise the amount of times within the sessions where Aziz became much more detached from the world around him. My impression was that he is much harder to reach in this state of mind and is at risk of becoming extremely isolated and withdrawn unless he is offered considerable support. The self-regulative and protective aspects of his behaviour are common features of autism and can impede development. At times he exhibited repetitive behaviours in the sessions. During these sequences it felt as though I was of no real interest to him at all, an experience that has also been communicated by parents and his key worker within the nursery Aziz attends.

Summary of the Psychoanalytic Formulation Based on Application of Template Coding[18]

Aziz showed the potential to make use of my careful thought and capacity to be minutely attentive to his more isolated and withdrawn states of mind. He was responsive to my interest in him. There were occasions where attempts to communicate with him resulted in my comments being ignored. This seemed to have the effect of leaving him feeling angry and misunderstood. Alongside this there were also times when he showed an awareness of the world around him and a desire to relate to people.

The strength of his wish to communicate and the frequency of his seeking contact with another person gave the impression of a little boy who had the capacity to become more interested in his own mind and to feel worthy of attention from those around him. Intensive psychoanalytic psychotherapy would therefore be indicated in order to give Aziz repeated experiences of seeking and finding contact with a receptive and observant other. This would help him to experience relationships with other people as meaningful and important to him.

[18] Assessment recommendations based on data analysis results and external factors can be found in Appendix Eight

CASE STUDY TWO: Psychoanalytic State of Mind Assessment (PSOMA): Katie

Summary of Family and Developmental History

Katie was a 9-year-old girl who had been removed from the care of her mother two years prior to the PSOMA due to concerns about neglect and domestic violence within the home. She had been placed in kinship care.

There was very limited detail available regarding Katie's early developmental history or the specific circumstances behind Katie coming to care, other than her birth mother had an extensive criminal record and was serving a custodial sentence at the time of the assessment.

During her placement Katie had expressed a wish to see her birth mother and described a belief that her mother 'was not well'. Katie felt this was the reason her mother had not contacted her. The initial referral describes Katie's birth mother as having a longstanding and pervasive drug addiction.

Reason for Referral

Katie was referred for a PSOMA by a Child and Adolescent Psychotherapist colleague within the service. It was felt some of her early experiences may be impacting on her current behaviour and emotional wellbeing.

At the time of referral Katie was smearing her excrement on the walls at home, despite continued attempts to support her with this. Katie was described as struggling to express her feelings, which resulted in her mood changing very quickly from withdrawn and introverted to extremely aggressive and violent.

Transference Relationship with Assessing Psychotherapist

There were n=67 occurrences where Katie was coded as feeling **anxious** during the course of her assessment sessions. This was by far the highest prevalence of any single code within the entire data set.

Katie Assessment Session 1 Lines 9-18

> Despite her broad smile she appears visibly anxious. She moves her body slightly closer to [carer] and is clutching a bag of sliced apple and grapes with both hands. She seems frozen to the spot and is trembling. I encourage her again, but this only seems to add to her anxiety. I allow a moment for her to settle. [carer] offers her some gentle encouragement 'Go on Katie. It will be okay. I will be right here'. She looks up at [carer] and seems to be searching desperately for reassurance.

Sequence of transference coding applied to the above example of clinical material:
First Order Code: Transference Relationship with the Assessing Psychotherapist
Second Order Codes: How they inhabit their own body
Third Order Codes: Anxious, Fearful/Frozen, Re-traumatised, Repetition of Earlier environmental failure

The sequence above was my first encounter with Katie. The level of **anxiety** was palpable. Much more intense than the ordinary anxiety you would expect from a child when faced with a new and unfamiliar encounter. This was perhaps best captured by the co-occurrence of codes such as **fearful/frozen, re-traumatised** and **repetition of earlier environmental failure** alongside that of **anxiety**. My first thought in relation to Katie was that her level of **anxiety** was so high, simply offering insights about her play and interpreting her feelings was not going to be enough. The very first interaction with her involved **offering containment** in response to her more immediate and intense distress. Bearing witness to her overwhelming **anxiety** and offering her some refuge from it formed the basis of the transference relationship within the assessment. I was repeatedly called upon to demonstrate my ability to stand and survive Katie's intense feelings of **distress** in order to establish a connection with her.

A further example of this is a sequence later on in the first assessment session where Katie recalls an experience where she had attended a travelling fairground with her birth mother and a man that was unknown to her:

Katie Assessment Session 1 Lines 173 – 182

> She then talks about how there had been 'big spiders with hairy legs' there as well, but that the man they were with had said it was time to go then so she didn't have to hold one of those. Again, in quite a light-hearted sort of way she says that she was really glad about that as she was frightened. Katie then becomes extremely anxious and is shaking as she begins to look around the ceiling to see if there are any spiders in the room. I say 'That frightening thought is making you feel worried about this room too' I pause and then add 'You are safe here. I can keep us both safe in this room'. She smiles in response to this and seems visibly relieved before replying that it has been 'okay coming here'.

Sequence of transference coding applied to the above example of clinical material:
First Order Code: Transference Relationship with the Assessing Psychotherapist
Second Order Codes: How they inhabit their own body
Third Order Codes: Anxious, Fearful/Frozen, Re-traumatised, Repetition of Earlier environmental failure Feeling understood, Worthy of attention, Can be helped.

The **repetition of earlier environmental failure**, **re-traumatised** and **fearful/frozen** coding in this sequence and others during the assessment helped me to register a feeling of unprocessed trauma. The frequency of this type of coding suggested past traumatic experiences were being communicated as a current and alive emotional and relational experience for her.

In the example above, Katie's smile and 'It's okay coming here' response to the transference interpretation was coded as her **feeling understood**, **worthy of attention** and that she **can be helped**.

A sequence at the beginning of the second session helped further my understanding of the link between her overwhelming **anxiety** and how unreliable she felt the world around her to be:

Katie Assessment Session 2 Lines 39 – 66

> I recall how last week she had asked what would happen to her session if I had been off sick and now there was this worry about if we would have our room for the session today. Katie looks at me and nods thoughtfully. I say there wasn't much hope that we could get back together today. She looks around the room and gestures to the therapy box. 'The box is still here!'
>
> I nod and go to speak but this is interrupted by a short coughing fit. Katie looks terrified by this and studies me closely. Aware of how frightened she looks I say 'Oh, sorry about all that coughing'. She replies by saying that she didn't think I was very well.
>
> I comment 'You are worried I will get ill and go away and then I won't be here for you?' The smile disappears from her face. She looks down at the floor and nods. I say that I shouldn't be coughing and making her worry about all of this when it is already so hard to come here and see me. She looks up at me and makes eye contact 'You can't help it if you don't feel very well'. It feels as though she is resigned to the idea something will inevitably go wrong for her.

Sequence of transference coding applied to the above example of clinical material:
First Order Code: Transference Relationship with the Assessing Psychotherapist
Second Order Codes: Response to a receptive and observant presence
Third Order Code: Negative Experience/Expectation, Feels Persecuted
Significant Fourth Order Codes: Sense of Disappointment, Anger, Suspicion

Coding of the sequence allowed her **sense of disappointment** and feeling of **anger** in relation to her experience of the world as a frightening and unpredictable place to be identified. This was an important retrospective insight into the transference dynamic as it was not sufficiently registered in the moment of the session. It alerted me to the lack of attention/thought that had been given to her sense of **anger** (n=18), **suspicion** (n=10) and **disappointment** (n=16)

across the assessment as a whole. Her disproportionate level of **anxiety** and **concern** for my wellbeing suggested an internalised object that lacked robustness. Katie's insight into the possibility I was feeling unwell seemed to equate to a fear that I was fragile and needy. Unable to help myself, or her. While I was alert to her experience of a fragile object and her anxiety that everything will collapse – communicated in her worry about the possibility I was becoming ill, I did not fully understand in the moment of the session that Katie felt *she* needed to look after *me*. This only occurred to me retrospectively while looking at the pattern of coding within the data.

Psychoanalytic Formulation of the Transference Relationship with the Assessing Psychotherapist Based on Application of Template Coding

Katie presented with a significant level of anxiety and fear during the assessment. She communicated an internalised experience of the world as unpredictable and frightening. At an unconscious level this placed her in the position of not feeling fully secure in the new family setting she now finds herself in. Despite her high levels of anxiety throughout the assessment she put considerable effort into developing a relationship between us. This effort suggests to me she is a little girl who hasn't given up on the idea of relationships being able to offer her something of value.

Her considerable anxiety at the beginning of the sessions had somewhat of a paralysing effect on her, making it hard to get any momentum in the session without me facilitating the conversation or activity. The more active role I assumed during the assessment with her was perhaps in response to the idea Katie would not be able to overcome her anxiety sufficiently for something creative to happen between us. My sense was that the paralysing quality of her anxiety leaves her feeling that she cannot be helped with some of her more painful experiences without the idea of a more robust object being available to her.

Katie did however allow me to draw her out of this when I communicated my awareness of this feeling in her. Towards the end of the first session she described how it had been 'fun' and that she had enjoyed coming. When I offered some supporting comments linked to the idea there could be a whole mix of feelings about coming for an assessment Katie was able to

talk much more openly about how worried she had been feeling before coming to see me. I felt there was a part of her who wanted to be noticed but at the same time was suspicious of my interest in her.

There was a feeling of unprocessed trauma, with some of Katie's intense communications appearing to have roots in past traumatic experiences. This was repeatedly communicated as a current and alive emotional and relational experience for her.

Assessing Psychotherapist's Countertransference Response

The **guilt**, **anxiety** and **concern** coded in the vignette above suggested a countertransference response to Katie's experience of deprivation. I was left in the position of feeling either neglectful and/or abusive or fragile and needy. The assessment required careful reflection in response to the countertransference feeling of being like an unpredictable, depriving or cruel parent. This suggested the importance of work with the carers and supporting network due to the painfulness of the countertransference response to the deprivation.

The combination of her **sadness** with an expectation to be **of no real interest** and her feeling that she **cannot be helped** left me with a strong sense of wanting to counter these feelings by giving her an experience of being **worthy of attention**. There were n=26 instances of **containment/reassurance** being offered to her as a result. This was significantly higher than the other two assessments (Ellis n=6 and Aziz n=18). Alongside this my response to Katie bringing the idea that she would be **of no real interest** seemed to draw me outside of normal clinical practice (coded as: **wish to help with something I normally wouldn't** n=17). This was by far the highest occurrence of this within the data set (Ellis n=2, Aziz n=5).

Understanding the nature and source of the countertransference response during the assessment had the potential to make Katie's placement more stable and reduce the risk of placement breakdown. A clear formulation around the nature of the countertransference experience would enable me to help other adults in the network to manage powerful transferences and countertransference feelings. Part of my role was to help facilitate other relationships in Katie's life, particularly with her carers. On the occasions where the strong

countertransference response to her called me into action, Katie seemed to make use of the containment offered. This felt to have the potential to be a significant protective factor for Katie and reflected her external situation, where I experienced her carer to be thoughtful and extremely invested in supporting Katie.

Katie Assessment Session 3 Lines 170 – 173

> The session is due to finish. In a pleading voice she asks 'Please, can I just finish sharpening the pencils. I'm nearly done'. I talk about how hard it is to end today and that there is a feeling around that there isn't enough time.
>
> Katie replies 'I just need to sharpen a couple more. Please? It won't take long'. She says that she wants them all to be ready for the next person that is going to use the box. I feel desperately sad in response to this. I'm left feeling cruel and depriving as I again encourage her to end despite her not yet completing all of the pencils. Becoming more desperate she says, 'I've only got two more to do, please can I just finish them'. I find it hard to say no.

Sequence of countertransference coding applied to the above example of clinical material:
First Order Code: Assessing Psychotherapist's Countertransference Response
Second Order Codes: Negative response, Other type of response
Third Order Codes: Guilt, Anxiety, Feeling Criticised, Wish to help with something I normally wouldn't, Concern.

There was a sense of mutual deprivation experienced within the assessment, where I was left feeling unable to offer Katie what she needed. It felt highly likely a similar dynamic was being played out with her current carer. It was therefore essential that Katie's present relationships and feelings were acknowledged in context of her past. A concern of mine at the time of referral was the feeling of failure in the network around Katie. This certainly felt alive in the transference-countertransference relationship described in the vignette above. There was a sense within Katie of not being given anywhere near enough by me. Such feelings were preventing her fully acknowledging the value and importance of the relationship with her current carer.

Psychoanalytic Formulation of the Assessing Psychotherapists Countertransference Response Based on Application of Template Coding

I found the end of the assessment filled with an acutely painful sense of loss. This seemed to be a feeling I needed to hold onto for Katie, rather than one that could openly be spoken about. The fleeting nature of her experience and her sadness, sense of disappointment and anger in relation to this was too difficult to be acknowledged. My observations about the potential of these feelings being around were denied with an 'It's okay, it doesn't matter' type of response. This is perhaps an indication of how transitory and precarious relationships feel to her, which would again contribute to the challenge of expressing her normal feelings, such as anger, sadness or disappointment in a more ordinary way. Such feelings may well carry with them the fear they will have a destructive impact on her current relationships, that she clearly values and is desperate to maintain.

Throughout the assessment there was a feeling of Katie's need to be careful and cautious around me. This I think was in part linked to her past experiences and an unconscious uncertainty about how safe and reliable the adults around her are.

Technical Approach of Assessing Psychotherapist

It appeared as though Katie had entered into the assessment encounter with the impression talking about her birth mother would be expected of her. My feelings of concern for her during the sessions was partly in response to the raw and unprocessed feeling of trauma some of her memories and associations seemed to have. It was clear that associations such as her experience at the fairground, referred to in the earlier discussion around the transference coding, were painful and confusing for Katie. They seemed to leave her with the expectation that even benign experiences, such as the assessment encounter, had the potential to quickly become dangerous and frightening. Whilst offering an interpretation to this effect served the purpose of establishing Katie's capacity to make use of it – in order to help inform the clinical formulation, I also needed to hold in mind the need for sensitivity in the timing and wording of my interpretation.

Katies description of her experience at the fairground had the following 'technical approach' coding attached to it:

Sequence of technical approach coding applied to the clinical material:
First Order Code: Technical Approach of the Assessing Psychotherapist
Second Order Codes: Offered transference interpretation, Offered containment, Made observational comments

The interpretation was combined with a comment to **offer containment** as a way of holding something of the **distress** for her. The coding in this sequence suggests Katie was responsive to this approach as she **demonstrates capacity to recover** in response to the combination of interpretation and containment. Analysis of the n=11 **offered transference interpretation** sequences coded shows they where consistently constructed with a more positive than negative ending. Subtle differences in the wording of comments and observations seemed to be of crucial importance for her.

The high number of **observational comments** coded within the assessment was also an important indicator of the need to be even more communicative and receptive than would perhaps be more typical in an assessment with a child this age. Katie seemed to experience moments of silence in the room as terrifying. Careful consideration needed to be given to this technical aspect of her PSOMA. The significant increase in observational comments to fill the space may well be in the service of avoiding what is felt to be too unbearable to tolerate in the countertransference.

Psychoanalytic Formulation of the Technical Approach of Assessing Psychotherapist Based on Application of Template Coding

Katie's extreme vulnerability to anxiety requires much sensitivity in responding to her communications of distress. When this was possible, she was responsive to this approach and demonstrated capacity to recover from her more anxious states of mind.

Katie appeared prone to hearing and focusing on the negative things which are said to her. This can have the effect of spoiling her more loving and thoughtful experiences. Careful attention needs to be given towards the wording of conversations with her around aspects of her behaviour – such as her soiling and aggression so that more positive elements of her personality and experience can be emphasised and reinforced for her.

Katie seemed to experience certain aspects of the assessment as terrifying. Network interactions with Katie need to hold this in mind in order to carefully pace work to address her past traumatic experiences with her.

Current Life Situation

The n=4 coding of **protective/supportive factor** within the assessment was based on the direct observation of loving and thoughtful interactions between Katie and her carer. The **protective/supportive factors** coded, along with the external information gathered within the network, suggested that Katie had a much needed, reliable and containing object in her current carer.

I was certainly aware of how hard I had needed to work to avoid becoming mindless and acting out in the countertransference in the midst of Katie's emotional bombardment during the assessment. The referral came at a time when the network around Katie seemed incredibly committed and thoughtful, but as a whole appeared at a loss in terms of supporting Katie with the smearing of her excrement. There needed to be space to think about the carer's experience of being subject to powerful projections and countertransference feelings – such as being placed in the position of feeling they lacked robustness and had become neglectful and abusive in a way that had been identified during the assessment. Perhaps both Katie and her carer needed the importance and security of their relationship to be acknowledged and communicated to them. This aspect of the formulation certainly contributed to the recommendation of additional support for Katie's carer in order to maintain/develop her containing function.

Psychoanalytic Formulation of the Current Life Situation Based on Application of Template Coding

The network around Katie report that she appears to be making good use of the new family setting she finds herself in.[19] She has begun to show signs of building an internal narrative that more closely links with the stable and supportive external environment she now finds herself in. The recent reduction in episodes of smearing and incidents of violent and aggressive behaviour, combined with no significant behavioural concerns at school are early hopeful signs. Careful thought is required to further establish a sense of stability and security in her mind.

The child psychotherapy assessment highlighted the importance of Katie's current relationship with her carer. At this point the main focus of the network should be to help Katie establish a sense of security in this relationship so that she can continue to have repeated experiences of a thoughtful and responsive carer-child relationship.

It is important to acknowledge the emotional task of providing care for Katie and her communications of how overwhelmed by anxiety and distress she feels. In the face of such powerful feelings, carers can often be at risk of having feelings of inadequacy and neglect projected into them. These feelings do not reflect the thoughtful and caring reality of the care being offered by Katie's current carer. Additional support should therefore be offered to help acknowledge this and to provide space for Katie's carer to think about the experience of caring for Katie.

Summary of the Psychoanalytic Formulation Based on Application of Template Coding

The current network around Katie appears to be approaching the provision of her care in a committed and thoughtful way. Katie seems to have made significant progress during the two years of her current placement. There continues to be concern around Katie's ongoing

[19] Based on consultation with the network that took place as part of assessment. This included CAMHS case manager, school, social worker and Katie's current carer.

communication of distress, in particular her smearing of her excrement in the home. This can be thought about as a communication of unprocessed trauma linked to her early childhood experiences. While a future psychoanalytic intervention should be held in mind[20], the immediate task should be to support the network around Katie, and in particular her carer to understand the nature of her communications.

[20] It is important to acknowledge the external context as a driver in this decision as the PSOMA was undertaken with the prior understanding that the offer of ongoing, long-term psychotherapy would not be immediately available within the service due to what Green, (2009) and other within the literature refer to as the 'scarce resource' of psychotherapy within the NHS CAMHS clinic where the assessment took place. The primary 'purpose' of the PSOMA (also discussed within the literature review) was therefore to support and inform the network how to most appropriately use the existing resources available to support Katie.

CASE STUDY THREE: Assessment for Short-Term Psychoanalytic Psychotherapy (STPP): Ellis[21]

Summary of Family and Developmental History

Ellis was seventeen years old at the time of referral. He was born female, but now identified as male. As a result, Ellis had been referred to a NHS Gender Identity Clinic approximately twelve months prior to the assessment and was awaiting an initial consultation appointment. There were concerns about the additional risk involved in the task of negotiating the unique and complex issues associated with gender expression and identity, however there were also a number of other external factors that the referring clinician, a Senior CAMHS Practitioner within the team, felt were significant contributing factors to his low mood.

Ellis described a very difficult family dynamic at home, and in particular the relationship with his mother. Autism Spectrum Disorder (ASD) was also a prominent feature in the family. Ellis received a diagnosis four years before the assessment. His father and younger sister also have an ASD diagnosis.

Reason for Referral

At the time of referral Ellis had reported a deterioration in his long-standing low mood, along with an increase in the occurrences of self-harming and suicidal ideation. While Ellis was regularly accessing support from CAMHS, this was primarily around risk management rather than to undertake a specific psychological intervention.

Transference Relationship with Assessing Psychotherapist

The overall occurrence of Ellis having a **negative experience/expectation** in response to a **responsive and observant presence** was n=65 over the three assessment sessions. This was a familiar pattern of relating for Ellis throughout the assessment. The **sense of**

[21] A note on pronouns: For 'Ellis', he/him/his pronouns will be used to reflect the gender Ellis identified with, rather than the female gender assigned at birth.

disappointment and **distress** coding alongside his **cannot be helped** feeling suggested an internal world where Ellis had little hope of meaningful help being available from those around him. Typically my attempts to offer insight and understanding through transference interpretations resulted in experiences of disappointment and frustration for Ellis, rather than him feeling they had helped something to be understood.

I began to formulate around Ellis' expectation that he can only rely on himself. The coding of a **repetition of earlier environmental failure** at the end of the following sequence also felt to be a useful indicator towards the strength of his response and the longstanding nature of this pattern of relating:

<u>Ellis Assessment Session 1 Lines 23 – 41</u>

> He explains a girl that used to go to his school was sitting in the waiting room. She had a rip in her trousers, a graze on her knee and another big graze on her face. He asks, 'I was just wondering if anyone was going to help her as she was just there bleeding in reception?' Ellis adds 'I mean, I was wondering if I should go over to her and see if she was okay? I've got a plaster in my wallet and I was thinking about offering it to her'.
>
> He pauses for a moment and looks at me with an anxious expression on his face. I say, 'I imagine there might be a question in your mind around my ability to help you?' He replies, 'Oh no, I was just wondering if anyone was going to help her or not?'
>
> I comment, 'It can be really hard to believe that anyone will be there to help sometimes'. Ellis seems increasingly uncomfortable with this sort of response as he repeats with more irritation in his voice this time, 'No, I was just worried about her and wondered that's all'. I suggest it might be quite frightening to see someone in a state like that just before coming in for your first session. Ellis nods and lowers his head. He says 'Well, it did make me wonder what has

happened to her and what goes on here, like has she been attacked or something'.

Sequence of transference coding applied to the above example of clinical material:

First Order Code: Transference Relationship with the Assessing Psychotherapist

Second Order Codes: Response to a receptive and observant presence, Response to what the therapists says

Third Order Codes: Negative experience/expectation, Feels persecuted

Fourth Order Codes: Cannot be helped, Sense of disappointment, Repetition of earlier environmental failure

Ellis was communicating his expectation to be met with an unavailable/preoccupied object in transference. He seemed to be wondering about my ability to care for the child in the waiting room. To defend himself from his anxiety that I could not or would not be able to help he adopted a position where he was the one to support the girl in the waiting room. This allowed him to feel that he could attend to the 'damaged girl' part of himself and therefore negated the possibility of disappointment or anger towards his objects being expressed in a more ordinary way.

Coding of **repetition of earlier environmental failure** n=7 within the assessment, along with the information gathered in the setting up of the assessment provided evidence of the relationship between Ellis and his internal objects. Later in the same session there is more of a sense of his **aggression** and **irritation** in response to feeling **misunderstood** and that he **cannot be helped.** There was a striking and familiar pattern that emerged in response to such feelings during the assessment. **Aggression** and **anger** consistently resulted in Ellis reverting to a harsh **self-criticism.** This began to give me insight into Ellis' very understandable need to protect the more vulnerable 'damaged girl in the waiting room' part of himself.

The coding of **suspicious**, **sense of disappointment** and feeling **misunderstood** alongside his **aggressive** and **irritated** response points to the conflicted nature of his **anger**. Ellis' repeated harsh self-criticism during the assessment had something of the feel of a pre-emptive strike that he repeatedly issued against himself in the face of anxiety about an imminent attack from the other. For Ellis, his self-criticism seemed to serve an additional function – where any

feelings of rage or anger are automatically turned against the self in an attempt to protect the object that is unconsciously hated and/or envied.

Psychoanalytic Formulation of the Transference Relationship with Assessing Psychotherapist Based on Application of Template Coding

The purpose of the assessment was to identify if STPP was indicated for Ellis. An element of the assessment was to explore some of his more uncomfortable feelings – such as anger, and sadness. When links were made to Ellis' current feelings or perceptions, he demonstrated a responsiveness to the idea of my interest in him. This allowed him to feel worthy of attention and interested in his own mind. His wish to communicate alongside an interest in his own mind allowed for some tentative exploration around the nature of the relationship between Ellis and myself.

He demonstrated a capacity to experience and express feelings in the session and was able to think about some of the recurrent patterns in his actions, feelings and experiences. Whilst Ellis showed a significant level of suspicion towards the assessing psychotherapist. There was some initial evidence of his ability to engage in thinking about significant issues, events and experiences during the course of the assessment.

One of the important developmental needs of adolescence is to have a sense of security in their relationships. An element of this is having the experience of creating a positive affect in the mind of others. Ellis presented in the assessment with a pervasive and excessive self-criticism that suggested it frequently became difficult for him to perceive himself as worthy of attention in the mind of those around him.

Ellis seemed to experience himself as flawed and inadequate. Whilst there were times when Ellis was able to respond to my receptive and observant presence in a way that could allow him to feel worthy of attention, it was difficult for him to acknowledge his positive attributes.

It was the degree of contempt in his self-criticism and sadness, and an inability to defend himself against these feelings, by coming up with counterarguments, that made him particularly vulnerable to low mood and depression. Ellis seemed to bring an intense sense of shame to the encounter that was rooted in his self-conscious feelings of inferiority, a sense of self being flawed, and being self-critical.

Despite his level of suspicion towards me Ellis was able to get in touch with thoughts that he needs and wants help. This important communication suggests to me Ellis has the potential and desire to work through his intense feelings of sadness and disappointment. Linking up his current perceptions and patterns of relating will form a significant part of any psychotherapeutic work.

Assessing Psychotherapists Countertransference Response

Ellis seemed to feel he was the only one willing or capable of helping her, while simultaneously feeling completely helpless to prevent the attack that had caused the girl her injuries. He was curious about my ability to notice, and in turn care for the child in need in the waiting room – and in turn my ability to offer him meaningful help.

My sense was that he began the encounter with an unconscious expectation that I would be a disappointed to him. He experienced my interpretation in relation to this as another attack, which served his defensive need to avoid his hostile feelings towards me. One hypothesis of mine was that this served the function of placing him in the position of being victimised, rather than the one with hostile or hurtful feelings. On the surface Ellis is therefore self-critical rather than critical of the other.

It was painful to hear Ellis' suffering in the form of his relentless self-reproach. This made it difficult to explore the aspects of his grandiosity that were rooted in harsh self-criticism. Whilst Ellis was not overtly critical towards me, my countertransference response was in fact to *feel* criticised by him during the assessment. This is to some extent captured by the n=10 occurrences of feeling **inadequate** in the countertransference.

The sequence of clinical material where Ellis referred to the girl in the waiting room was coded with the following countertransference response:

Sequence of countertransference coding applied:

First Order Code: Assessing Psychotherapists Countertransference Response

Second Order Codes: Negative response, Other type of response

Third Order Codes: Feeling inadequate, Irritation, Concern

There was a noticeable absence of **irritation** (n=3) coded in the transference for the assessment. One of the three occurrences was in response to Ellis' reference to the strange situation test. Analysis of the assessment data, through the coding of countertransference feelings such as **inadequate**, helped me to spot a potential blind spot in my experience of the assessment. While feelings of irritation were not readily apparent within the data, careful reflection allowed me to identify a general feeling of **irritation** towards Ellis throughout, alongside the feelings of concern and a wish to help, that had not been recognisable until the data analysis had taken place. In this case, it was the *absence* of something in the coding that had alerted me to a previously unknown and important aspect of the transference-countertransference relationship. While it is difficult to categorically know why I was reluctant to acknowledge my underlying sense of irritation throughout the assessment, my sense was this was linked to a fear that some of Ellis' fierce self-criticism would be turned in my direction.

Psychoanalytic Formulation of the Assessing Psychotherapists Countertransference Response Based on Application of Template Coding

The sadness and concern felt towards Ellis was linked to an awareness of his harsh self-criticism. Ellis experienced my interest in this aspect of his personality as confirmation of a deficit within him, resulting in further self-critical comments. This suggested a perpetual cycle where the function of this sort of self-reproach seemed to be to keep Ellis away from any hostile feelings he might have towards those around him. While Ellis was not overtly hostile or critical towards me, there was a subtle feeling of this throughout the assessment. There was a wish to protect Ellis from pointing out this aspect of his personality within the assessment for fear that he would feel criticised and humiliated. This dynamic within the

therapeutic relationship would be an important element of any future psychoanalytic intervention and will need to be addressed with careful thought.

Technical Approach of Assessing Psychotherapist

Ellis' pervasive self-criticism posed a particular problem in understanding the multiple meanings of this behaviour within the context of the assessment encounter. In the following sequence Ellis had been in touch with some **anger** in response to the feeling that his father did not notice how desperate he was for contact with him. Ellis had immediately become **guilty** and apologetic, saying that he (Ellis) was being unreasonable and needed to be more considerate to his father's autism:

Ellis Assessment Session 3 Lines 104 – 107

> I observe that he had been in touch with some feelings of anger and disappointment, but that he had quickly moved away from them as soon as there was any contact. He had taken up the position of justifying why someone had let him down, and then gone one step further by placing the blame at his own door. Ellis looks deflated in response to this and says that he knows he does that sort of thing. My sense is Ellis has taken my comment as further evidence of his own deficiency.

Sequence of technical approach coding applied to the clinical material:
First Order Code: Technical Approach of the Assessing Psychotherapist
Second Order Codes: Offered transference interpretation, Made observational comments

While interpretations, such as the one above, were offered in the hope of generating some understanding, it seemed to be experienced by Ellis as further confirmation of his own perceived inadequacy. The intense countertransference feelings of **sadness** and **concern** felt for Ellis in response to his self-criticism left me feeling wary about the effect of offering further transference interpretations.

Ellis Assessment Session 3 Lines 122 – 129

> I point out how strong his feelings are in relation to [sister] and that maybe through the lens of thinking about her we can understand something of Ellis' experiences and how he feels.
>
> Ellis nods in response to this and describes how he has always felt his mother was disgusted by him and that he really wants to protect his sister from that.

Sequence of technical approach coding applied to the clinical material:
First Order Code: Technical Approach of the Assessing Psychotherapist
Second Order Codes: Made observational comments, Encourage to be curious

There were n=19 occurrences (including the example above) of Ellis being **encouraged to be curious** about the way he was relating to me in the transference during the assessment. Generally, he was responsive and this suggested he had some potential to think about the origin of his feelings during the assessment.

Psychoanalytic Formulation of the Technical Approach of Assessing Psychotherapist Based on Application of Template Coding

Ellis was able to respond to my active enquiry during the assessment by thinking about the effect some of his past experiences were having on his current low mood. This frequently resulted in self-criticism from Ellis and required the psychotherapist to hold a receptive and observant presence while alerting Ellis to this pattern in his responses.

Current Life Situation

Ellis' assessment contained n=15 excerpts of data that provided information about his **current life situation.** Of those excerpts, n=10 were coded as **perpetuating factors** to the reasons for his referral – concerns about his low mood, self-harm and suicidal ideation. The following is an example of perpetuating factor coding. Ellis is talking about a recent episode where his mother had been communicating her feelings about his choice of a male name:

Ellis Assessment Session 2 Lines 46 – 49

> '…She always makes such a big thing about how she will only ever call me [given female birth name]. She said that even saying Ellis was like someone giving her an electric shock – it hurt her whole body'. Ellis goes on to talk about how awful this made him feel.

Sequence of current life situation coding applied to the clinical material:
First Order Code: Current Life Situation
Second Order Codes: Perpetuating factor
Third Order Codes: Re-traumatised, Repetition of earlier environmental failure

The coding of **re-traumatised** and repetition of **earlier environmental failure** within the sequence where Ellis expands on how awful such experiences made him feel was an important indicator towards the aetiology of his presenting concerns.

The scope of this research thesis does not allow me to study the factors associated with mental health and Gender Identity Dysphoria (GID) in more detail. This was however very much in my mind throughout the assessment. Both in terms of the practical anxiety of ensuring I used Ellis' preferred pronouns, through to the conceptualisation of GID in relation to what I understood of the configuration of his internal world. Little is known regarding adolescent-onset gender identity dysphoria and the factors that influence the completion of the developmental tasks of adolescence among young people with GID.

Psychoanalytic Formulation of Ellis' Current Life Situation Based on Application of Template Coding

Ellis was able to communicate a number of features within his current life situation that he felt were contributing to the risk factors associated with his ongoing low mood, patterns of self-harming behaviour and suicidal ideation. While Ellis' ability to communicate some of his experiences was a positive indicator for the offer of psychoanalytic psychotherapy, it is important to note that there was a sense of suspicion towards my interest in his life history and a common theme throughout that little could be done to change the reality of his

situation. Part of future work would therefore need to address the aspects of his personality that contribute to perpetuating this dynamic within in his current life.

Summary of the Psychoanalytic Formulation Based on Application of Template Coding

Ellis was able to communicate an overall sense that he was able to access a part of himself that wanted help with his current emotional distress. Whilst there was a tentative feel to this communication, it suggested to me that with significant support and careful consideration to the technical aspects of working with him, Ellis has the potential and desire to work through his intense feelings of sadness and frustration. At present Ellis appears to reflect on his experiences in a rather two-dimensional way as a way of defending himself from his more uncomfortable feelings. Linking up his current perceptions and patterns of relating will form a significant part of any psychotherapeutic work.

Ellis showed some potential to think symbolically about the cause of his feelings during the assessment. This seemed to be in the shadow of a critical internal voice and his fear of being attacked or humiliated by those around him. He worked hard to avoid angry feelings during the assessment as a way of avoiding intense feelings of guilt and shame. Although there were moments within the session where he responded to an interested observer enthusiastically, there was an anxiety around not being good enough that made it difficult to maintain the idea that relationships are something of value to him.

Discussion of Findings

The aim of the study was to explore how a Trainee Child and Adolescent Psychoanalytic Psychotherapist generated clinical formulations when undertaking assessment work The presentation of findings illustrated the process of systematically evaluating the nuanced detail of psychoanalytic assessment work using a Template Analysis (TA) approach. The systematic analysis of the assessment encounter has provided evidence for the origin of my understanding in relation to the unfolding transference-countertransference relationship. It has also provided evidence of my technical approach to undertaking assessment work. This is particularly important in the field of child psychotherapy as assessment forms an increasingly important aspect of our workload within CAMHS.

Summary of Findings

Part of the process included furthering my understanding of transference and countertransference dynamics within assessment encounters. Understanding these concepts is core to 'achieving real understanding of clinical problems and safeguarding the primacy of patients being treated as complex individual human beings' (Rustin & Quagliata 2000 p.4) The systematic analysis of detailed written descriptive commentaries captured the often subtle details that, when identified, combine to inform clinical understanding of the child's unconscious feelings and beliefs.

In Case Study One, the application of the coding template identified Aziz's movement between moments of being object orientated, in response to the receptive and lively presence of the assessing psychotherapist, through to a state where I felt there was an absence of an object relation. Elements of the transference-countertransference relationship identified within the coding helped to develop the clinical formulation that, with careful thought and attunement, Aziz had the potential to further develop and deepen the moments where he was able to be more object-orientated. Psychoanalytic psychotherapy was therefore recommended.

In Case Study Two the coding identified that Katie presented with a significant level of anxiety and fear during the assessment. Systematic analysis of her patterns of relating within the assessments suggested an internalised experience of the world as unpredictable and frightening. Coding my technical approach, along with countertransference responses to the assessment evocatively captured the powerful feelings of distress communicated by Katie. This allowed the formulation to include some thought around the impact of such projections on the support network around Katie. This indicated the importance of space to think about the impact of Katie's communications distress was having on her carers capacity to support her.

The purpose of the assessment within Case Study Three was to identify if STPP was indicated for Ellis. Applying the coding template to the descriptive commentaries allowed me to systematically assess if data for the positive markers for STPP as outlined in the STPP treatment manual (Cregeen et. al. 2017). The data coding evidenced Ellis' capacity to experience and express his feelings in the assessment. It also retrospectively identified elements of the transference-countertransference relationship that I was not cognisant of in the moment of the sessions. This allowed the formulation to include insight into the function of his harsh self-criticism. This gaining of new retrospective understanding, as a result of the coding application, was an important feature of all three assessments.

All three case studies gave a unique and important insight into the technical challenge of undertaking psychoanalytic child psychotherapy assessment in order to arrive at clinical formulations and recommendations.

<u>Consideration of the Literature Reviewed and its Relevance to the Current Study.</u>

The following section will consider if the study findings are in agreement with the existing literature or if the findings reveal previously unrecognised aspects of the assessment process.

This will be approached by systematically discussing the study findings in relation to the literature reviewed earlier.

All three of the case studies support the assertion within the literature that clinicians undertaking child psychotherapy assessments are attempting to understand the nature of a child's difficulties along with the attributes that may facilitate a child's development. (For example; Mees 2017; Green 2009; Walker 2009; Petit & Midgley, 2008; Rustin & Quagliata, 2000). Comprehensive analysis of the detailed descriptive commentaries demonstrated a technique of close and detailed observation of a child during the course of the assessment as a core skill used to inform clinical understanding of the child. This is in line with various authors description of the psychoanalytic technique within assessment (Rustin, 1982; Wittenberg, 1982; Dyke, 1985; Parsons, 1999; Waddell, 2002; Rustin & Quagliata 2004; Petit & Midgley 2008)

The findings also agree with the current literature that an assessment of both the child's internal and external resources takes place. Using the assessment to explore and understand these factors leads to a 'formulation of the child's difficulties and a recommendation of appropriate therapeutic intervention' (Walker, 2009 p.9). For example; identifying the fleeting and precarious nature of Aziz's ability to become object orientated within the clinical formulation helped to inform the recommendation to offer long-term psychoanalytic psychotherapy to support and develop this capacity within him.

The findings also support Bolognini's (2006) description in relation to the purpose of assessment. There are examples within the sessions where I attempt to clarify the patient's suffering and their ways and levels of functioning. Consideration around the child's difficulties, fears, motivations and expectations are also identified within each of the studies. Katie's PSOMA provided clear evidence for the consideration of each of these areas within the assessment. This was captured through some of the second and third level 'transference relationship' coding such as fearful/frozen, re-traumatised and repetition of earlier

environmental failure along with coding in response to my interventions – such as her ability to demonstrate a capacity to recover from her more uncontained and anxious states of mind.

Bolognini (2006) also refers to the need for the assessing clinician to gauge if there is a 'real possibility for change' (p.25). With Katie, a significant amount of evidence for this was obtained from information provided through consultation with the network. This important element of information gathering within the assessment process occurred outside of the sessions with Katie and is therefore beyond the range of the study to systematically explore how this contributed to the clinical formulation. Further evidence of 'real possibilities for change' are supported by the coding of the session data – particularly the coding that demonstrated her ability to make use of the containment offered to her.

Klauber (1971) referred to establishing the patient's motivation to get better. While this was able to be tracked through coding within the template such as 'Response to a receptive and observant presence' and 'Response to what the therapists says' the subjective nature of the understanding added to the complexity of arriving at a clear formulation. Ellis is a good example of this: There were examples presented within the data when Ellis was able to be responsive and curious as a result of what I had said to him – this was however in the context of his intense suspicion towards me and his own harsh self-criticism. This is potentially an area where the template could be further developed to more effectively capture the complexity of the transference relationship. This is something Perry et al. (1987) refer to in their thinking around case formulation when they describe information that contains contradictions and inconsistencies in their state of mind. The current research thesis aimed to develop a more systematic structure to help facilitate an understanding of those contradictions in terms of their unconscious mental processes and conflicts.

The findings within Katie's assessment also captures what Spurling (2003) described as the conflict between the roles of therapist and gatekeeper. Time limited carer sessions were offered in order to further establish the placement with a view to hold the possibility of

psychotherapy in mind for Katie in due course. It was beyond the current study scope to capture the interaction between external factors (in this case what was felt to be the priority within the network) and the session data that informed the formulation. It is however acknowledged as an important factor in how assessment formulations arise.

The process of assessment, captured through the analysis of the descriptive commentaries, reflected that of Parsons (1999) clear outline of the assessment process. The data presented in the findings demonstrates how the close and detailed observation of a child can facilitate the expression of their inner world. There is also some evidence within the findings to confirm what Parsons *(ibid)* describes as approaching the assessment encounter with the context of the child's defences in mind. For example; in case study one there was an adjustment in my technique in order to facilitate brief moments of contact with Aziz in a way that felt more manageable for him. In case study two the coding of 'offered containment/reassurance' significantly increased in response to Katie's distress in relation to the end of the assessment. Analysis of the data suggests this adjustment in technique was due to the high co-occurrence of codes such as fearful/frozen, re-traumatised and repetition of earlier environmental failure alongside that of anxiety. The guilt, anxiety and concern coded in my countertransference response to Katie helped me to understand why I had opted to offer observational comments and containment, rather than direct transference interpretations, particularly in the final assessment session. As Parsons (1999) states 'It is important to recognise that the child's defences need to be kept intact or reinstated in order to help him to contain his anxiety and reduce the possibility of harmful acting-out' (p. 222).

Template analysis of the descriptive commentaries has added to the gathering of evidence within all three assessments included in the research study. The use of current literature, such as Wittenberg's (1982) questions to hold in mind during an assessment helped to construct the template. Analysis of the coding enabled evidence to be presented about each child's response to transference interpretations. Rustin (2000a) suggested this should be closely observed and consideration given to whether they produce an opening out and deepening of communication' or a 'freezing and defensive drying up' (p.5). The systematic application of

coding to capture this type of response allowed me to evidence this within the findings and then in turn to link this to the formulation.

An example of this in case study three was Ellis' response to the transference interpretation of his expectation to be met with an unavailable/preoccupied object. It allowed something to be understood and evidenced about the nature of his relationship with his internal objects. It also provided evidence of his ability to engage in thinking during the course of the assessment. Both Oelsner (2011) and Anderson (2000) also recommend that assessment takes place through an exploration of the relationship that develops between the assessing psychotherapist. They suggest this is achieved through the active exploration of the child's suspicion, indifference or ability to make use of a psychotherapist's interest in them in a helpful way. While all three case studies demonstrated an 'active exploration' of the child's internal world, the degree and depth of this exploration varied considerably. Schachter's (1997) suggestion that engaging the patient in the transference relation should not be central aim of the assessment and a discussion in relation to negative transference causing resistance to exploration in the assessment all seem relevant here.

Katie's PSOMA was a discreet piece of work, therefore the assessment was approached with a prior knowledge of no further therapeutic involvement on my part. While there were still n=11 transference interpretations made, close analysis of the interpretations suggested they were more tentative than the interpretations made in Ellis' assessment. While the same number of transference interpretations were offered to Ellis (n=11), the coding of suspicion and other negative transference codes within the data seemed to link with Schachter's (ibid) assertion of negative transference causing some resistance to active exploration. Transference interpretations made in the assessments seemed to support Hinshelwood (1991), Steiner (1993), Garelick (1994), Truant (1999) and Crick (2013) who all suggest that creating dependence or deepening the transference interpretations should not lead to avoidance of interpretation in an assessment. The tracking of each child's response to transference interpretations within the current study indicates such interpretations can facilitate the process of exploration. The importance of an active exploration of the

transference is further supported by Binder et al's. (2013) qualitative study. It reported adolescent interviewees feeling that the assessment was an opportunity to establish emotional contact with the psychotherapist. This was evidenced in the current research study by presence of 'Positive Experience/Expectation', 'Feels helped' and 'Opening out and deepening of communication' coding in all three of the assessments.

Literature discussing the process of arriving at assessment formulations provided a significant contribution to my thinking in relation to the formulations made in the current study. The current assessment literature in relation to formulation also significantly contributed to the development of the template. This facilitated the analysis of data in a way that provided a structure to assess a child's internal world in terms of their unconscious mental processes and conflicts. Application of the template and analysis of the data provided a source of evidence for the clinical formulation and was replicable across different types of assessment. For example; Hinshelwood's (1991) outline of three levels of object relations as a useful framework for thinking about the synthesis of information within formulations were all incorporated into the template and evidenced in the coding discussed in the presentation of the findings.

Systematic analysis of the data through the development and application of the template has facilitated understanding something of the child's object relations in order to pick out common themes that will have some 'approximation to an internal object-relationship' in the patient (Hinshelwood, 1991 p.170). This is referred to by Hinshelwood as a baseline hypothesis, which represents formulations in assessment as 'a baseline on which the future work can be guided and grounded' (p. 170). The clinical formulations in the current study are 'guided and grounded' by the evidence provided in the analysis of the data.

The participant's response to interpretations within the study were used as an indication of the appropriateness of their further use within each session. As Hinshelwood suggests, in terms of arriving at a clinical formulation, this was considered an indication of the suitability

of the child for psychotherapy, as well as giving them an experience that will help the parents and the child to make a more informed decision about entering into psychotherapy should it be indicated.

The findings also support Herbert's (2005) distinction between differing functions of a formulation – such as for ongoing psychoanalytic treatment or as a tool for conceptualising a child's presenting difficulties to facilitate understanding and decision making within the network. The structure and focus of the PSOMA formulation was such that it suggested the purpose of the assessment does impact how the clinical formulation are communicated and structured, but not the process by which they arise. The findings therefore support Mees' (2017) statement that the purpose of a PSOMA is to have a therapeutic and consultative component which she describes as a 'package of assessment' (p.380) offered to the referring clinician, parents and the child or young person.

Ellis' assessment for STPP was conducted prior to the commencement of a manualised twenty-eight session STPP intervention. Cregeen et al. (2017) describe the need for 'an agreement to proceed' (p.87) to be established prior to STPP beginning. This seems to be an extension of Klauber's (1971) assessment of the patient's motivation to get better. Whilst the coding of data did provide some evidence in relation to the nature of Ellis' relationship with his internal objects, and in turn his ability engage in thinking during the course of the assessment, it did not definitively capture 'an agreement to proceed' within the assessment sessions themselves. I would suggest that typically such an agreement would be made as part of the review process through a joint exploration of the of the assessment formulation and recommendations. Some consideration was given to applying the coding template to a detailed descriptive commentary from an assessment review. On reflection this was felt to be outside the scope of the current study and the primary data source of descriptive commentaries from assessment sessions. More detailed analysis of assessment reviews is therefore a potential area of future research.

The process of systematically applying the coding template to the session descriptive commentaries deepened my understanding of the elements to be considered within a psychoanalytic assessment for STPP[22]. This has the potential to contribute to the depth of understanding I am able to communicate as part of the review process. This would hopefully allow Ellis to make a more informed decision about his wish to proceed.

Irrespective of the assessment purpose within the three case studies analysed, they all demonstrated a process of close and detailed observation as the basis of clinical understanding (Rustin 2000a). This confirmed the narrative throughout all of the psychoanalytic assessment literature – that detailed psychoanalytic observation of the transference-countertransference relationship forms the core psychoanalytic lens through which clinical formulations are generated when undertaking an assessment.

<u>The Contribution the Current Research Study Has Made to Developing Knowledge within the Area of Child Psychotherapy Assessment</u>

The systematic exploration of assessment data, through the application of template analysis coding, has enabled a more fine-grained tuning of the assessing psychotherapist's interpretative apparatus than would otherwise be possible. The data analysis also allowed previously unknown elements of the assessment encounter to be brought to the fore. For example; the identification of the countertransference feelings of sadness and rejection loomed large throughout the data analysis of Aziz's assessment. Prior to the coding of the sessions, this had not consciously been linked to the rejection I felt in response to the continual movement between Aziz opening out and deepening his communication and his subsequent defensive turning away from me. The coding of Ellis' assessment alerted me to the intensity of his suspicion and my own countertransference response. Similarly, a more detailed understanding of the overwhelming nature of Katie's anxiety and the countertransference response this produced were only identified retrospectively – through the application of the coding template. The coding of the data allowed for modifications in

[22]A summary of the STPP elements are outlined within the literature review.

my technique to be understood in the context of the transference-countertransference of a particular moment within each session – and in relation to each individual child.

The presentation and discussion of the findings has shown that my understanding of the child being assessed was validated by the template analysis process. It also suggests that while my technical adaptations within the assessments appeared to have been intuitive in the moment, they were in fact supported by my comprehension of the transference-countertransference relationship as evidenced in the application of the coding template.

The application of the coding template has allowed me to systematically track and evidence the fundamental aspects of technique that have informed my clinical understanding – namely the close and detailed observation of a child during the course of an assessment. Coding of the descriptive commentaries has demonstrated how a tracking of the transference and countertransference dynamics within all three of the assessments significantly contributed to the development of my clinical formulations. Although detailed analysis of external factors within the assessment is beyond the scope of this study, it is acknowledged they also contribute to the process of developing clinical formulations.

Whilst the research study has not taken the conceptual understanding of child psychotherapy assessment to a point beyond that achieved by the current available literature (For Example; Rustin and Quagliata, 2000), it has demonstrated the ability to enhance my own capacity to identify and understand complex and often subtle transference and countertransference communications within the child psychotherapy assessments.

Conclusion

Previous empirical studies of child psychotherapy assessment and the psychoanalytic theoretical frame of reference relating to the nature of the transference-countertransference dynamics of an encounter contributed to the development of the coding template. Information gathered during an assessment was synthesised and understood using the application of the coding template in order to arrive at clinical formulations. Whilst Bradley (2019) is the only known empirical study that used the analysis of primary data to develop a finely detailed understanding of the child's emotional state of mind within an assessment, this research study is the first to use template analysis in order to examine how a Trainee Child and Adolescent Psychoanalytic Psychotherapist generates clinical formulations when undertaking assessment work

The rigorous and systematic application of the coding template enabled an emersion in the data. This allowed appropriate supporting evidence to be identified for inclusion in the presentation and discussion of findings. The depth of interpretative understanding, facilitated by the analytic power of the CAQDAS, identified patterns in the data and the most appropriate clinical vignettes to be selected in order to support and illustrate broader patterns within the data. These factors combined to illuminate further understanding of the assessment material.

<u>The Specific Benefit of Undertaking a Template Analysis of the Clinical Material</u>

The coding template was constructed using an understanding of the of the current available literature, clinical supervision and the trainee child psychotherapists own clinical understanding of the assessment process. The systematic application of the coding template to the assessment sessions detailed descriptive commentaries enabled a more rigorous approach to the analysis of large amounts of rich clinical material than a detailed psychoanalytic reading might otherwise achieve.

The application of coding to the clinical material enabled a detailed tracking of transference-countertransference dynamics within the assessment sessions. Analysis of the frequency and relationship between individual codes identified new aspects of all three of the participants internal worlds that had not previously been identified through detailed psychoanalytic reading and clinical supervision of the sessions. The flexibility of the coding structure in template analysis allowed an exploration of the richest aspects of data in real depth. For example; identifying the continual movement between Aziz briefly becoming object orientated, through to a state where there appeared to be an absence of an object relation. Coding my technical approach, along with countertransference responses to Katie's assessment evocatively captured the powerful feelings of distress communicated by her. For the assessment of Ellis, the process of coding retrospectively identified elements of the transference-countertransference relationship that I was not cognisant of in the moment of the sessions, or in the supervision that followed.

Undertaking a template analysis of the assessment sessions descriptive commentaries facilitated a systematic and well-structured approach to data handling. The hierarchical list of codes that emerged provided a much richer interpretation of the data through the inductive process of immersion in the text. The process of applying a hierarchical coding template enhanced the quality of the clinical formulation. It provided a mechanism for tracking and evidencing aspects the trainee psychotherapists close and detailed observation of the transference-countertransference. This facilitated a deeper understanding of the child's inner world. It also significantly contributed to the structure, management and communication of data within the clinical formulation in a way that was responsive to the complexity and context of the assessment encounter.

Implications for Future Clinical Practice

The use of a Template Analysis research method could effectively be applied to all three different types of assessment purpose – assessment for psychotherapy, PSOMA and assessment for STPP. It has attempted to capture the subjective experience of the child and the assessing psychotherapist (Levitt, Neimeyer, & Williams, 2005) through careful,

psychoanalytic attention to the central role of the transference-countertransference relationship in the assessment encounter. Coding of the session data allowed for the fine detail of the communications between the child and assessing psychotherapist to be illustrated and tracked in a way that provides the origin and validity of child psychotherapy formulations to be captured and evaluated.

The research offered an internal framework for me to become more open to the subtle, nuanced communications within the assessment sessions. The systematic application of the coding template is not an attempt at producing some sort of automated and standardised psychological assessment, it is in fact an analytic tool, that supported and deepened my psychoanalytic thinking and clinical judgement, rather that replacing it. I found that supporting my thinking in this way greatly added to the richness of meaning I was able to communicate in the formulation. This method of systematic analysis could be further applied to future assessments and wider clinical practice. It also provided a lens through which my technical approach to working with children could be examined in detail.

Suggestions for Future Research in Child Psychotherapy

The complexity of the process of assessing a child is such that consultation and supervision from colleagues is a primary requirement of assessment. Space has precluded more meaningful exploration of the important role clinical supervision has in the process of assessment. Rustin and Quagliata (2000) describe supervision as:

> 'A crucial protective factor in helping us to ensure that our observations are properly rounded, not distorted by our own prejudices, limitations, special professional interests etc. The process of second order reflection on first impressions is a core aspect of good assessment practice' (p.4).

Further research is required in order to understand how clinical supervision contributes to the development of clinical formulations. Other significant factors within the assessment process, such as the consideration of external factors and the assessment review process also contribute to the development of the formulations. They are examples of two further areas of research that would contribute to a more rounded understanding of how clinical formulations are generated.

Future research could focus on the application of the template analysis methodology in larger scale studies. This would allow further consideration to the feasibility of the research methodology in providing evidence of how clinical formulations are generated. This could include multiple sites and assessing psychotherapists, as well as different assessment purposes, presenting problems and ages of children and young people being assessed. The current research looks to generate further understanding of the assessment process, rather than an evidence base for outcomes. Future research could focus on efficacy through an outcome-based approach. One possibility would be to track the clinical effectiveness of formulations post-assessment over a number of time intervals. The research methodology of template analysis could also be applied to other forms of child psychotherapy work, such as on-going, open-ended weekly or intensive psychotherapy.

Strengths and Limitations

A strength of the research has been the ability to examine the process of assessment in depth and detail. Brooks et. al. (2015) suggest that Template Analysis (TA) offers a clear, systematic, and yet flexible approach to data analysis. The flexibility of the coding structure in TA allows researchers to explore the richest aspects of data in real depth.

It is important to reflect on the process of sampling and on the overall scope of the research. The research consisted of a small data set – consisting of three case studies, all undertaken in the same CAMHS and by the same assessing psychotherapist. Whilst the sample size was a necessary constraint of the thesis, this prevents drawing broad inferences from the findings.

The quality of the research is heavily dependent on the individual skills of an individual researcher, who is also the assessing psychotherapist. Some effort to increase reliability of the findings has been provided through the clinical supervision of each of the assessment sessions included in the study. The unstructured nature of the development and application of the coding template risks losing sight of the original research objective. This was mitigated against by repeatedly referring back to the original research thesis objectives and the guidelines for the application of template analysis as outlined in King (2012; 2015) and Brooks et al. (2015).

Further thought needs to be given to the reliability of the data being analysed. As discussed in more detail in the accompanying framing chapter, reliability is concerned with the consistency, stability and repeatability of generating detailed descriptive commentaries, as well as my analysis of this data. A method of assessing the accuracy of the descriptive data collected and recorded would further add to the reliability of the study (E.g. Creaser's comparison of process notes and audio recordings, 2019 and Spence 2007).

Another limitation of the study was the retrospective development and application of the template to the descriptive commentary data. A future recommendation would be to apply the template in real time as each assessment session is completed. This would allow emerging understanding to be applied to subsequent assessment sessions and has the potential to further the assessing clinician's understanding of the transference-countertransference dynamics. In the case of Aziz and Ellis I had engaged in post-assessment psychotherapeutic work by the time the analysis of the assessment data took place. This potentially affects the validity of the findings as the further clinical engagement in longer-term work with them may have introduced unconscious bias into my interpretation of the assessment data.

<u>Contribution to the Knowledge Base</u>

The application of template analysis enabled a systematic exploration of assessment data. This identified some of the key processes by which clinical formulations are generated by a

trainee psychotherapist within assessment work. It also provided a more in-depth understanding of the transference-countertransference dynamics within the child psychotherapy assessment sessions than would otherwise be possible.

Although small scale, the research provides a template for the systematic qualitative analysis of primary data within child psychotherapy assessment. The study also contributes to establishing a systematic evidence base for the conclusions reached in child psychotherapy assessment formulations. It also emphasises the important contribution child psychotherapy assessments can make to understanding a child's internal world within a multidisciplinary setting. Further research is required and has the potential to show this method of systematic template analysis enhances the capacities of the assessing child psychotherapist.

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Appendix One – Notes on Literature Review Search Procedures[23]

08/10/17 Begin Scoping the Literature

i. Started searching terms linked to 'Assessment' into specified databases. See Literature Search Activity Record.
ii. Mainly selected relevant articles by title. I have included some articles I'm unsure about in initial scoping search with intention of skimming abstracts before making decision to include/exclude.
iii. Initial search constructed using terms from 'Search Terms' document. Combined using AND and OR operators.
iv. Including duplicate articles when returned in results from different search terms. Will be classed as 'relevant' at this stage and then all duplicates will be removed when all database/other searching complete.
v. I will track number of times articles are duplicated as this may indicate a higher relevance if they have been identified by a number of different search terms.
vi. Selected articles exported into EndNote
vii. All relevant results have been saved into dedicated search folder within my EBSCOhost account.
viii. All searches have been saved within my EBSCOhost account to enable me to refer back to results. Any results disregarded due to title at this initial scoping stage remain accessible via these saved searches so I can revisit them again at a later stage for further consideration if required. They will be identifiable as 'not saved to folder'.
ix. Search history saved on server 08/10/17

10/10/17 Scoping Search

i. Continuation of scoping search.
ii. Further refinement of search parameters within PsycINFO including reduction of search terms used and addition of search limiters. Seems to be producing more relevant results.
iii. Search of PsychINFO saturated giving 28 relevant results for further review. Refer to activity record for limiters Etc.
iv. I plan to assess abstracts in more detail once all of the database searching is complete.
v. This initial screening of abstracts will be used to help me firm up inclusion and exclusion criteria. I feel this is important to have a clear structure in place to produce more consistent screening of results. I think this will help as I still have some concerns results are not focused purely on child & adolescent psychotherapy assessment.

[23] The following two pages in Appendix One are an example of a larger 11 page document that forms the complete notes taken during the search process.

11/10/17 New idea and an ongoing question in my mind.

Question: Do I want to do a Systematic Literature Review OR a Literature Review Systematically?!

i. I have been looking at guides for completing systematic review ahead of my meeting with tutors. This has made me question what value there is for the overall research project in completing a systematic review – and how I would go about this.
ii. I have looked extensively at information around conducting a Narrative Literature Review. This increasingly seems like a more viable option.
iii. Read through a number of example systematic and narrative literature review for comparison.
iv. I plan to discuss this in more detail as part of my research tutorial.

12/10/17 Research Tutorial

i. General progress update given in relation to literature searching completed. Provided copies of Search activity records and key search terms used to ensure correct focus and strategy so far.
ii. Discussion with tutors around the question of Systematic V's Narrative. This was very helpful in developing my thinking around what the objective of my literature search is – In essence to gain a broad overview of current psychoanalytic literature in relation to the assessment of children and adolescents.
iii. Separate discussion regarding the importance of operationalising key theoretical terms utilised within assessment theory and to offer clarification of my position in relation to them for my future research.
iv. On balance after these discussion I feel it is more appropriate to conduct a Narrative Literature Review as I feel this is more practicable and will more effectively meet the objective of the review.

12/10/17 Further Scoping Searching

i. Focus on PEP Archive, Psychology and Behavioural Sciences Collection (via EBSCOhost) and PsycARTICLES.
ii. Search conducted following more refined terms and limiters (where possible in different databases) established from 10/10/17 searches. This seems to produce more relevant results.
iii. Searches of the above databases saturated with the following relevant results PEP Archive 18 results saved, Psychology and Behavioural Sciences Collection (via EBSCOhost) 12 results saved and PsycARTICLES 10 results saved.
iv. Saved to dedicated search folder.
v. Results exported to EndNote.
vi. I have not accounted for duplicates at this stage. As stated I plan to do this once database searching complete.

Appendix Two - Literature Review Database Search Activity[24]

STAGE ONE

My research question:	**How do Psychoanalytic Clinical Formulations and Recommendations Arise from Child & Adolescent Psychotherapy Assessments? A Qualitative Study**
Places to search for information:	**STAGE ONE: Main Literature Search** PsycINFO (via EBSCOhost) The Pep Archive (via EBSCOhost) Psychology and Behavioural Sciences Collection (via EBSCOhost) PsycArticles (via EBSCOhost) PsycBOOKS (via EBSCOhost) Medline (via EBSCOhost) PubMed The Cochrane Library Citation Search Manual search of reference lists from retrieved articles. Handsearching a number of specified journals and books.

List of sources searched:	**Date of search**	**Search strategy used, including any limits**	**Total number of results found**	**Comments**
PsycINFO	08/10/2017	See Appendix S24 AND S25 AND S26 AND S27 AND S28	377	Initial feasibility search Results lacked relevance to search question.

[24] The following two pages in Appendix Two are an example of a larger 5 page, document that forms the complete database search activity.

		Limiters - Linked Full Text; Publication Year: 2000-2017 Search modes - Boolean/Phrase		
PsycINFO	08/10/2017	See Appendix S4 AND S17 AND S24 AND S26 No Limiters Search modes - Boolean/Phrase	189	Initial feasibility search with reduced number of concept terms used. Results lacked relevance to search question. Reduce search terms further.
PsycINFO	10/10/2017	assessm* formulat* psychoan* No Limiters Search modes - Boolean/Phrase	184	Initial feasibility search with reduced number of concept terms used. Results lacked relevance to search question. Search for terms included in title only.
PsycINFO	10/10/2017	assessm* psychoan* Within Title No Limiters Search modes - Boolean/Phrase	100	Improved relevance of results. Apply language limiters.

Appendix Three - Critical Appraisal Rating Scale[25]

Score paper as appropriate

1 = Absent 2 = Present but not complete 3 = Present and complete

Initial Impression

1	2	3	Relevant to Child and Adolescent Psychotherapy Assessment

Abstract

1	2	3	Specific purpose of the paper stated.
1	2	3	Context for the assessment work stated.
1	2	3	Process by which the child is assessed clearly stated.
1	2	3	Important findings discussed.
1	2	3	Major conclusions and recommendations clearly outlined.

Introduction

1	2	3	Is the specific purpose of the paper clearly stated based upon a brief review of the literature?
1	2	3	Is the need/importance of this and context of this study established?
1	2	3	Are novel terms operationalised?

Main Body of Work

1	2	3	Places paper in context of its contribution to understanding of psychoanalytic assessment work.
1	2	3	Describes relationship of their work with others under consideration.
1	2	3	Identifies new ways to interpret/approach assessment.
1	2	3	Reveals any gaps. E.g. Technical aspects of assessment.
1	2	3	Resolves conflicts amongst seemingly contradictory approaches.

[25] Adapted from Green et al. (2006) Narrative Overview Rating Scale

			E.g. Use of transference interpretations.
1	2	3	Suggests new approach to assessment. Gives new insight.

Discussion

1	2	3	Themes summarised in a comprehensible manner.
1	2	3	Clear critical appraisal of psychotherapy assessments.
1	2	3	Quality of included articles/sources of evidence assessed objectively.
1	2	3	Variations/anomalies in assessment process critically analysed.
1	2	3	Meaning/rationale behind process addressed.
1	2	3	Links made with previous theoretical papers in a meaningful manner.
1	2	3	Weak points and untoward events of the assessment process considered?

Conclusions

1	2	3	Clear summary of pertinent findings provided.
1	2	3	Authors conclusions supported by evidence provided.
1	2	3	Specific directives of new research initiatives proposed.
1	2	3	Specific implications to clinical practice addressed.

References

1	2	3	References are relevant, current and appropriate in number.
1	2	3	All papers reviewed are cited in the references.

Overall Impressions

1	2	3	Merits outweigh the flaws.
1	2	3	Author(s) unbiased in their approach to the paper.
1	2	3	Will the paper help in my approach to technical or evidence based approach to psychotherapy assessments?

Additional Comments and Notes:

Appendix Four - Patient Information & Consent Documentation

Patient Information Sheet for Young People

Service Evaluation – Child & Adolescent Psychotherapy Assessment

Project Title

How do psychoanalytic clinical formulations and recommendations arise from Child & Adolescent Psychotherapy Assessments? A Qualitative Study.

Why have we contacted you?

I'm interested in how we make decisions around what help to offer you. This sheet will tell you about how we will do this. Please read it carefully, and feel free to ask questions if you would like more details or if anything is unclear.

Why are we asking you to take part?

I would like to think about how the psychotherapy assessment you are having is used to decide what to do next.

What will happen next?

Choosing to take part won't change what happens in the assessment or what happens when it's completed. The focus will be on the work I do to think about what might be making you feel unhappy.

This will involve writing up a description of what happens in the assessment. It won't include your name or any personal information that would allow people to work out that it is about you.

Some of the written descriptions of what happens might be used in an evaluation report, published in a book or presented to other people involved in helping children and young people. I will be careful to make sure that any written descriptions used will not contain your name or any information that people might recognise about you.

It's okay if you decide not to take part. Your assessment will still take place as normal.

Will information be kept private?

Yes. The hospital has lots of strict rules about keeping your information private. I will always follow these rules. Your real name or any information that people might recognise about you will never be used.

It's really important we keep you safe. The only time I would discuss material from your session is if you tell me something that makes me feel that you or someone around you is in danger of getting hurt. I will always let you know if I feel I need to talk to someone about anything you have told me.

Suppose I change my mind & want to pull out of the evaluation?

It's okay if you decide that you do not want me to use information from your assessment as part of my evaluation. Please let me know and I will make sure that none of the information you provided will be used.

Who do I contact if I'm not happy with the person doing the study?

If you aren't happy with the person doing the research and want to speak to someone else please contact Simon Carrington, Head of Academic Governance and Quality Assurance, from the Tavistock and Portman NHS Foundation Trust (academicquality@tavi-port.nhs.uk).

Who to contact if you want more information:

If any of the information in this sheet is unclear, or you want to know more about the evaluation you can contact:

****

You will need to state that you would like more information regarding the Child & Adolescent Psychotherapy Assessment 2017/2018 Service Evaluation and quote the reference number AS********

Participant Consent Form for Young People

Service Evaluation – Child & Adolescent Psychotherapy Assessment

How do psychoanalytic clinical formulations and recommendations arise from Child & Adolescent Psychotherapy Assessments? A qualitative study.

Providing Consent

Please complete this form and return it to show that you give your consent to take part in the process. If you need more information about the evaluation there are some contact details on the attached information sheet.

Please tick and sign the following if you consent to taking part in the evaluation:

Please tick and sign the following if you consent to take part in the interviews:	**YES √**	**NO √**
I have received information about why the psychotherapy assessment is being evaluated and how the information will be used.		
I have been able to ask questions and I am happy with the answers given.		
I understand that any information about my assessment will be kept securely.		
I understand that written information won't contain my name or any personal information that could identify me.		
I understand that the only time something from my session will be discussed is if I say something about myself or someone around me being in danger of getting hurt. I understand its important I'm kept safe and that I will always be told if there is a need for the person doing the assessment to talk to someone about anything I've said.		
I understand the evaluation may be published in a book or journal. It has been explained to me that care will be taken to ensure any information published will not contain my name or any personal information.		
I am happy for written information about my assessment session to be used in the evaluation as long as it doesn't contain my name or personal information.		
I understand that I can change my mind and ask that information about my assessment to be removed from the evaluation.		

Participant Consent Form for Young People

Service Evaluation – Child & Adolescent Psychotherapy Assessment

Young Person's Name (please print) _____

Young Person's Signature _____

Date _____

Clinician Name _____

Clinician Signature _____

Date _____

Appendix Five – How the Template was Constructed

The following is an example of how the different elements of supervision and an awareness of key themes within the literature contributed to the creation of the initial template. This is important as it demonstrates the coding has been developed through a combination of the current available evidence base, clinical supervision and my own conceptual understanding. This process was then repeated for each of the other codes identified within the final template.

Higher-Order Code: Transference Relationship with Assessing Psychotherapist

1. **Current psychotherapy assessment literature that contributed to the initial development of the higher-order code 'Transference Relationship with Assessing Psychotherapist'[26]:**

The following papers, referred to in the literature review, made a specific contribution to the formation of the 'Transference Relationship with the Assessing Psychotherapist' code. They also contributed to the development and refinement of associated second and third order coding for the final template. For example; Mees (2017), quoting Anderson (2000) states that:

> 'Assessment takes place through discussion, through consideration of the young person's behaviour and, importantly, through an exploration of the relationship which develops between the assessing therapist and the patient. The way the therapist is regarded whether with suspicion, with indifference or in a helpful way, gives some indication of the young person's internal capacity to use any help offered going forward' (p.382).

Freud (1904a, 1905a, 1912e, 1937e)

Jones (1920)

Tyson & Sandler (1971)

Bachrach & Leaff (1978)

Bloch (1979)

Erle & Goldberg (1979)

Garelick (1994)

Green (1994)

Wittenberg (1982)

Quagliata (2000)

Petit & Midgley (2008)

Parsons (1999)

Mees (2017)

Johnstone Et al., (2011)

Coltart (1986)

Tantam (1995)

Malan (1979)

Milton (1997)

Wolberg (1977)

Walker (2009)

Cooper and Alfillè (2011)

Bolognini (2006)

Stone (1954)

[26] Listed in the order they are referred to within the literature review.

Chadwick et al. (2003)	Mees' (2017)	
Horowitz (1997)	Cregeen et al. (2017)	
Robson's (2009)	Oelsner (2011).	Truant (1999)
Winnicott's (1971)	Anderson (2000)	Crick (2013)
Dyke (1985)	Schachter (1997)	Langenbach's (1994)
Parsons (1999)	Hinshelwood (1991)	Eells (1997)
Waddell (2002)	Steiner (1993)	
Rustin & Quagliata (2000)	Garelick (1994)	

2. Clinical Supervision

Clinical supervision notes of assessment sessions that contributed to the initial development of the higher-order code 'Transference Relationship with Assessing Psychotherapist' are detailed below. The supervision notes also further contributed to the development and refinement of associated second and third order coding for the final template. For example; One of the notes from the consultant child and adolescent psychoanalytic psychotherapist in supervision of Aziz's Assessment Session 1 refers to Aziz 'Feeling overwhelmed and turning away from me'.

Clinical supervision with consultant child and adolescent psychoanalytic psychotherapist:

Aziz Assessment Session 1 &3

Ellis Assessment Session 3

Katie Assessment Session 1

Supervision within a small supervision group – NSCAP Clinical training in child and adolescent psychotherapy:

Aziz Assessment Session 2

Ellis Assessment Session 1

Katie Assessment Session 3

Supervision within a specialist applied workshops, NSCAP Clinical training in child and adolescent psychotherapy.

Ellis Assessment Session 2

Katie Assessment Session 3

3. **My own initial annotated thoughts and free associations form reading through the detailed descriptive commentaries**

Sessions where reference to the transference relationship had been made within my initial annotated thoughts and free associations that were added to the detailed descriptive commentaries for each of the three case studies. For example; One of my annotations to Ellis Assessment Session 1 read 'Has little hope I will offer him anything of value'.

The following sessions had commentary referring to transference-countertransference dynamics:

Aziz Assessment Session 1,2 &3

Ellis Assessment Session 1,2 &3

Katie Assessment Session 1,2 &3

Appendix Six – Final Template

1. Transference Relationship with Assessing Psychotherapist

1.1. Response to a receptive and observant presence

1.1.1. Negative Experience/Expectation
- 1.1.1.1. Misunderstood
- 1.1.1.2. Suspicious
- 1.1.1.3. Disliked
- 1.1.1.4. To be of no real interest
- 1.1.1.5. Cannot be helped

1.1.2. Positive Experience/Expectation
- 1.1.2.1. Understood
- 1.1.2.2. Liked
- 1.1.2.3. Believed
- 1.1.2.4. Worthy of attention
- 1.1.2.5. Can be helped
- 1.1.2.6. Seeks help/support

1.2. Response to what the therapists says

1.2.1. Feels helped
- 1.2.1.1. Containment of psychic pain
- 1.2.1.2. Creates Hope
- 1.2.1.3. Sustains Hope
- 1.2.1.4. Demonstrates an ability to mourn

1.2.2. Feels Persecuted
- 1.2.2.1. Re-traumatised
- 1.2.2.2. Repetition of earlier environmental failure
- 1.2.2.3. Sense of disappointment
- 1.2.2.4. Feels criticised
- 1.2.2.5. Self-criticism

1.2.3. Defensive Turning Away
- 1.2.3.1. Comment dismissed
- 1.2.3.2. Comment Interrupted
- 1.2.3.3. Comment Ignored
- 1.2.3.4. Demonstrates lack of ordinary anxiety
- 1.2.3.5. Puts on a ‘brave face’
- 1.2.3.6. Isolated – In own world

1.2.3.7. Becomes withdrawn in response to my comment/action
1.2.3.8. Desire to keep things congenial

1.2.4. Opening out and deepening of communication
1.2.4.1. Provide more detailed information
1.2.4.2. Interested in their own mind
1.2.4.3. Became curious
1.2.4.4. Provide new information
1.2.4.5. Responsive to the idea of my interest in them
1.2.4.6. Wish to communicate

1.3. How they inhabit their own body

1.3.1. Relaxed
1.3.2. Excited
1.3.3. Anxious
1.3.4. Restless
1.3.5. Uncomfortable/Awkward
1.3.6. Distressed
1.3.7. Sense of agency
1.3.8. Curious
1.3.9. Demonstrates capacity to recover (e.g. from initial anxiety)
1.3.10. Angry
1.3.11. Aggressive
1.3.12. Irritated
1.3.13. Violent
1.3.14. Playful
1.3.15. Seeking Contact
1.3.16. Fearful/Frozen
1.3.17. Confused
1.3.18. Sadness

2. Assessing Psychotherapists Countertransference Response

2.1. Negative Response

2.1.1. Anxiety
2.1.2. Distracted/Disinterested
2.1.3. Frustration
2.1.4. Anger
2.1.5. Irritation
2.1.6. Hopeless/Stuck
2.1.7. Sadness
2.1.8. Shut Out/Rejected
2.1.9. Guilt

2.1.10. Feel under threat
2.1.11. Feel inadequate

2.2. Positive Response

2.2.1. Hopefulness
2.2.2. Paternal Protective Feeling
2.2.3. Excitement

2.3. Other Type of Response

2.3.1. Confusion
2.3.2. Concerned
2.3.3. Ambivalence
2.3.4. Need to be tentative in what I say
2.3.5. Wish to help with something I normally wouldn't
2.3.6. Wish to persevere with a comment/thought when child not initially receptive

3. Technical Approach of Assessing Psychotherapist

3.1. Offered transference interpretation
3.2. Made observational comment
3.3. Asked a question
3.4. Asking for further clarification
3.5. Needing to simplify what I'm saying

3.6. Physical interaction with child

3.6.1. Engaged in Play
3.6.2. Helping the child master an activity (e.g. Moving doll's house)
3.6.3. Move to prevent harm to child (e.g. to stop falling)

3.7. Adopt a lively presence (e.g. in order to engage child)
3.8. Act Out
3.9. Offer containment/reassurance
3.10. Demonstrate my curiosity in the child
3.11. Seek to encourage curiosity in the child (e.g. what do you make of that…?)
3.12. Form an impression of the child
3.13. Allow space for thought
3.14. Giving Information

4. Current Life Situation

4.1. Aetiology of Psychopathology

4.1.1. Perpetuating Factor
4.1.2. Precipitating Factor
4.1.3. Predisposing Factor

4.2. Protective/Supportive Factor

4.3. **New disclosure of unknown information**

Appendix Seven – Examples of coding applied to excerpts of text.

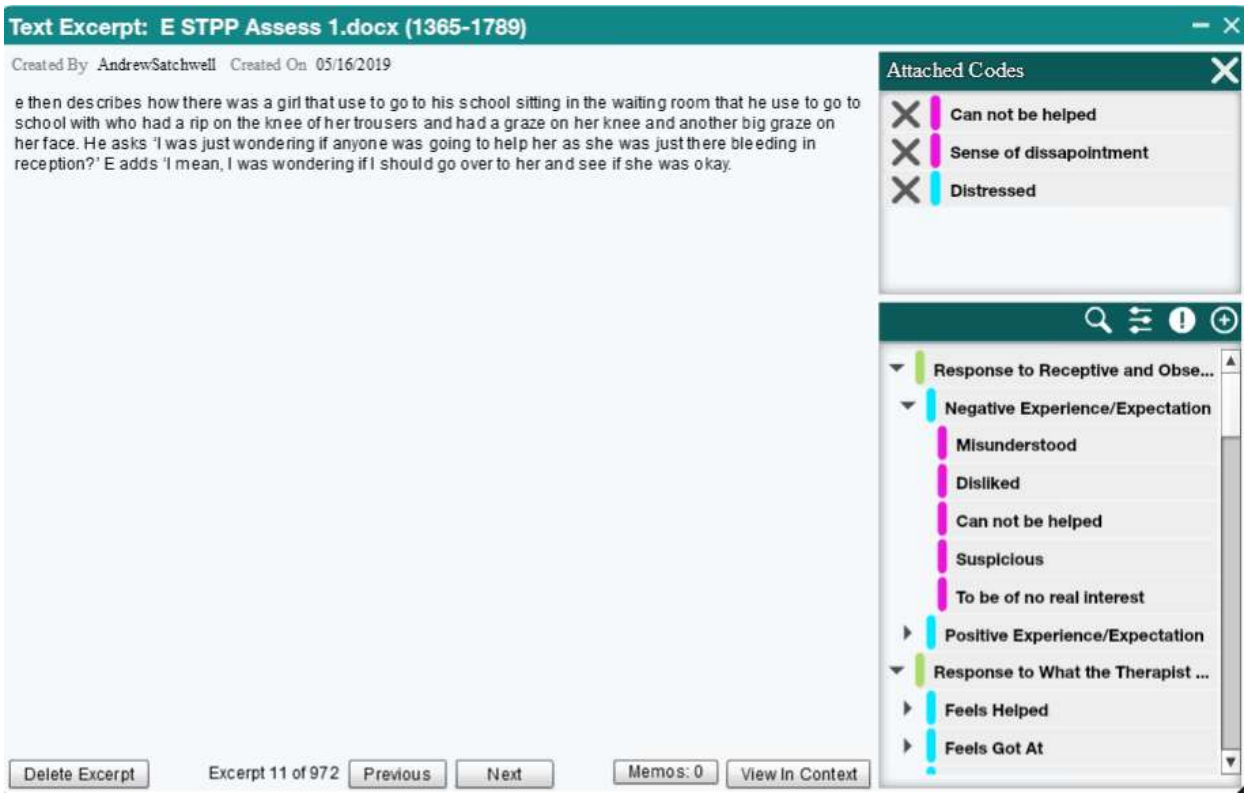
The following are examples of how the template codes were assigned to sections of text. This is a screen grab from Deedose, a Computer Assisted Qualitative Data Analysis Software (CAQDAS) package that was applied to all nine of the descriptive commentaries within the study.

The 'Attached Codes' on the right-hand side of the screen grab are the codes that have been applied to the text excerpt. The codes below in the untitled box are the complete final template codes that can be scrolled through, selected and added to the excerpt as required.

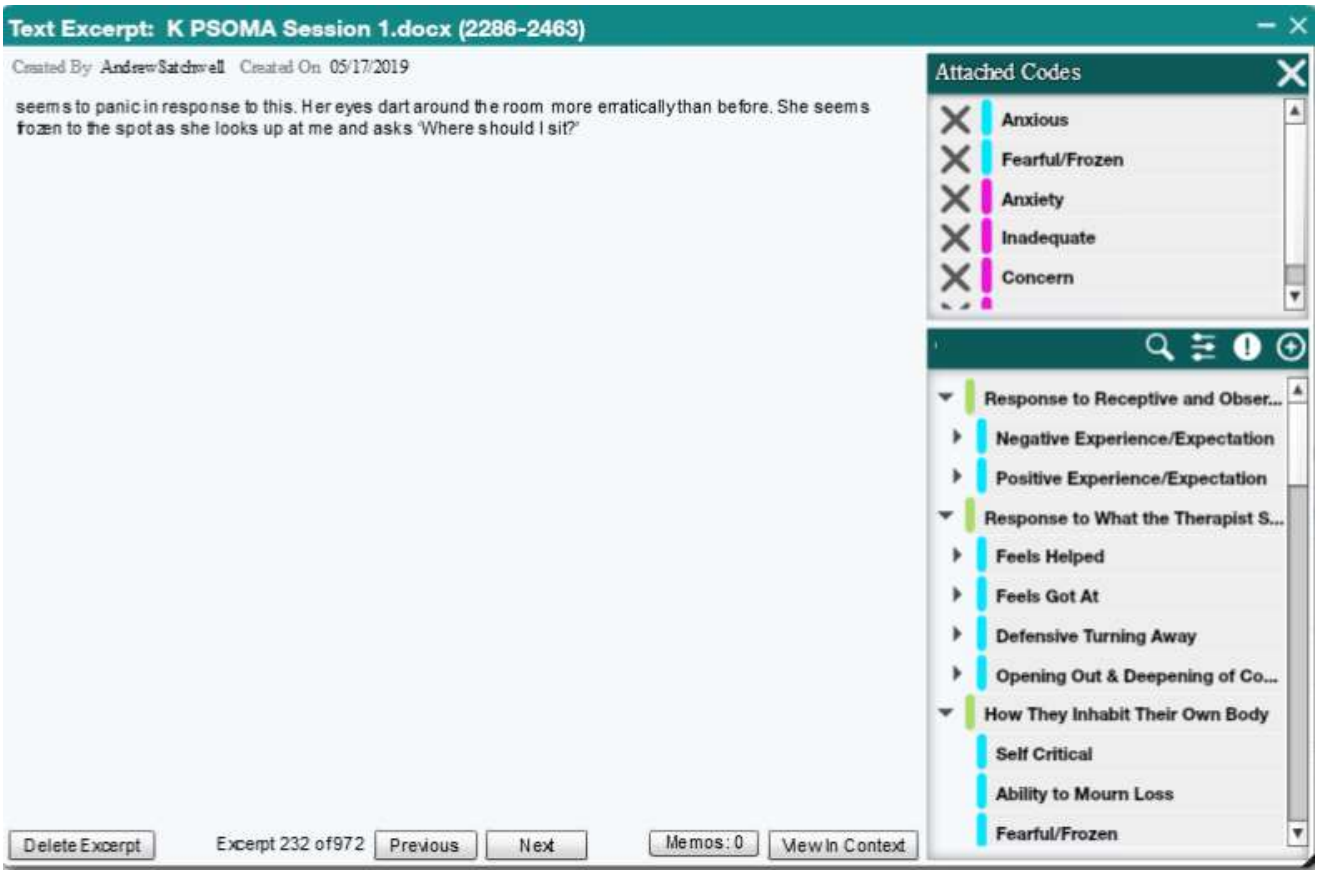
So, for example; taking the first Attached Code of 'Can not be helped' we can see from the final template that it has been applied from the higher order code of Transference Relationship with Assessing Psychotherapist:

1. **Transference Relationship with Assessing Psychotherapist**
   - **1.1. Response to a receptive and observant presence**
     - 1.1.1. Negative Experience/Expectation
       - 1.1.1.5. Cannot be helped

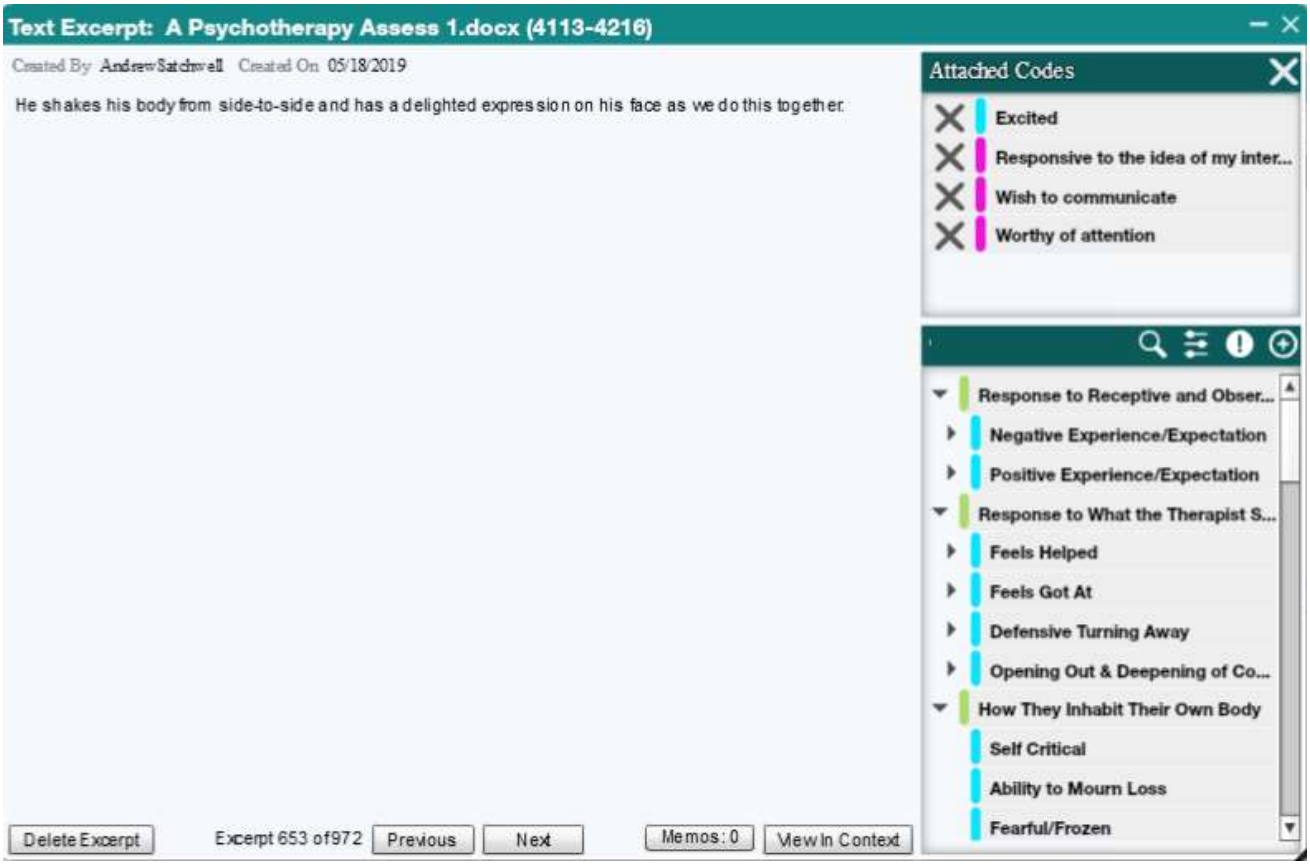
Ellis Assessment Session 1



Katie Assessment Session 1



Aziz Assessment Session 1



Appendix Eight - Summary of Case Study Recommendations

Aziz: Primary Recommendation Based on Application of Template Coding and External Factors

1. Psychoanalytic psychotherapy is indicated in order to further develop his capacity to communicate and form meaningful relationships.

Aziz: Additional Recommendations Based on Data Analysis Results and External Factors

1. Long-term, three times weekly, intensive psychoanalytic psychotherapy is indicated in order to further develop his capacity to communicate and form meaningful relationships.
2. Aziz's presentation should be considered in the context of his Autism Spectrum Disorder Diagnosis.
3. Parent sessions will be offered alongside psychotherapy to support Aziz's parents during the intensive work.
4. An application for specialist one-to-one support under current EHCP provision should be made to help support his future transition from intensive psychotherapy into education.
5. CAMHS involvement and support will be provided through a designated case manager.
6. Close multi-agency liaison will be required and should have a strong emphasis around supporting Aziz and his parents during intensive psychotherapy and his future transition into education.
7. Regular reviews will take place to ensure the efficacy of the psychoanalytic work.

Katie: Primary Recommendation Based on Application of Template Coding and External Factors

1. Carer sessions will be offered in order to allow space to consider the emotional impact on [carer] and the wider family of caring for Katie.

   This will help Katie's carer to better understand her internal situation before she is presented with the potentially unsettling experience of child psychotherapy treatment.

Katie: Additional Recommendations Based on Application of Template Coding and External Factors

1. Katie's behaviour needs to be considered in the context of her past experiences of trauma and neglect and as a communication of her anxiety and distress.
2. At present Katie is demonstrating a clear capacity to make use of thoughtful and attentive supporting adults around her.
3. Support should be offered to the network around Katie in order to deepen their understanding of the link between her past traumatic experiences and her current patterns of behaviour. This will help open up thinking around the different types of behaviour management strategies that might be appropriate for her.
4. Carer sessions will be offered in order to allow space to consider the emotional impact on [carer] and the wider family of caring for Katie. Space will also be given to consider further strategies that could be implemented support continued progress.
5. Katie will remain open to CAMHS via her case manager for an agreed period of time while we continue to track her progress.
6. Possibility of Katie accessing psychoanalytic psychotherapy to be held in mind for a later stage of her development.
7. Additional school-based support and access to school therapy/counselling service to be discussed in upcoming TAC meeting.

Ellis: Primary Recommendation Based on Application of Template Coding and External Factors

1. Ellis to be offered Short-Term Psychoanalytic Psychotherapy. The work will aim to carefully explore possibilities of establishing the capacity for reflective self-functioning and an internal narrative more closely linked with his external reality.

Ellis: Additional Recommendations Based on Application of Template Coding and External Factors

1. Parent sessions to be offered alongside this work in order to support Ellis's parents. In particular, to create a bridge between the insights and understandings gained in psychotherapy and the effect this may have on him.
2. Case management will continue to be held by the referring clinician who will continue to liaise with the network around Ellis and offer additional risk management support as appropriate.

Appendix Nine - Positive Markers for STPP

Coding of the assessment sessions allowed for some of the positive markers for STPP (Cregeen et al. 2017 p. 28) to be identified:

Positive markers of STPP (Cregeen et. al. 2017, p. 28)
The therapist encourages the exploration of feelings regarded by the young person as uncomfortable (e.g. anger, envy, excitement, sadness or happiness)
The therapist links the young person's current feelings or perceptions to experiences of the past
The therapist focuses attention on similarities among the young person's relationships over time, settings or people.
The therapist focuses discussion on the relationship between the therapist and the patient.
The therapist encourages the young person to experience and express feelings in the session
The therapist addresses the young person's avoidance of important topics and shifts in mood.
The therapist suggests alternative ways to understand experiences or events not previously recognised by the young person.
The therapist identifies recurrent patterns in the young person's actions, feelings and experiences.
The therapist allows the young person to initiate the discussion of significant issues, events and experiences.
The therapist encourages discussion of the young person's wishes, fantasies, dreams or early childhood memories (positive or negative).

Appendix Ten – The Role of Supervision in Child Psychotherapy Assessment

The Use of Clinical Supervision

Each of the detailed descriptive commentaries were presented in clinical supervision with a consultant child and adolescent psychoanalytic psychotherapist, in a small supervision group or in specialist seminars that form part of the clinical training in child and adolescent psychotherapy. This included the assessment seminar, brief work and endings seminar and the adolescent seminar. All three assessments used a combination of these forms of supervision, which typically included at least one session presented to the consultant psychoanalytic psychotherapist holding clinical responsibility for the assessing child psychotherapist's cases. Information obtained from the presentation of the detailed descriptive commentaries in these various settings was recorded via annotations to the original copies of the session commentaries.

Whilst it is beyond the scope of the current research study to systematically explore the function of clinical supervision within assessment, I felt it was necessary to acknowledge its importance within the process and to give some insight into its function within assessment work. As Rustin & Quagliata (2000) emphasise the 'discussion of work in progress with experienced colleagues is a crucial protective factor in helping us to ensure that our observations are properly rounded, not distorted by our own prejudices, limitations, special professional interests etc.' (p.4). From a research perspective this is also an opportunity to further establish the validity of the research in terms of the accuracy and truthfulness of findings (Le Comple & Goetz 1982: 32). Incorporating feedback from supervision into the coding of the template further helped to establish a valid instrument to capture how clinical understanding is arrived at within the assessments.