How do the narratives of depressed adolescents and their parents compare?

Jessica Maliphant

A thesis submitted for the degree of Professional Doctorate in Child and Adolescent Psychoanalytic Psychotherapy

Tavistock and Portman NHS Foundation Trust

University of Essex

March 2021

Abstract

This qualitative study used psychoanalytically informed narrative analysis to explore the narratives of two clinically-depressed adolescents alongside their parents' narratives. The study also aimed to explore the co-construction of narrative as observed in psychoanalytic psychotherapy sessions.

Two cases were transcribed and analysed. For each case, two adolescent therapy sessions were compared with one parent session. From this analysis, several overlapping themes were seen to arise between the adolescent's and their parent's narratives. These themes included a sense of persecution and anxiety related to expressing distressing emotion. It is suggested that the way in which the adolescents' narratives often mirrored their parents' narratives indicates a close link between how the adolescents and their parents understood and experienced the world around them. Significantly, it is argued that the difficulties faced by the parents – as seen principally in their narratives revealing a sense of persecution and difficulty expressing distressing emotion – combine to leave the adolescent feeling isolated, fearful and lacking capacity to manage the tumultuous period of adolescence. These factors are considered to be key to the adolescent's difficulties and, as such, contributing to their depression.

Several comparable themes were also seen to arise between the two depressed adolescents. These themes included an idea that talking about emotions might be dangerous, the difficulty of being in between quarrelling family members, lack of belief-in-self and a wish for robust containment. It is hoped that this small study supports the ongoing need for parent work within resource-pressurised times and adds to an understanding of contributary factors in adolescent depression.

Table of Contents

Acknowledgements

I would like to thank Jocelyn Catty for her meticulous supervision, inspiring knowledge and constant support through this project. I'd also like to thank my fellow researchers who were simultaneously engaged on research using data from the IMPACT Study.

Always, my heartfelt thanks go to my family and friends whose constant support and encouragement enabled me to complete this project.

Introduction

No story lives unless someone wants to listen

J.K. Rowling[1]

This study explores narrative discourse found in psychotherapy session transcripts with a specific focus on how adolescents' and their parents' narratives compare and how narratives might be shaped within psychotherapy. Psychoanalytic theory underpins rich narrative analysis.

Adolescence entails a period of turbulence. Individuals are absorbed in the often-painful process of becoming independent and separating from their parents/carers. Arguments between adolescents and their parents are commonplace as both parties attempt to navigate this transition. Alongside interpersonal conflict, adolescents experience a wide range of emotions with dramatic hormonal shifts, and often feel low and despondent. As professionals working with adolescents, we understand the adolescent's rapidly changeable emotional states as being par for the course. The present study examines narratives of adolescents whose emotional experience range beyond the usual highs and lows – those who have been diagnosed with clinical depression.

Research literature indicates that feeling connected to and understood by one's parents is a protective factor for children and adolescents (Fortune et al., 2016). Conversely, clinical practice and psychoanalytic theory highlight how strained relations between adolescent and parent pose a potential risk. If feeling connected to one's parents is important, we might expect depressed adolescents to feel disconnected from their parents.

[1] Rowling, J, K. https://www.goodreads.com/quotes/408960-no-story-lives-unless-someone-wants-to-listen Accessed online on 17th February 2021

During the initial phase of psychotherapy, adolescents may find their therapist's attempts to tune in, make sense of their experience, and relay something of this back to them in a way that is understandable, quite alien. Amongst other things the therapist attempts to gather the young person's experiences into a coherent narrative. This may involve the young person being exposed to a completely new way of thinking about and constructing a narrative. In some cases, particularly where there has been very early developmental trauma, individuals may have a limited capacity to form narratives by themselves. Where individuals have suffered early abuse, more urgent survival needs have often been prioritised over other areas of development (Music, 2014*,* 2015; Porges, 2004; Dana, 2018). In the case of early neglect, it is unlikely that a primary carer has been consistently available to contain the infant's experience and model how experience can be contained in narrative. In psychoanalytic and attachment theory, we understand that the primary carer's ability to tune into their infant's experience, to digest something of that experience and to return it to the infant in a bearable form through soothing words and reassuring bodily contact (Bion, 1962) enables the infant to begin to perceive the world as a place in which they can survive. Infants are supported to understand, for example, that a terrible tummy-ache does not imply the end of existence. Over time, they begin to recognise that they may be hungry: experience is contained in narrative. Where a child has not experienced this kind of containment, in later life it can be difficult to contextualise experience: to be able to step back, observe and think about experience and to thread life events into a coherent story.

The importance of being able to tell one's story and be listened to has become a ubiquitous concept in our society. This can be observed in a host of avenues such as the news, music, and literature, for example, the novelist, Hustvedt, writes:

> *We are more than the accumulation of empirical data … more than a heap of recorded trivia, more than our wanderings and our meetings and our jobs, but what is that moreness? Is it what we create between us? Is it a neurological business? Is it the product of narrative, of the imaginary?*
> (2014, p.320)

In the world of music, the British rapper, singer and songwriter, Stormzy, has spoken about his own struggle with depression. In his collaboration with artist H.E.R on the song 'One Second' (2019), they sing:

> *I get this daunting feeling on the days I'm on my best*
> *When all these demons that I carry get to messin' with my head*
> *So could you give me just a second to get 'em off my chest, please?*
> *If you give me just one second of your time*
> *I could tell you stories 'bout my life*
> *I've seen hope and I've seen struggle through these eyes*
> *So give me just one second of your time*
> *(https://genius.com/Stormzy-one-second-lyrics)*

In clinical practice and psychoanalytic theory, we are aware of the impact and power of inherited stories which can be specific to a particular family and which, for better or worse, can pass down through generations (Fraiberg el al, 1980). Stories can also outlive families, transgressing the boundaries of generations. As Lesser (2020) describes with reference to age-old stories such as of Eve, Cassandra and Pandora, stories can be older than nations and can be so embedded in culture that individuals can be deeply affected by them without being consciously aware of it. In psychotherapy, individuals sometimes bring ready-formed stories, or they might need support to process and gather together the pieces of their lives into a narrative that enables them to reflect and understand themselves better. At other times, together with their therapist, individuals might discover that a narrative which has directed their life thus far actually belongs to somebody else and can be discarded in favour of their own.

In my clinical practice, as I began to think more about the opportunity for experience to be contained in narrative, I noticed that there were also circumstances so painful that parents could feel emotionally incapable of talking about them. In these cases, my depressed adolescent patients described how there were taboo subjects, completely off limits for discussion with their parents. J.K Rowling's words came to mind (ibid), and I began to think, 'What happens to a story if no one listens?' In my sessions, I observed that where individuals had not been supported to build up an

ability to contain painful experience in narrative, or where there was no opportunity to explore difficult subjects with parents, distress was often communicated by somatisation or aggressive or risky acting out. Adolescents often expressed a sense of disconnection to their parents and a feeling of abandonment. We can understand how this experience of isolation from the parental figures, coming at such a developmentally challenging period, is likely to contribute to adolescent depression. Over time, I noticed also how particular difficulties faced by my depressed adolescent patients had first been, or were still being, experienced by their parent/s. This link often took time to identify and I think part of the reason for this may stem from the limited opportunity for work with parents of adolescents. Without regular time for such parent work, a pattern often seemed to occur whereby any difficulty was located exclusively in the adolescent and there was little room to think about how transgenerational patterns of relating and managing painful experience might be involved in the picture of adolescent depression. This observation inspired me to undertake the present research project to add to literature evidencing the need for supportive work with parents of adolescents with the hope of breaking unhealthy transgenerational patterns. The opportunity found in the current study to listen to audio-recordings of adolescent and parent sessions provided a privileged position to hear a wealth of rich material related to how a parent's narrative may impact and shape their children. I will outline key literature related to psychoanalytic understanding of adolescent depression and parent work, and literature that illustrates narrative analysis studies relevant to my study.

Literature Review

Adolescent Depression - Where are we now?

Awareness of childhood and adolescent depression is rising. This is not only apparent in clinical studies but is also reflected in society generally as indicated by frequent newspaper headlines. This rise can be thought about in different ways. Weissman and colleagues (1999) point out that in the 1980s 'there was no empirical research to guide the clinical management of depressed adolescents' (p.1712). They suggest this reflects the lack of awareness that adolescents could experience

depression. At this point, '… depression was seen as a disorder of the middle aged and elderly' (ibid). The fact that the DSM[2] only included diagnosis for children and adolescents from 1980, suggests that society was previously less conscious of childhood and adolescent depression. Perhaps, therefore, it is not surprising that incidence of childhood depression has been seen to rise since we have started to become more aware of it. Seen in this light, a question emerges: is the perceived rise in childhood depression accurate or, are we simply more alert to it?

Even though awareness has increased, many clinicians and researchers agree that since the eighties there has been a rise in childhood depression and suicide. Anderson (1998) refers to a 75% increase in suicide of European men aged between fifteen and twenty-four years since the 1980s (p.65). Anderson refers to research identifying suicide as contagious where copy-suicides result from media reporting with 'observed clusters or epidemics of suicide in certain groups such as the children at a school' (p.66). Since this book was published, the dawn of social media set in and there is growing concern over the influence of this domain in terms of copy-suicides and a culture where self-harm is sometimes encouraged or celebrated online. Each new generation faces challenges that are different to their parents' generation, but adolescent experience is now so different that it can be hard for parents and professionals to fully understand the current challenges that adolescents face. Waddell (2018) highlights the destabilising effect of 'rapid technological and cultural changes' (p.32) which have advanced society in many ways, but which have also added to 'the toxic mix of adolescent challenges' (ibid):

> *There is no doubt but that, for the moment, we have a generation of struggling adolescents. The number of students seeking counselling at university has risen by 50% in the last five years. The suicide rate is rising too … In fact the incidence of self-harm, depression, and suicide, especially among 14- to 15-year-old girls, is currently the highest ever recorded.*
> (p.32)

[2] The Diagnostic and Statistical Manual of Mental Disorders

Children and young people suffering from depression are also likely to suffer from other difficulties. Cregeen and colleagues (2017) suggest that a co-morbid picture may include 'anxiety disorder … disruptive disorders, substance abuse, eating difficulties, or emerging personality disorder' (p.5). Weissman and colleagues (1999) outline that:

> *Clinical outcomes of adolescent-onset MDD into adulthood compared with control subjects without psychiatric illness include a high rate of suicide (7.7%); a 5-fold increased risk for first suicide attempt; a 2-fold increased risk of MDD … an increased occurrence of psychiatric and medical hospitalization; and impaired functioning in work, social and family life.*
> (p.1707)

At the time of writing (March 2021), the World Health Organisation identifies that, within Europe: 'Suicide is the leading cause of death among 10-19-year-olds in low- and middle-income countries of the Region, and the second-leading cause in high-income countries.' (www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/areas-of-work/child-and-adolescent-mental-health)

Research funded by the Mental Health Foundation, asking 'How many children have mental health problems?' indicated that in 2004, '1 in 10 children aged 5-15 had a mental health disorder (either emotional, behavioural, hyperactive, or other)' whilst their data reveals that in 2017 the figure had risen to 1 in 9. However, when they extended the upper age-limit to 19 they found that: '1 in 8 (12.8%) have at least one mental disorder'. They conclude: 'This change was largely driven by an increase in emotional disorders (including anxiety and depression), which for 5-15-year-olds rose from 3.9% in 2004 to 5.8% in 2017'. (www.mentalhealth.org.uk/blog/what-new-statistics-show-about-childrens-mental-health).

The psychoanalytic perspective on adolescent depression: Historical context

In writing about the psychoanalytic perspective on adolescent depression, Waddell (2018) highlights the work of G. Stanley Hall (1904), a lesser-known figure today but

immensely important when considering the psychoanalytic view of adolescence. Hall 'broke new ground' (Waddell, 2018, p.4) in his research when he identified adolescence as developmentally separate to all that has come before and all that will be afterwards: a turbulent, conflict-ridden period extending beyond the realm of puberty and preoccupied with sex. Simultaneously, Freud (1905), identified adolescence as a period in which the infantile sexual life takes on its final shape and individuals seek a sexual object. At this stage of psychoanalytic endeavour, the focus of adolescence was thought to be sexuality. As Waddell (2018) points out, 'There was nothing of the later sense of adolescence as performing a major developmental task: that of providing a crucial period for the restructuring and final organization of the personality' (p.5) that we understand now. At this point in time, psychoanalytic formulations were mostly derived from work with adults and thus provided a different emphasis to that of current theory. This helps to contextualise the lack of theoretical consideration about the specific developmental function of adolescence, or the adolescent's experience of loss as childhood is departed from.

The subject of loss, however, is crucial when considering early psychoanalytic thinking regarding depression. In 1915, Freud was writing about the difference between mourning and melancholia. He linked both to loss. He viewed mourning as being related to an actual loss where the primary object may be actually missing or dead. Here a period of grief will be endured as a response to the sorrow caused by this loss[3]. Freud linked melancholia to the loss of something much less clear to

[3] Though different language is used currently, the definition of 'major depressive disorder' (MDD) as defined in the most recent edition of the DSM (Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association, 2013) also emphases the importance of differentiating between grief and a major depressive episode (MDE) stating:

> *In distinguishing grief from a major depressive episode (MDE) it is useful to consider that in grief the predominant affect is feelings of emptiness and loss, while in MDE it is persistent depressed mood and the inability to anticipate happiness or pleasure. The dysphoria in grief is likely to decrease in intensity over days to weeks and occurs in waves, the so called pangs of grief. These waves tend to be associated with thoughts or reminders of the deceased. The depressed mood of MDE is more persistent and not tied to specific thoughts or preoccupations. The thought content associated with grief generally features a preoccupation with thoughts and memories of the deceased, rather than the self-critical or pessimistic ruminations seen in MDE. In grief, self-esteem is generally preserved, whereas in MDE feelings of worthlessness and self-loathing are common.*
>
> (p.161)

define. Here ambivalence felt towards the object is felt to be unacceptable. Anderson (1998) describes how in melancholia:

> *… an ambivalently loved figure ... cannot be faced, and instead, the figure or object is taken in and felt as part of the self. The sufferer comes to feel as if he is the lost object, and as such, is attacked and hated, giving rise to the self reproaches and despair of the depressive.*
> (p.69)

Freud (1917) powerfully described the effect of this loss of object in his phrase, '… the shadow of the object fell upon the ego' (p.249). Freud's evocative phrase helps us to appreciate the internal gloom that predominates in the experience of melancholia.

A further concept relevant to childhood and adolescent depression is Freud's Death Instinct. Freud (1920) suggested that an internal, innate capacity for love is countered by an innate tendency for, and pull towards, destructiveness and death. Some individuals were thought to have greater capacity for love whilst others have greater capacity for destructiveness. This concept marked a shift in thinking and a move away from a perspective which placed greatest emphasis on sexual desire being the main anxiety in relation to development. Psychoanalysts began to consider how an individual's tendency for destructiveness would lead to anxiety about their aggression and its effect on those they felt closest to. Anderson (1998) points out, '... a primary problem faced in development is how to manage our hatred and that of others in order to protect ourselves, and others whom we love and need' (p.71). The infant can become overwhelmed by their own destructiveness and by their fear of the object's destructiveness. To mitigate this, the infant makes use of primitive mechanisms such as splitting and projection. In this way the infant is enabled to relate, in part, to a loving object. However, this way of managing is precarious and underscored by the threat of collapse. Optimally, the primary-object allays the infant's overwhelming feelings of destruction and aggression, helping the infant integrate these feelings with their loving, life-seeking feelings; however:

> *… when either the infant's aggression is too great, or the quality of maternal holding is inadequate or even actively hostile then these bad experiences are never reintegrated into the self and have to be dealt with in other ways. Thus where there really are bad or confused objects … these may be incorporated into the personality where they constantly threaten the stability of the personality.*
> (Anderson, 1998, p.71)

Post-Kleinian controversy around Freud's theory of the death instinct continues to this day. Bott Spillius (1994) identifies two dominant strands. One focuses on a strong, inherent tendency for self-destruction where individuals turn away from life-affirming experiences and relationships: powerful feelings of desire are defended against in an attempt to convince the self that it is self-sufficient. The second focuses on, '"what Rosenfeld (1987), following Freud, calls 'the silent pull of the death instinct'" (Bott Spillius,1994, p.341) where a believed-in promise of a 'nirvana-like state of freedom from desire, disturbance and dependence' (ibid) dominates. Bott Spillius (1994) acknowledges that analysts have different views on what may be 'innate or acquired, inherent or defensive' (p.341). She suggests it is impossible to distinguish between these different root causes but advises instead, 'What one can tell is how deep-rooted the patient's negative tendencies are in the present analytic situation' (p.341).

Abraham (1924), a contemporary of Freud, identified the significance of hostility in the infantile relationship to the mother as being related to depression. He suggested that hostility towards the mother could result from innate temperament or relational experience with depression ensuing when guilt related to feelings of aggression and hostility towards the object can only be escaped by '… turning against himself the hostility he originally felt towards his object' (p.438). He posited that depressed adults may experience loss or disappointment as a repetition of early experience.

Klein used the work of Freud as a platform to develop her own ideas, adapting and elaborating the concept of the death instinct (1933, 1948, 1957) by linking feelings of love to the life instinct and feelings of hate and destructiveness to the death instinct. However, as her thinking developed, Klein attributed greater importance to object

relations. In this way her ideas took a slightly different trajectory to Freud's: Freud considered drives as biological forces which become attached to objects through postnatal experience of familial relationships; Klein believed drives were attached to objects from the very beginning of life.

As psychoanalytic theory progressed, there was a shift away from Freud's view of the oral, anal, and phallic phases, to a view proposed by Klein in which the individual traverses a path from the paranoid-schizoid position (Klein, 1946) towards and, hopefully, into the depressive position (Klein, 1935, 1940, 1945). Klein originally postulated that this takes place within the first year of the infant's life. As Waddell (2018, p.11) describes, Bion, however, thought there was more of a to-and-fro between the states – mirrored in the way that individuals oscillate between different states of mind. In this sense we all fluctuate between the different developmental states: '...the adult may be found in the baby; the infant in the adolescent; the young child in the man; the middle-aged man in the 7-year-old boy' (Waddell, ibid). Whilst we all encounter these fluctuations, it is adolescence that entails the most frequent and powerful oscillations between these states of mind. The adolescent who has limited internal resources, combined with impoverished external support, is at greater risk of depression during this destabilising period.

As Klein was developing her ideas, so too was Anna Freud. Taking her father's work as a basis for her own thinking, Anna Freud's work also made use of her extensive experience teaching and taking care of refugee children. She considered the developmental stage of the child and viewed regression as often occurring as a natural response to extreme stress. Whilst Klein was predominately concerned with the influence of the early years, Anna Freud focused on the difference of each developmental stage. Motivated by the idea of preventive treatment, she stressed the importance of understanding normal development as well as pathology. Her development of an assessment tool called the Provisional Diagnostic Profile (A. Freud, 1965), considered elements of both the child's internal as well as external life, exemplifying the importance she attributed to the child's environmental reality.

Bibring (1953) and, later, Sander and Joffe (1965) focused their ideas about childhood and adolescent depression on the experience of helplessness and

hopelessness. They suggest that it is not so much the actual experience of loss which causes depression but, rather, the consequent sense of lack of control and helplessness that loss evokes. Therefore, in depression, a real or perceived loss leaves the individual feeling unable to repair the link and they are left feeling apathetic and disconnected, not only from their object but also from a former self that previously felt connected with the loved object or ideal. Freud's concept of mourning and melancholia indicates that an actual loss does not automatically lead to melancholia but rather, that where the relationship to the object is imbued with ambivalence, loss (perceived or actual) removes the opportunity to repair the link with the object. Consequently, feelings of aggression towards the object cannot be worked through and the process of reparation, as defined by Klein (1937), is impossible. Potentially, guilt about feelings of aggression is then turned inwards, leaving the self disconnected and hopeless. Clinically, we appreciate that the adolescent in this position is at greater risk of depression. There is a link here with the work of Bowlby (1960) who shows that a child's attachment to a primary-object defines their sense of self and emotional development. Bowlby observed that children with secure attachments protest when left by their parent but can be comforted upon their return. Securely attached children feel confident that their aggressive and ambivalent feelings can be tolerated by their parent. However, insecurely-attached children are characterised by a difficulty or inability to protest and then be comforted, suggesting that they do not feel their aggression or ambivalence can be tolerated. We can imagine that as such children develop they are likely to turn what they feel to be their unacceptable feelings in on themselves. With no adjustment to this way of operating, the individual is potentially left unable to manage their ambivalence, the consequences of which may lead to a ripple-effect of depression through the lifespan.

As psychoanalytic theories of depression developed, greater credence was given to the impact of the relationship to the primary object/s. Winnicott (1963), provided a bridge between psychoanalytic instinctual theories and theories which privileged object relations. Winnicott perceived two different pathways leading to depression: the first, referred to at the time as 'reactive', was where obvious triggers in the environment gave rise to depression; the second, which he termed 'psychotic or endogenous', was where obvious causes for depression are not necessarily

apparent but may stem from what Cregeen and colleagues (2017) describe as 'fundamental vulnerabilities in the patient's sense of self' (p.20). Like Bowlby, Winnicott considered these vulnerabilities were likely linked to an experience of the relationship with the object.

Winnicott (1967) identifies how the baby's experience of the mother's face affects their developing sense of self. Optimally, the baby has an experience of mirroring when the mother/father reflects the baby's state. However, when the parent is unable to tune into the baby's state, perhaps because of depression or extreme anxiety, the baby will experience:

> *… not getting back what they are giving. They look and they do not see themselves. There are consequences. Firstly, their own creative capacity begins to atrophy, and in some way or other they look around for other ways of getting something of themselves back from the environment.*
> (p.19).

Winnicott suggests that an infant who has to pay premature attention to the mother's state may develop a 'false self' (1948, 1960) where 'Other people's expectations can become of overriding importance, overlaying or contradicting the original sense of self, the one connected to the very roots of one's being' (Winnicott, quoted in Klein, J. 1987, p.365). The false self builds false relationships and, over the course of childhood, this way of relating can become rigidified. Overall, this false façade disguises a void – an empty, barren absence in the place of a 'true' or 'authentic self' (Winnicott, 1960). With such unstable foundations, the challenges of adolescence – where 'other people's expectations' (ibid) become particularly significant – poses an additional difficulty and the individual is left vulnerable to depression.

Tustin (1972), influenced by Winnicott and by Bick's (1968) writing on the experience of skin in early infancy, noted that her autistic patients often found the realisation that they were separate from their mother as catastrophic. She noticed that the experience of separateness could lead to a form of depression that was manifest bodily: her patients appeared floppy as if lacking a firm skeletal structure to keep them up. They appeared to rely on physical sensations and movement as if to

provide reassurance of their existence. We might think about Tustin's observation of how her autistic patients experienced separateness as helpfully representing a more severe version of non-autistic patients' experience. This links to Hobson's (2002) suggestion that 'abnormality betrays a feature of normality writ large' (p.8), indicating that work with severely disturbed patients helpfully informs our thinking regarding patients who are suffering but whose experience wouldn't be classified as pathological. Cregeen and colleagues (2017) identify the potential parallel between the autistic reliance on physical sensations and the temporary relief experienced by some depressed adolescents' self-harming (p.20).

It is generally understood that 'good-enough' parenting (as originally coined by Winnicott, 1973, p.10) provides the basis for the infant to learn to tolerate their primitive and ambivalent feelings. Bion (1987) described how this is managed:

> *If the infant feels it is dying it can arouse feelings that it is dying in the mother. A well-balanced mother can accept these and respond therapeutically: that is to say in a manner that makes the infant feel it is receiving its frightened personality back again but in a form that it can tolerate – the fears are manageable by the infant personality.*
> (pp.114-115)

The infant whose primary carer cannot sufficiently contain their primitive anxieties is left with what Bion (1962) termed 'nameless dread'. Deprived of the opportunity to develop their own robust internal resources, they are unable to believe in a life worth living. Consequently, the infant's development is negatively affected, and the likelihood of suffering future bouts of depression is significantly increased.

Psychoanalytic perspective on adolescent depression: Current Day

As psychoanalysis developed, there was a shift away from a perspective which privileged internal forces to a developing understanding of the impact of early relationships on the aetiology of depression. How the Oedipus Complex was negotiated was thought to be of prime significance to development. Klein postulated that the Oedipus Complex arose from birth onwards. This was earlier than Freud had

first supposed and illustrates how existing psychoanalytic ideas were used as a foundation on which to build. The psychoanalytic lens began to focus more broadly, taking into account external and sociological factors such as poverty and the mental health of family members. Waddell (2018) indicates that the trauma of the first and second world wars forced society to consider how children were affected. She poignantly describes how, when Anna Freud fled Vienna with her family, she took with her tiny stretchers in readiness for assisting with the care of injured children. As Waddell points out, this detail indicates that these early child practitioners were conscious of the interplay between internal states and the external environment. It became essential that psychoanalytic theory take on board a fuller spectrum when considering childhood depression.

The growth of psychoanalytic theory has continued at a pace matched by what appears to be ever-increasing levels of childhood and adolescent depression. One might consider that the rise in childhood and adolescent depression may have been a driving factor in developing psychoanalytic thinking: professionals have been compelled to consider the root cause of the perceived rise and the likelihood that it is indicative of something different occurring. Contemporary views of adolescent depression now take account not only the early relationship within the context of the Oedipus Complex but also the effect of pre-oedipal experience. Clinicians working with depressed adolescents nowadays often pay attention to what the infant's experience would have been within the uterine environment. Music (2011) describes how the pregnant mother's emotional state impacts her growing foetus. He cites the work of Talge and colleagues (2007), Kashan and colleagues (2008) and Markham and Koenig (2011) as examples of clinical studies evidencing the potentially long-lasting effects of trauma and stress during pregnancy:

> *Severe antenatal stress affects levels of hormones that regulate mood, such as dopamine and serotonin and has been increasingly linked to a range of childhood emotional and behavioural problems such as ADHD, the effects of which remain present at least into early adolescence.*
> (p.18)

Neuroscience and clinical research highlights how intrauterine experience influences the baby: if high levels of cortisol are passed from mother to baby during pregnancy, the baby is likely to be born highly stressed and suffer the concomitant results of this as they develop. There is also an ever-growing pool of research indicating the detrimental effect on infants of having a depressed primary carer. Gerhardt (2014), referring to the work of Murray and colleagues (2010, 2011), Laurent and Ablow (2012), and Lupien and colleagues (2011), depicts how the brains of children who had depressed mothers as babies are often shaped by the lack of positive interaction leading to higher levels of cortisol, larger amygdala volume and a predisposition to experience depression themselves:

> *When they grow up, these babies of depressed mothers are highly at risk of succumbing to depression themselves. Some 40 per cent of them will experience depression before they are 16 years old – especially those who did not develop a secure attachment with their mother…*
> (p.145)

Psychotherapists such as Music and Gerhardt are examples that show how the psychoanalytic perspective has broadened in range, enriched by other ways of looking, including attachment and neuroscience. Just as Anna Freud took note of her little patients' wartime trauma, clinicians are conscious of contributory factors involved in childhood and adolescent depression, such as social, familial, environmental and psychosocial. Music (2011) notes how a baby's prognosis 'exponentially worsens' (p.19) when you take into account a home-life where there is poverty, domestic violence or little social or emotional support. Outcomes for children who have been abused or neglected are bleak in different ways. Music describes how abused children learn to be hyper-vigilant, viewing the world as a dangerous, hopeless place where they can make little sense of their frightening and chaotic experiences. Even if the abuse stops, these children are left with 'highly aroused stress systems' (p.210) and little or no trust in others. As a result, their development is hindered twofold (Henry, 1974) – firstly by the repercussions of the abuse, and secondly by their impaired experience of the world and relationships thereafter. In contrast, the neglected child is preoccupied with lonely attempts at self-regulation. Music identifies how these children have missed out on vital 'building blocks' (2019,

p.10) necessary for the development of ordinary emotional and social life. As with abuse, it is not simply the impact of neglect that children suffer from but also the disabling domino-effect that neglect sets in motion. Music clarifies (2011):

> *Children who are overtly traumatised but whose experiences remain unacknowledged by anyone else, do not develop the ability to manage such affects in themselves or anyone else.* (p.209)

We appreciate how these children will be vulnerable when it comes to the challenges posed by adolescence, especially when we consider the fact that adolescence is viewed as a repetition of the infantile phase (Jones, 1922) where primitive and all-encompassing emotion is once again at a height. Waddell (2018) defines adolescence as '... a developmental process of working through endocrinological, physical, psychological, neurological change in the context of wider social and cultural pressures…' (p.35). Adults are vitally necessary to contain the adolescent's turbulent emotions as they undergo this transition which also brings with it an element of loss as the adolescent begins to recognise childhood will soon be left behind.

Where adults are unavailable to contain the adolescent's unsettled and often violent emotions, the adolescent is severely disadvantaged. Amongst others, Anderson (1998) and Waddell (2018) identify that difficulties such as deprivation or marital conflict pose a potential risk factor where 'underlying fault lines in the personality can give way leading to breakdowns' (Anderson, p.72).

Current neuroscientific theory argues that emotions are not innate and do not follow so-called 'hardwired' pathways as previously thought. Instead, Feldman Barrett (2017) proposes that emotions are created through experience. This marks an interesting parallel to the shift in psychoanalytic thinking where increasingly more emphasis is placed on how the child's experience of the world influences their internal experience. If emotions are created through experience, then we can truly appreciate the difficulty that an infant will face if born into a family where depression is entrenched. Trowell and Dowling (2011) reflect on their experience of conducting a study (Trowell et al., 2007) into childhood depression, describing the 9-15-year-old

children as often seeming to lack the capacity to describe their emotional state, and appearing 'stuck' and emotionally frozen as if not wanting to engage in adolescence at all. A commonality to these children was the fact that their parents were struggling with their own difficulties and generally had little or no emotional resources to support their children in the process of growing up. Depression was seen as a norm, creating a vicious cycle where enmeshed dynamics and impoverished psycho-social structures were perpetuated. This presents a bleak picture made worse by the knowledge that health and social-care resources are as under-resourced as the parents I am describing, making it very difficult to support families adequately. More optimistically, neuroscience sheds light on the physical structure of the adolescent brain, confirming that during adolescence the brain undergoes a period of dramatic development. As Siegel (2013) suggests, 'The reconstruction of the cortex enables conceptual thinking and creative explorations to emerge and blossom. With this expanded capacity for consciousness, we are entering a potentially new way of approaching the world and how we fit into it' (pp.93-94). This presents a period of potentially very significant change.

Whilst clinicians and researchers have widened their perspective and now consider the interplay between internal states and the external environment, my literature review highlights an interesting dearth of literature which explores the relationship between depressed adolescent and their parent during the adolescent period. There is a parallel here with my own study where parent sessions were often unrecorded by clinicians. This apparent lack of focus on the parent-adolescent relationship is particularly interesting given the fact that adolescence represents a developmentally crucial period and is seen as a repetition of the formative infantile phase. As described by Siegel (ibid), adolescence is a period where change and growth can occur with dramatic effect. However, as this literature review has indicated, change and growth occur in relationship. Why, then, is the pivotal relationship between parent and adolescent such a clinically neglected topic? One possible reason might relate to clinicians and researchers inadvertently shying away from exploration of this relationship because we are subconsciously reminded of the pain that this period entailed for ourselves. Perhaps the necessary separation between adolescent and parent that occurs during adolescence represents too great a loss. In contemplation of these possibilities, I wondered if the lack of literature reflected the 'taboo subjects'

that my adolescent patients described occurring in their own families. In this way, the lack of clinical literature exploring the adolescent-parent relationship might reflect an unconscious collusion whereby clinicians inadvertently go along with a perspective that separates the adolescent – making the adolescent the sole receptacle for any difficulties felt. Whilst it is essential to be respectful of the adolescent's need to separate, and for this reason work with parent and adolescent needs to be carefully navigated, adolescence represents a crucial opportunity for unhealthy ways of managing emotion (which may have operated in several generations of a family) to be thought about and for new ways of relating and managing to be fostered. For these reasons I set about analysing the narratives of parents and their depressed adolescents.

The Psychoanalytic perspective on parent work

Historically, the psychoanalytic community viewed work with parents with caution. Child psychotherapy evolved from psychoanalytic adult work where a conscious effort to minimize contact with the external world was thought to safeguard the analytic relationship (Rosenbaum, 1994; Novick and Novick, 2005). Anna Freud's view that parent work was important to support the successful treatment of children was unusual (1974). She believed that a therapeutic alliance with parents promoted a better understanding of the child's need for treatment and minimised the parent's likelihood of terminating treatment. In contemporary practice, it is customary for parents to be offered their own space to reflect with a therapist alongside their child's sessions. The way in which this happens varies greatly. In the public healthcare service, resources are sparse. Work with children and adolescents is often prioritized over parent work. In some cases, weekly parent work may occur whilst in many cases parent work is less frequent. Occasionally, parents don't attend at all. A wealth of literature explores the multifarious ways in which parents are supported. Rustin (2009) outlines key principles involved in successful parent work:

> *The first is attention to establishing and maintaining a reliable setting in which it is possible to talk about very upsetting things… The second element is the co-creation of some shared language to describe painful emotional states… Third*

> *is the valuing of boundaries and differentiation... Fourth is an adequately complex understanding of human emotion and intimate relationships… Lastly, and most important, there is the focus on giving meaning to behaviour.* (pp.213–214)

As Rustin describes, several elements of parent work overlap with individual psychoanalytic work. There is, however, much debate about key differences between individual therapy and parent work, including thoughts on how the transference should be addressed. Sutton and Hughes (2005) argue that though therapists working with parents may not take up the transference in the same way they would within individual work, it may be necessary to address how elements of the transference affect the work, particularly at the beginning and particularly where parents are likely to feel shame or anxiety related to perceived authority figures. Others such as Horne (2000) suggest that individual therapy should be recommended when elements of the transference intrude too forcefully.

There is also debate about the extent to which a parent's own history should be addressed. This issue was studied by Whitefield and Midgley (2015) who interviewed five therapists about their parent work. They concluded that parent workers often ascribed importance to exploration of a parent's past, but various elements of the work meant they were unable to give as much attention to this area as they would like. Some therapists reported feeling ill-equipped due to inexperience or lack of training. Others felt there were too few parent sessions in which to build a strong-enough therapeutic alliance for parents to feel comfortable exploring issues related to their past. In some circumstances, therapists who were younger than the parent felt that their age negatively affected the therapeutic alliance, increasing projections and criticism. Whitefield and Midgley (2015) outline how a parent's past should be interpreted and framed within the context of helping to support the child and their therapy rather than exploring the parent's past for its own sake. One of the therapists interviewed in this study succinctly described this technique:

> *The important issue seems to have been not so much what the parent or carer has experienced as whether they have a coherent story about it … how*

> *their … experiences of being parented have been able to be digested, or not, so as to not intrude too much…*
> (p.277)

A parent's unprocessed past may harmfully intrude into their relationship with their child especially when they experienced a disturbed relationship in their early life with their own parents. With reference to work with parents of psychotic children, Tischler (1979) suggests:

> *The shadow of … a mother's early 'bad', 'destroyed' and punitive mother falls between her and her infant. Fantasies and images related to such a harsh, damaged internal mother and the 'bad' aspects of Self, guilt feelings and need for punishment, invade her relationship with him and colour her illusions about him. His 'constancy' as a good object is lost. In this way 'primary maternal preoccupation' becomes affected by mother's infantile needs, impulses, anxieties, depressions, illusions and defences …*
> (p.34)

Part of the opportunity in parent work is to tease out the past experience from the present. The amount of support parents require will vary and is indicative of the level of trauma or disturbance they have experienced. Parent workers can support parents to explore elements of their past with the intention of improving 'parental functioning' (Rustin, 2009, p.213) in the present.

Klauber (1998), writing about work with parents of severely disturbed children, outlines how they arrive at their initial session with a history of trauma. In such cases, parents have often suffered years of difficulty relating to, and understanding, their child and may have a score of professional interventions and diagnoses behind them. She describes how their consultation with a therapist may indicate a powerful wish for a rapid cure. The realisation that such a miraculous cure is not possible may impede their capacity to hope that change can be possible over time, since hope entails a realistic ebb and flow which can be intensely painful to endure. We can imagine that parents of depressed adolescents may also be able to relate to these intense feelings.

The specific focus for parent work in the Short Term Psychoanalytic Psychotherapy model is outlined by Cregeen and colleagues (2017) as follows:

> *The task of working with parents and carers is multifaceted. It includes the engagement of the parents in the treatment process, thinking about the young person and his or her experience of the treatment, and considering issues connected to parenting. It also includes thinking about relational issues within the family; containment of parental anxieties aroused by the young person's depression; parents' own issues where these impinge on the young person (if they can be addressed within the time frame of STPP); and, where appropriate, addressing historical and transgenerational factors within the family.*
> (p.134)

The parent worker also considers how Oedipal factors may imbue the parent-child relationship. This can benefit the relationship and help parents to better understand how their child may perceive and relate to others. Stapley and colleagues (2016) interviewed parents of adolescents taking part in the psychotherapy arm of the IMPACT trial prior to treatment commencing. They found that parents were often confused and overwhelmed by their child's depression. Sometimes parents had not realised their child was experiencing depression at all. Stapley and colleagues highlight how this confusion can arise due to the nature of adolescence entailing dramatic fluctuations of mood where adolescents may be more likely to internalise their distress than when younger. The opportunity found in parent work allows for parents to be supported to perceive and understand their child's depression and for parents to make links to their own experiences and how these may impact their child.

Cregeen and colleagues (2017) highlight that when a child is adopted or fostered, questions may be raised by both parent and adolescent about the impact of possible genetically-inherited traits or traumatic experience which have not been recorded and therefore cannot be fully known. In his paper, 'Family Scripts: A Concept which can Bridge Child Psychotherapy and Family Therapy Thinking', the family therapist Byng-Hall (1986) describes how each member of the family is cast and casts others in a particular role created from experience of past relationships. He refers to Freud's

(1909) premise: '… a thing which has not been understood inevitably reappears; like an unlaid ghost, it cannot rest until the mystery has been solved and the spell broken' (p.122). Byng-Hall views the inclination to repeat as providing an important opportunity to do something differently. The chance that something will be done differently, and the relationship will improve is increased if individuals can be supported by reflective professionals. Overall, the parent worker is seen to hold many aspects of work in mind whilst also maintaining strong boundaries and a focus on the child/adolescent.

Use of narrative in research

Narrative is a form of language use and meaning making that is embedded in place and forms of life. The concept of narrative is, therefore, central to therapy—any kind of therapy—because it conveys a sense of the interwoven quality of subjectivity and social context. It is impossible to imagine a form of psychotherapy that did not involve the telling and retelling of stories.

(McLeod, 2004, p.6)

During the 1980's, the American psychologist, Jerome Bruner, in a criticism of cognitive psychology, explained that he felt the field had become too simplistic and, as González-Monteagudo (2011) describes in his critique of Bruner, there was a need to move away from a 'computational model of the mind' (p.296). There followed a shift in qualitative research as thinking turned towards a more relational understanding of the individual or group in their context and in relation to the researcher. In placing the relational at centre stage, this perspective recognised the impact of the researcher on the participant, denouncing the notion that the researcher could remain an uninvolved observer and interpreter of the data. This shift reflects the psychoanalytic shift away from a perspective which saw the patient's experience as emerging only from their own internal processes to one which placed greater emphasis on the impact of the relational.

In 2004 Angus and McLeod created the first reference book to focus on understanding the client narrative process in psychotherapy. 'The Handbook of Narrative and Psychotherapy: Practice, Theory and Research' compiled work from leading practitioners and researchers bringing together theory, applied research findings, and insights from practice to create an integrative approach to thinking about narrative and questions of identity in psychotherapy. The first section of the volume describes the 'narrative turn' and explores 'why stories matter in psychotherapy'.

In both the qualitative research and clinical, psychoanalytic sphere more emphasis began to be placed on the dyad – the way in which each affects the other. Illustrating this point, Bruner (2006) wrote that, '… most would agree that the Self is indeed constructed through interaction with the world rather than being just there immutably, that it is a product of transaction and discourse' (p.146). Bringing together insights from sociology and psychoanalysis, a new discipline emerged in the 1980s. Psychosocial methods utilised by researcher-theorists such as Hollway and Jefferson (2008), Clarke and Hoggett (2009), Emerson and Frosh (2004) highlighted that there are always questions around recovery or construction of meanings. Words do not mean the same thing for everyone as outlined by Hollway and Jefferson (2008): 'Current theories of language and communication stress that any kind of account can only be a mediation of reality. Hence there can be no guarantees that different people will share the same meanings when it comes to making sense of an interviewee's account' (pp.298-299). Drawing on a psychoanalytic framework, Hollway and Jefferson outlined how anxiety compels people to 'forget' or modify memories which are felt to be too anxiety-provoking: 'Defences will affect the meanings that are available in a particular context and how they are conveyed to the listener' (p.299). Both participant and researcher are affected by their own defences and both considered to be 'defended subjects' (Hollway and Jefferson, 2008). Hollway (2009) continued to develop the theme of psychoanalytically informed research methods to describe a process that is based on, 'a way of understanding people – that emphasises the effects of affect, dynamic conflict, unconscious intersubjective processes and embodied practices on the formation of identity' (p.4). With reference to the process of listening to and transcribing audio-recordings,

Hollway (2009) proposes, '… listening to the participant's voice means more than listening to the audio record. It requires attention to the initial research encounter in which researchers can use their own relationship to the scene to register the ways they are emotionally affected by it' (p.3). Much like in a psychoanalytic session, Hollway identifies that tuning into one's counter-transference is a particularly important tool in the research process whereby feelings or thoughts evoked in the researcher are considered not only valuable but indispensable. Hollway (2009) continues: 'Researchers can pursue validity and reliability (to use old-fashioned scientific terminology) in their data-analysis, but can start from the premises that it is necessary and desirable to use our own subjectivities as instruments of knowing and that our knowledge is provisional' (p.12-13).

Adolescent depression and the links with narrative

In order for depressed adolescents to feel able to tolerate their emotions, to make sense of their experiences, and to develop healthy new ways of seeing and experiencing the world, they need to be listened to and their feelings of intense pain need to be contained. For many depressed adolescents the experience of being listened to by an attentive and reflective listener may be unprecedented. The adolescent may benefit from the experience of psychotherapy by developing a new concept of others as holding potential to listen as well as benefitting from the possibility that their experience may be contained in a narrative which can be jointly thought about and worked through. Schafer (1980) describes this process in his work exploring narrative within psychoanalytic dialogue:

> *People going through psychoanalysis … tell the analyst about themselves and others in the past and present. In making interpretations, the analyst retells these stories. In the retelling, certain features are accentuated while others are placed in parenthesis; certain features are related to others in new ways or for the first time; some features are developed further, perhaps at great length.* (p.35)

This process is assisted by the analyst encouraging the analysand to freely associate everything that comes to mind. Schafer (1980) suggests that following free-association the analyst proposes something along the following lines:

> *… let's see how we can retell it in a way that allows you to understand the origins, meanings and significance of your present difficulties and to do so in a way that makes change conceivable and attainable.*
> (p.42)

Schafer's work illustrates how the analyst listens to and gathers the facts in a way that can then be reflected on and retold in order to help the analysand. Narrative analysis provides a method that helps to untangle the many threads that run through psychotherapy. The importance of stories has always been at the heart of psychoanalysis. This is clear from Freud's use of archetypal stories to help him define and outline his theories. Psychoanalytic literature, contemporary and historic, outline the crucial position of the experience of the relationship to the object. However, as we now understand, this experience is based on a complex interplay of factors. Professionals are becoming increasingly conscious of the impact of intergenerational dynamics where entrenched views and impoverished survival strategies can be passed down through the generations, that is, unless these ways of surviving can be thought about with a safe, reflective other. As the oft-quoted maxim has it, 'Those who do not learn from history are doomed to repeat it.'[4]

Researchers investigating narrative examine the subject from many different perspectives. All narrative researchers, however, are interested in the stories that people tell and the context in which they tell them. Methods to analyse narrative include examining themes that arise and what the main characters and plot appear to be. Of prime importance is the way that events are spoken about. Dallos and Vetere (2005) describe how individuals may attempt to 'edit their own story in ways that are more emotionally bearable for them' (p.70).

[4] Attributed to the philosopher and writer, George Santayana (https://bigthink.com/the-proverbial-skeptic/those-who-do-not-learn-history-doomed-to-repeat-it-really)

Denzin (2015) writes, ‘Stories and lives connect and define one another’ (p.xii). This notion is also reflected in the work of narrative researchers McLeod and Balamoutsou (1996) who propose: ‘Any story that is told is a relational event. A story implies an audience, and the nature of the audience will have an impact on the way the story is told, and on what is said or not said’ (Balamoutsou,1996, Results Section). This line of thinking mirrors the psychoanalytic perspective in recognising how our intimate relationships affect and shape us. The way parents ‘edit their own story’ (Dallos and Vetere, 2005, p.70) impacts their children. This is apparent in McDougall and Lebovici’s (1989) analysis of Sammy and his mother where the mother-child relationship is imbued with feeling related to the present but also to memories of the past:

> *Everything points to the fact that Mrs Y re-lived through Sammy her own voyeuristic wishes forbidden by her own mother. Sammy was to express her wishes and thus to create by proxy another link in her primitive bond to her own mother.*
> (p.267)

Fraiberg and colleagues (1980) draw our attention to the disturbing impact of parents who, prior to therapeutic intervention, were unable to feel or process their own childhood traumas. Fraiberg and colleagues describe how psychotherapeutic work provided a space for parents to be listened to and supported to put words to their experience. Through this process, their traumatic experiences were shared and contained, helping to avoid the repeat of intergenerational trauma. The power of this process is highlighted in the formative work on narrative analysis of psychotherapy by Luborsky and colleagues (Luborsky and Crits-Christoph, 1990; Luborsky, Barber and Diguer, 1992; Luborsky et al., 1994). In their work to create a coding manual to analyse narrative processes and to formulate quantitative measures about narrative, they revealed how successful psychotherapy cases witnessed significant change in patients’ stories about their relationships, suggesting that a positive relationship with the therapist contributes to the patient’s ability to transform their perspective of what relationships can be.

Literature that explores narratives of depressed adolescents, their families or therapists

Whilst searching specifically for literature using the search terms 'stories', 'narratives', 'depressed adolescents' and 'parents' on Psych Info and the Pep archive, I did not find any studies that directly compare the narratives of depressed adolescents with their parents. However, I did find several studies relevant to my topic from these searches and by using a snowball technique where one paper led to another. I also found papers by including narrative literature that included reference to transference. I now outline the most relevant of these papers.

In their paper, 'The stories that families tell: Narrative coherence, narrative interaction, and relationship beliefs', Fiese and colleagues (1999) explore different studies that examine family narratives. From this analysis they suggest that family narratives are shared within the family and have a direct impact on child development. They argue: 'Family system influences on child development range from directly observed proximal factors, such as parent-child interaction patterns, to more distal factors, such as the parent's family of origin experiences' (p.1). Their findings highlight the bearing that intergenerational patterns of relating have on how a child develops and creates their own concept of the world and relationships. The authors also quote the work of Goldstein and Strachan (1987) and Hooley and Teasdale (1989) as further examples of studies providing, '… considerable evidence that the emotions expressed about relationships are related to psychological functioning in the family' (Fiese et al., 1999, p.10).

In a recent study, interviews with adolescents, parents and therapist participants in the IMPACT trial were analysed by Krause and colleagues (2020). The researchers described this as a 'post-hoc analysis of interview data collected through the qualitative IMPACT-My Experience (IMPACT-ME) study' (Midgley, Ansaldo and Target, 2014). Krause and colleagues (2020) studied and mapped treatment outcomes following STPP. This study is relevant to my own study as it illustrates areas of congruence between the adolescents, parents and therapists. They found that:

> *Adolescents, parents, and therapists tended to reflect on change holistically, across the high-level domains of symptoms, self-management, functioning, relationships, personal growth, youth wellbeing, and parental wellbeing and support. A number of specific outcome categories were frequently discussed across groups and treatment arms: changes in mood and affect were the single most-discussed outcome, although improved coping and resilience was discussed just as often by adolescents; and changes in family functioning, and academic and vocational functioning were discussed by close to half of participants.*
> (Krause et al., 2020, Discussion Section)

Significantly, adolescent participants emphasised the importance of 'being worthy of another person's attention, of feeling listened to' and, 'discovering new perspectives on life were described as … transformative by more than a third of adolescents' (ibid).

Ratnarajah and Schofield (2008) describe a qualitative narrative method with thematic analysis exploring the short-term and lifelong impact of ten adults' experiences of losing a parent to suicide. The authors describe how relatives of people who have committed suicide are more at risk of suicidality and completed suicide and suggest there is a great need to better research and understand the dynamics within these families and, specifically, to think about the potential for intergenerational transmission. This study explores the trauma associated with losing a parent to suicide but also acknowledges the effect of dysfunction prior to the suicide. The authors refer to Schore's findings (2003) on how the early parent-child relationship influences the formation of the psychological foundations of personality in young children, highlighting that dysfunctional family patterns compromise these foundations. Suicide is described as like the tip of the iceberg in a sea of suffering; the act of suicide representing not a one-off trauma but the culmination of dysfunction compromising the child's attachment relationships. The narrative accounts of participants identified a strong theme indicating that participants attempted to restore to themselves what they felt they had lost during childhood. Participants made great efforts to surround themselves with material possessions and seek out educational opportunities but, most significantly, they placed high

importance on attempts to create security and love within families they formed as adults. This need led nine out of ten participants to marry young and inappropriately, leading to a repetition of rupture when these relationships broke down, perpetuating the cycle of intergenerational dysfunction.

Vanheule and Hauser's (2008) study analyses the narrative accounts of forty psychiatrically hospitalized depressed adolescents, focusing on the participants' accounts of feeling helpless. The authors suggest these accounts can be taken as spontaneous as they were not guided by specific questioning. This mirrors my study in the way that we can assume that the narratives that occur within the IMPACT Study arise spontaneously as therapists have followed the lead of the participant rather than their own agenda. Vanheule and Hauser's study describes the different patterns seen to arise in adolescents' experience of helplessness in relation to their depression. A major factor which the authors identify as often being present in the narratives of the depressed adolescents is '... a disturbing confrontation with a significant other' (p.1323). Where the other is experienced as frightening and unpredictable, the adolescent becomes anxious and uncertain. Thus the 'protagonist's helplessness arises as a direct result of not knowing how to manage the "unbearable riddle" of the other's intentions' (ibid). Interpersonal difficulty was the largest pattern found in their study of helplessness in depression. In a way that reflects the studies described above, this study focuses on how relational factors contribute to adolescent depression.

In their critical review of narrative research, Avdi and Georgaca (2007) highlight that 'In narrative theory, therapy is conceptualized as an interactive dialogical process' (p. 416). However, their review revealed a dearth of narrative research analysing the dialogical narrative. Rather, the majority of studies they reviewed focused on the micro-narratives of the client. This is taken up by McLeod and Balamoutsou (1996) in their paper, *Representing narrative process in therapy: Qualitative analysis of a single case.* They refer to the way in which a narrator is influenced by their audience and consequently adapts their story. This indicates the need to think about the dyad involved in the telling of, and listening to, the narrative. From a psychoanalytic perspective, we are mindful of how the therapist is likely to be a vessel for transference. We are also conscious of the impact of potential differences in the

dyad, for example of power, hierarchy or class. McLeod and Balamoutsou remind us that of key importance when analysing the therapeutic dyad is to question what the therapist represents to the client and how this might influence what the client says or refrains from saying. They conclude their paper by identifying how in this particular case, 'stories' told later in the session 'appeared to be re-workings of earlier ones' (McLeod and Balamoutsou, 1996, Conclusion Section) which had been altered by the therapist's active involvement leading to a new, re-constructed, reframed version of the original story.

Conclusion of Literature Review

If we want to find out how people make identities, make sense of the world and of their place within it – if we want to find out how they interpret the world and themselves – we will have to attend to the stories they tell.
(Lawler, 2011, p.255)

In this literature review, key themes are seen to overlap between psychoanalytic and narrative literature relevant to adolescent depression. These include a developing awareness of intergenerational transmission of trauma, how environmental factors contribute to disturbance, and how the experience of conflict with one's object can lead to feelings of helplessness and apathy.

Narrative analysis places emphasis on the need to consider the inter-relational aspect of narrative creation; specifically questioning why this story is being told by this particular teller to this particular listener. However, as Avdi and Georgaca (2007) highlight, historically there has been limited narrative analysis exploring the patient-therapist dyad. More commonly, therapist and patient narratives have been separated and the client's narrative, stripped from context, has been hierarchized in the analysis. As described, early psychoanalytic literature privileged instinctual drives as underlying personal development and pathology. As psychoanalytic theory progressed, greater credence was placed on the interaction between the self and object. Depression has often been viewed as a response to hostility where ambivalence towards the object has been felt as unacceptable and consequently

turned inwards. As psychoanalytic theory fostered ideas about the aetiology of adolescent depression, emphasis was also placed on the impact of familial, societal and environmental factors. Psychoanalytically-informed therapists recognise that in the transference-relationship they often represent the patient's object. The opportunity to analyse therapist and patient narratives in their original dyadic format (i.e. not separated) is important as it lends potential for us to explore how the therapist can be experienced by the patient as representing the object. In this way, we may be able to extrapolate underlying relational components present in the adolescent's depression. Simultaneously, we can analyse how the therapist, by not *actually* being the object, brings a new perspective to the patient. It is the therapeutic combination of containing and attending 'to the stories they tell' (Lawler, 2011, p.255) whilst bringing a new perspective that 'makes change conceivable and attainable' (Schafer,1980, p.42).

Just as patient and therapist narratives have often been separated before analysis, the literature review indicated a similar pattern in the analysis of narratives of depressed adolescents and their parents. As far as I am aware, there has not been a systematic analysis of the narratives of depressed adolescents in psychotherapy and their parents. As we have grown clinically more attuned to the importance of familial, societal, and environmental factors in the aetiology of depression, the lack of analysis of parent-adolescent pairs becomes of interest. Clinically, we appreciate the need to respect the adolescent's growing independence. Indeed, some adolescents are resistant to their parents being involved in their therapeutic treatment and find meetings where parents are included, such as joint reviews, extremely difficult. However, in my experience, others have argued for the need for greater involvement with parents. These adolescents indicate that limited or no parent work can be experienced as a communication that the difficulty is located exclusively in them. This notion parallels Avdi and Georgaca's (2007) suggestion that the separation of client and therapist narratives 'sidesteps the situated and co-constructed dimension of narrative production' (p.414) The opportunity found in the present study to analyse both the adolescent and their parent's narrative, provided rich material which, in the cases here analysed, suggested a link between how a parent and their child function. Further study into this field could usefully add to our understanding of the

familial factors which contribute to adolescent depression, potentially supporting our work with both adolescents and their parents.

Method

Data set

This study made use of audio-recordings of two separate Short Term Psychoanalytic Psychotherapy cases where adolescents and their parents had taken part in a UK based, national, randomised controlled trial called 'The Improving Mood with Psychoanalytic and Cognitive-Behavioural Therapy Study', hereon referred to as IMPACT (Goodyer et al., 2017). The IMPACT study compared Cognitive-Behavioural Therapy, Short Term Psychoanalytic Psychotherapy (hereon referred to as STPP, consisting of 28 sessions) and Brief Psychosocial Intervention for the treatment of adolescents between the ages of 11 and 17 with unipolar major depressive disorder. The focus of STPP is outlined in the treatment manual by Cregeen and colleagues (2017):

> *STPP for young people with depression aims to focus not only on "symptom relief" (although this is, of course, important) but also on addressing some of the underlying vulnerabilities to depression, in order to try and create increased resilience and foster a capacity in the young person to manage difficult feelings and experiences. In the STPP model, the young person's symptoms are understood as directly related to the underlying dynamics. The fostering of increased resilience is achieved by means of its focus on the central personality organization that may have contributed to the young person's depression.* (p.56)

In addition to the adolescent's sessions, parents were invited to attend approximately seven of their own sessions. Cregeen and colleagues (2017) outline this work:

> *Psychoanalytic parent work in STPP, as with all psychoanalytic child psychotherapy, is clinical work conducted in parallel to the young person's own*

> *therapy, by a different therapist, with the aims of supporting the therapy, fostering the parents' or carers' understanding of their adolescent child's difficulties, and helping them with the inevitable anxieties aroused by their child suffering significant difficulties, such as depression.*
> (p.134)

Parent work was offered by experienced clinicians, not exclusively psychotherapists. The adolescent sessions were undertaken by experienced psychotherapists and child and adolescent psychotherapy trainees in their fourth year of training. All therapists completed training in STPP. Therapy sessions lasted fifty minutes and participants agreed for sessions to be audio-recorded.

Ethical approval

Use by Tavistock and Portman doctoral students of the anonymised patient data (audio recordings of clinical sessions) from the IMPACT trial is covered by the ethical agreement between the trial's principal investigators and the National Research Ethics Service (NRES Committee East of England – Cambridge Central), in a substantial amendment submitted on 27 May 2011 and approved on 16 June 2011. To ascertain that the current study was deemed appropriate, and to authorise the data use, permission was sought and granted by the Principal Investigator at the Tavistock and Portman Trust, Dr Rob Senior. In addition, the current study was approved by the Tavistock Research Ethics Committee (See Appendix 4).

Since the IMPACT data had already been gathered, the present study is considered a secondary qualitative study. There was no direct contact between the present researcher and the IMPACT study's participants. Audio recordings were encrypted to ensure that non-unauthorised individuals could not access the data. Names of the patients, parents and therapists were not shared with me as the researcher other than as heard occasionally on the audio-recordings. In this thesis, all patient names have been replaced with pseudonyms, while therapist and parents are referred to as 'Therapist', 'Mother' or 'Father', and place names are altered to protect confidentiality.

Design

I was part of a group of Child and Adolescent Psychotherapy doctoral trainees undertaking research using data from the IMPACT study. As a group of four trainees, we met together with our research supervisor to discuss our individual research projects and to identify data from the IMPACT study relevant for our studies. For this purpose, we made use of the APQ scoring system (Calderon et al., 2013) where one session per participant had been scored. Calderon and colleagues (2017) define this system as:

> *... a newly developed instrument, adapted from the well-established Psychotherapy Q-Set (PQS) and the Child Psychotherapy Q-set (CPQ). The APQ aims to describe the psychotherapy process in the treatment of adolescents in a form suitable for quantitative comparison and analysis.* (p.106)

APQ scores assist researchers by rating themes heard in the audio-recordings on a scale of 1-9 where 1 indicates 'Extremely uncharacteristic or negatively salient' and 9 indicates 'Extremely characteristic or salient' (Calderon et al., 2013, p.2). The present research group obtained access to the APQ scores of 35 session recordings of different patients undertaking STPP in London. With the intention of locating data relevant to my research question, 'How do the narratives of depressed adolescents and their parents compare?', and with the support of my research supervisor and research group, I identified the following items on the scale as being relevant to my study:

> 6 - 'Young person describes emotional qualities of the interactions with significant others' (Ibid, p.6)
> 63 - 'Young person discusses and explores current interpersonal relationships' (Calderon et al., 2013, p.21)
> 92 - 'Young person's feelings or perceptions are linked to situations or behaviour of the past' (Ibid, p.28)
> 86 - 'Therapist encourages reflection on the thoughts, feelings and behaviour of significant others' (Ibid, p.27)

100 - ‘Therapist draws connections between the therapeutic relationship and other relationships’ (Ibid, p.30)

The conclusion of the research group was that items 63, 92 and 6 were likely to be most significant to my study so these were set as prioritised items (see chart below). Following this, all cases which scored 8 or 9 on item 63 were selected. Then we looked at scores on the other 2 priority items. Finally, we looked at scores on the remaining items. The following chart illustrates the respective results:

Key

9 is highlighted in yellow and indicates ‘Extremely characteristic or salient’

8 is highlighted in orange and indicates ‘Quite characteristic or salient’

Item	63 (top priority)	92 (priority)	6 (priority)	86	100
101	9	5	9	5	8
106	9	7	8	4	4
123	9	4	8	6	6
129	9	7	8	6	5
135	9	5	2	4	3
156	9	3	7	2	3
157	9	6	8	4	5
176	9	7	2	5	6
255	9	6	9	4	8
258*	9	8	9	6	6
260*	9	8	9	6	7
274	9	6	8	4	4
290*	9	9	9	6	6
292	9	6	9	4	4
104	8	4	6	6	6
122	8	6	8	3	6
252	8	6	9	4	5
289	8	6	7	4	5
315	8	6	9	6	6

Once suitable cases had been identified, we checked whether there were audio recordings of corresponding parent sessions. At this point, we discovered several cases where the parent sessions had not been recorded, limiting my choice to three as indicated above with asterisk symbols.

I decided to transcribe and analyse the first recorded session, the APQ-rated session, and one corresponding parent session for each case. In psychoanalytic

practice, it is a commonly held view that, were the therapist skilled enough to understand it, the first session holds the key to the whole case. This belief is utilised in the narrative analysis work of McLeod and Balamoutsou (2001) who describe how their extensive clinical and research experience led them to notice, and reflect on, '… the extent to which issues and meanings which were to open out later in therapy were apparent, in a hidden or implicit manner, from the beginning' (p.140). In keeping with this concept, I analysed the young person's first session in order to investigate how themes and narratives present in the APQ-rated session might have already been present. Then I compared the young person's sessions with their parent's session. My study was exploratory in nature: although my psychoanalytic training grounded my thinking and I was conscious of the impact that parents have on their children, I was not certain how similar the narratives of parents and their depressed adolescents would be. Given depressed adolescents are often found to feel a sense of estrangement and disconnection from their parents, it might have been the case that the narratives in my study reflected this disconnection by their lack of congruence. In an effort to remain open to the different possibilities, I attempted to set aside my own expectations.

Transcription

I used an orthographic transcription notation system devised by Braun and Clarke (2013, p.165-166) and based on Jefferson's (2004) system. As advised by Braun and Clarke, I was careful to record speech as it was said, making note of abbreviations and vernacular idiosyncrasies. I felt this was important because I wanted to represent the participants' speech as accurately as possible. I felt that to transcribe the speech without representing the specifics of the dialect would strip the material of an element that was intrinsic to the participants and would also entail me imposing more of myself onto the transcriptions than necessary. In the process of supervision, the subject of how best to present speech raised interesting discussion as we reflected on how the often middle-class, well-educated therapist is likely to use and understand a large vocabulary. If a patient does not identify with their therapist's background, there is potential for a power imbalance. Patients may envy their therapist's extensive vocabulary or feel diminished, patronised or inferior. We must bear this in mind when analysing patient narratives as it may impact on the way that

a patient communicates within their session. It may be possible that patients feel that they do not have the 'right' words or that they talk a 'different language' to their therapist. Within the transference, therapists may be experienced as distant, authoritarian figures. When these aspects are thought about by the therapist, the opportunity to reflect on this dynamic can lead to connection and growth, and patients may be introduced to new words, augmenting their vocabulary and helping to contain their experience.

During the process of transcription, I numbered each line for ease of reference. Transcribing the sessions enabled me to fully immerse myself in the data and to notice fine details.

Below is a table describing elements of the notation system used by Braun and Clarke (2013) that I used for my transcription:

Feature	**Notation and explanation of use**
Identity of the speaker	Speaker's role or name followed by a colon (e.g. Therapist:) YP: indicates Young person
Laughing, coughing etc	((laughs)) ((coughs))
Overlapping speech	((in overlap))
Pausing	((pause)) indicates a significant pause of a few seconds or more and (.) indicates a short pause
Inaudible speech	((inaudible))
Uncertainty of utterance	Best guess of utterance placed in parentheses

Methodology

The basis of the present study comes from a social constructionism perspective as outlined by Gergen (1985):

> *From the constructionist position the process of understanding is not automatically driven by the forces of nature, but is the result of an active, cooperative enterprise of persons in relationship.*
> (p.267)

This theory finds a counterpart in psychoanalytic and attachment theory where object-relations are understood to form the basis for personality development. Whilst holding in mind the idea that, just like any adolescent, the adolescents involved in this study are influenced by their early object-relations, the present study aimed to explore, compare and contrast the narratives of the adolescent and parent. In their critical review of narrative research in psychotherapy, Avdi and Georgaca (2007) highlight how many research studies examining narrative within psychotherapy focus almost exclusively on the client's narrative:

> *… they tend to study narrative as a reflection of inner states and narrative 'pathology' is seen to represent problems in the client's underlying cognitive processes. Accordingly, the analysis focuses almost exclusively on the clients' narratives, which are in this way decontextualized both from the immediate interactional context of the psychotherapeutic encounter and from the wider cultural, institutional and ideological contexts. In our view, this reproduces the basic assumptions of more conventional psychological approaches, which are individualised and internal, and sidesteps the situated and co-constructed dimension of narrative production.*
> (p.414)

In keeping with a psychoanalytic viewpoint, in addition to what the adolescents report about their relationship with their parent, communication from the adolescent towards the therapist can also be understood as a potential transference communication. The ability to make use of the psychoanalytic concept of

transference offered the potential to uncover further aspects related to the adolescent-parent relationship. As described, during the process of researching narrative analysis, I learnt about narrative analysis techniques which separated the client's narrative from the therapist's. For the purpose of the present study, it was essential to preserve and present the narratives together – to examine the dialogue *between* the adolescent and therapist, exploring how one influences the other. Separating the narratives would overlook the relational element of narrative-construction, eliminating the potential to explore the 'situated and co-constructed dimension of narrative production' (ibid). However, there were instances when, in order to extract deeper narrative meaning, I decided to adopt the method proposed by Gee (1986, 1991) to present sections of the transcribed sessions in stanza form. In these instances, I separated the patient narrative from the therapist. McLeod and Balamoutsou (1996) describe the benefits of preparing the transcript in this way:

> *This technique essentially involves taking account of speech rhythms and pauses and using this type of information to display the story in a form that enables the reader to participate more readily in the story as it was actually told.*
> (McLeod and Balamoutsou,1996, Results Section)

The opportunity to re-present sections of the transcription in stanza form enabled me to notice significant details which were at risk of being overlooked in the original transcription. Much like reading a poem, narrative patterns and specific word choices were then able to stand out and capture my attention: it was possible to see patterns such as repetition more clearly and, in turn, consider what might be communicated by the repetition. Following in the footsteps of Mair (1989), McLeod and Balamoutsou (1996) describe how the technique of presenting transcriptions in stanza form enables the researcher to, '… speak from the world of psychotherapy rather than about that world' (McLeod and Balamoutsou,1996, Conclusion Section). I used this method when I wanted to home in on a specific theme described by a participant. Generally, however, it was important to present the data as originally transcribed, allowing me to observe areas such as how few pauses there were, how long a monologue lasted and if the therapist had space to add their own reflections. When analysing the narratives, I focused on the content of the narrative but also on

the way that individuals expressed the narrative, for example, I paid attention to times when non-verbal utterances were made, such as coughing or laughing. This was important as my analysis indicated that non-verbal utterances were often made at times of significance, for example, laughing when describing a stressful or sad situation. Once I identified this pattern in one part of the parent/adolescent configuration, I was able to look to see if it was evident in the other part. When I found examples of this occurring in both parent/s and adolescent, I was able to explore and hypothesise about the ways in which parent and adolescent both managed intense emotion.

Procedure and Analysis

Following transcription, I read through the transcripts multiple times to further familiarise and imbed myself within the data. I then used Dallos and Vetere's (2005) description of narrative analysis steps as a basis for my own analysis. However, narrative analysis is an extremely flexible method. As McLeod and Balamoutsou (2001) report, researchers using narrative analysis often use a wide range of *bricoleur* (Denzin and Lincoln, 1994; Polkinghorne, 1992) principles carefully gathered to 'assemble a set of procedures and sensitising constructs appropriate to the job in hand' (p.129). In this vein, the current study made use of narrative analysis methods proposed by McLeod and Balamoutsou (2001) to compliment those of Dallos and Vetere (2005). The present study is interpretive in orientation: 'The researcher's presuppositions ... supply a horizon of understanding from which the research material (psychotherapy transcripts) can begin to be understood' (McLeod and Balamoutsou, 2001, p.130). I attempted to step in and out of pre-existing epistemological frameworks to maximise the potential for greater reflexivity, the emergence of new concepts, and subsequent richer understanding.

For the purposes of this study, the term 'narrative' was used in the way outlined by McLeod and Balamoutsou (1996):

> *… the term 'narrative' will be used to refer to the therapeutic discourse as a whole, and the term 'story' will refer to accounts of specific incidents*.
> (McLeod and Balamoutsou,1996, Results Section).

My principal aim was to investigate, compare, and contrast the narratives of adolescent and parent. I describe the steps I used to analyse the transcripts below. All steps are taken from Dallos and Vetere's suggestion (2005, p.70), apart from those I have underlined which are additional steps as suggested by McLeod and Balamoutsou (1996, 2001). In line with a psychoanalytic perspective, privileging object-relations theory, I also considered material referring to the relationship between the therapist and the adolescent as a potential indicator of the quality of the relationship between the adolescent and their parents/carers, that is, a transference communication. In addition, and again in line with a psychoanalytic perspective, I paid attention to my counter-transference in relation to the audio-recordings. During my analysis, my counter-transference response often acted like a signpost to particularly important and rich themes as experienced by the participants.

I colour-coded each step so I could highlight corresponding material in the transcripts (See Appendix 1). Simultaneously, I created a document for each session which drew together the colour-coded themes and a summary of each session. For each case, I spent time comparing the themes and points of significance between the young person's and parent's sessions. I concluded the study by reflecting on overlapping themes between the cases. The steps which I undertook produced an extremely large amount of data. It was not possible to reflect on all the data within the scope of this thesis. However, taking these steps and becoming truly immersed in the data enhanced my reading of the material.

The steps were:

> *1 Read through the transcript a number of times to gain a sense of the person's story. This initial reading can be guided by a drama-based metaphor of people's lives and stories.*
>
> *2 Note the key features – who are the main protagonists (the main people in the story)? What are the key events or scenes/actions? What is the plot of the story?*

3 Make a note of what the dominant theme/story appears to be, perhaps starting to make connections with wider culturally shared stories – the prodigal son, triumph over adversity, and so on. When I felt that a particular theme or story warranted further analysis, I re-presented it in stanza form (as outlined above – see Appendix 2)

4 Reflectively note how you may be making connections with your own experiences, how you have become aware of feelings and images as you read the story. How evocative is their story? What aspects evoke particular feelings in you?

5 How is the person telling their story? People express feelings, may become animated, sad, happy, laugh and so on, as they tell their story.

6 Note the variety of stories and themes that emerge from the narratives that people tell. There may be a dominant theme or story that changes at different points in a person's life, for example, a time when things were going well. Here, I add in topic and topic shifts as suggested by McLeod and Balamoutsou (2001). It is interesting to identify topics that are discussed and when these might shift to another topic.

7 Significant events or turning points. We can look for events that seemed to mark a change in a person's life or are seen as significant in forming the person that they have become.

8 Coherence. We can focus on many aspects of the narrative in terms of its form and style. One point of focus can be on whether the events as told fit together or appear coherent. This can have a number of components:

- *Temporal – whether the events described make sense over time or are scattered and contradictory.*
- *Semantic – whether the events make sense or whether there are clear contradictions in how events or people are described.*

Overall it is important to look for examples where there is a fit between how events are labelled semantically and the episodes that are offered to illustrate them. For example, in telling their story a person may describe a parent as kind but offer very few examples of kindness on their part, or even in contrast, examples of where they have been quite unkind or cruel. This may suggest that they are attempting to edit their own story in ways that are more emotionally bearable for them.

9 Language and discourse. Frequently people's ability to be coherent and clear in their use of language may change at points where very significant events have occurred. Here narrative analysis overlaps with discourse analysis in exploring how feelings are revealed in the way we use language when we describe our lives. For example, the frequency of hesitations may increase, sentences may not be completed, people may hop from one topic to the next without completing them or there may be inappropriate laughter or nervous coughing, perhaps indicating that the person is talking about difficult events.

10 *Here, I added identification of voice as proposed by McLeod and Balamoutsou (2001, p.143) who suggest that reports of other people talking in the sessions may indicate the extent to which the patient feels or wants to show the strength of that individual and can indicate 'the speaker is being "spoken through"' by the person whose words he or she voices. McLeod and Balamoutsou (2001) also refer to 'social or cultural "voices" in the sense of dominant discourses' (p.143).*

11 My final step was inspired by McLeod and Balamoutsou (2001) who describe a research strategy intended to address the qualitative problem of vast amounts of data. McLeod and Balamoutsou suggest that it is important for qualitative researchers to summarise their findings so that readers can easily access an overview of their work. In this way, individual qualitative studies can be considered to cumulatively add to the research field. They suggest that this method can also be used within a research project where the findings from one case can be 'tested and modified in the light of data from subsequent cases' (p.146). As such, I completed my analysis by summarising each session. This

helped to consolidate the main themes from each session and highlighted the sequence of topics discussed (See Appendix 3)

Reflexivity

As a child and adolescent psychotherapy trainee engaged in doctoral research, certain key psychoanalytic principles imbued my understanding and interpretation of the data. This psychoanalytic lens was also mirrored in the IMPACT therapist's position. For the purposes of reflexivity, it is important to acknowledge this and hold it clearly in mind throughout the research process. Boothe and colleagues (1999) highlight how, '… therapists receive a patient's narrative in a process of unnoted self-interested acquisition that rearranges what is heard' (p.259). This statement also extends to the researcher. Multiple factors influence the therapist's/researcher's interpretation of clinical material including their own unconscious bias, professional training and alignment to a theoretical perspective. Boothe and colleagues continue, 'The patient's story … must have a chance to find a hearing in the therapeutic process. The therapist must learn to hear it' (p.260). Narrative analysis encourages the researcher to take note of their response to the data. This process is akin to the therapist's attempt to pay attention to their counter-transference. Processes such as supervision assist in the therapist 'hearing' the patient's 'story'. The process of undertaking research can also encourage greater reflexivity as the researcher strives to follow rigorous and systematic processes with an emphasis on the need to stand back and reflect on the underlying factors which influence their interpretation of the data.

Limitations

A limitation of this study is that it only analyses a small number of session-recordings. It would be extremely interesting to analyse a great many more psychotherapy cases where both adolescents and their parents have taken part. Specific questions might be addressed, such as whose story is really being told – does it belong to the adolescent or to somebody else in the family? Though I did have access to a single recording of a parent session for each case, a further limitation of my study was that I did not have access to information about the

parent's history or 'back story' which would add to an understanding of the historical context of the narrative.

It could be argued that this study is limited by the fact that I was not the therapist in the room and only had access to audio-recordings, meaning that I could not pick up on the majority of non-auditory communications. I also could not analyse my counter-transference response as the therapist in the room. Whilst these factors did affect my interpretation of the data, it was also possible that, as an external listener, whose sole purpose was to concentrate on what was communicated audibly (with the privilege of being able to stop and start the recording, rewind and play again), certain details may have been clearer to me than they would be were I to be the therapist in the room. In addition, as a researcher using narrative analysis and trained in understanding and reflecting on my counter-transference, I was able to attend to what the material raised within me.

Another limitation is that I did not have contact with the original participants (neither participants nor therapists) and, therefore, could not ask them what they thought of my analysis. I also did not have access to further data relevant to the cases that I analysed such as post-treatment follow-up interviews or outcome measures which could be used for triangulation purposes as proposed by McLeod and Balamoutsou (2001, p.139). It could be argued that a further limitation is that I was analysing the data individually and therefore did not have the opportunity for cross-reference or potential enrichment with fellow researchers. However, much enrichment of understanding was achieved through supervision.

Justification of small scale of data

Of principal importance to the analysis of narratives within psychotherapy is the idea that the patient, affected by the therapist's presence, decides which events or stories to talk about. As discussed, the patient and therapist engage together in a process of redefining and co-constructing the stories told (McLeod and Balamoutsou, 1996). The present study aimed to compare and contrast narratives found in adolescent and parent sessions. Analysing three sessions from two separate cases lent potential to observe how stories and narratives or strong themes weave, shift, grow,

or remain stagnant between the first adolescent session and the APQ-rated adolescent session. It also allowed me to observe similarities and differences between the stories and narratives or themes of adolescents and their parents/carers, and to begin to formulate questions, considering how stories and narratives or themes may pass between generations.

As is characteristic of STPP, topics of conversation were led by the participants. Therapists were actively involved but did not introduce topics (other than circumstances such as where the therapist might reflect on the point in time of the session, for example, commenting on how the therapy was in a beginning, middle or final stage, or to reflect on breaks in the therapy for holidays, etc). Since therapists did not generally lead session topics, the material of the sessions can be viewed as occurring spontaneously. This contrasts with more formal interview structures where participants are asked specific questions with the aim of eliciting specific information. An argument against the traditional interview structure is that participants can attempt to answer questions as they imagine the interviewer wishes them to or by making an effort to appear in a better light. Vanheule and Hauser (2008) refer to this phenomenon as a 'social desirability bias' (p.1326). It can be argued that the narratives which occurred in the present study represent genuine accounts of personal experience. However, as also highlighted above, the present study recognises that human interaction and narrative formation are affected by the other. As such, though not directly led by the therapist, the participants may have been influenced by the psychoanalytic framework, privileging object-relations theory. Schafer (1980) highlights this point further when he writes:

> *... there is no single, necessary, definitive account of a life history and psychopathology, of biological and social influences on personality, or of the psychoanalytic method and its results. What have been presented as the plain empirical data and techniques of psychoanalysis are inseparable from the investigator's precritical and interrelated assumptions concerning the origins, coherence, totality, and intelligibility of personal action.*
> (p.30)

He continues, ‘The sharp split between subject and object must be systematically rejected’ (ibid) due to the fact that the psychoanalyst (and, one may substitute researcher here for psychoanalyst) names and interrelates in a way that is systematic to their original assumptions, using ‘technical practices [which] shape phenomena’ (ibid) complicit with their preconceptions.

Though the present study examines the narratives which occur in two cases only, a wealth of rich material was generated by the close narrative analysis. As described by Schafer, it is paramount to keep in mind that the therapist and researcher bring their own specific perspectives. The fact that the epistemological framework is shared by both therapist and researcher may also enhance the angle with which the data is viewed. It is important to bear in mind that the therapist and researcher must be viewed as active participants as much as the adolescents and parents engaging in the therapy. In this way, the researcher makes use of their thoughts and emotional responses to the data in a similar way to how the therapist makes note of their counter-transference response to the patient (McLeod and Balamoutsou, 2001, p.131-132).

The choice of methodology used for the present study, was influenced by the psychoanalytic tradition where individual case studies are accepted as valuable individual entities contributing to a broader picture when viewed together with other cases, as advocated by Midgley (2006) and Rustin (2003). It is to be presumed that other researchers might draw different conclusions from the same data. This can be understood by comparing the process of research and interpretation to that of an individual viewing a piece of art: each viewer’s response is unique and cannot be replicated in its entirety by any other human. Viewed in this way, we can understand the present study as a small contribution to the field of qualitative research into the process of psychotherapy as well as into adolescence.

Findings

I will now describe the major findings from the two cases, here named May and Chloe.

May

May was 14 years,10-months-old at baseline. She identified as white and female and rated herself as ‘Yes’ for ‘family medical or mental health problems’. She lived with her parents and was the youngest of four brothers and two sisters. Only her youngest brother also lived at home. She had sixteen nieces and nephews. I analysed Session One which occurred in June, Session Ten which occurred in October and the Parent Session which occurred in September. During May’s first session, she identified that she was also accessing counselling at school; she was adamant that she did not want to give up this support.

Main protagonists and significant turning points

During the process of analysing and comparing the narratives of the adolescents and their parents, I began by paying attention to who the main protagonists appeared to be, before moving on to explore major themes and stories. I then took note of other important aspects such as significant incidents or turning points in the young person’s life. In many ways, narrative analysis techniques mirror key aspects of psychoanalytic thinking as the researcher attempts to understand and situate the individual within the context of their emotional and relational experience. This parallel was apparent during the first session when the therapist asked May:

> *… so that brings me up to my other big important question is about your family. And who’s in your family?*
> (lines 236-237)

May described her large family. In this first session, standing out from the crowd as the main protagonists were her niece (one year younger than herself) and her adult sister. I noticed that in the beginning of the first session, May appeared as if she were a supporting character rather than the main character. She brought her mother into the session and it was her mother who spoke and introduced herself first. When May introduced herself, it was impossible to hear her name as she spoke so quietly. Until her mother left the session, much of the speech occurred between the mother

and therapist. It was not until line 56 that May very quietly answered one of the therapist's questions. Again, very quietly, she answered a further question at line 74. My initial listening to the audio-recordings led me to wonder about the reasons for May's quietness – perhaps she was anxious about meeting a new therapist or used her mother to hide behind. Conversely, perhaps she was overshadowed by her mother.

Dallos and Vetere (2005) encourage the narrative researcher to consider 'Significant events or turning points … events that seemed to mark a change in a person's life or are seen as significant in forming the person that they have become' (p.70). May talked about specific events which had a profound impact on her. More generally, she also identified how she was at a crossroads in her life and described uncertainty about some major decisions that she needed to make. As such, she was beginning her psychotherapy at a significant turning point. She continued to describe feeling confused about the underlying reasons for her depression. This overarching sense of uncertainty was also apparent in her discussion about what she might like to do after her GCSE exams. I found that presenting this account in stanza form highlighted her confusion better than in its original transcription layout. She commented:

> *I'm like confused about it all at the moment*
> *Whenever someone asks me what I want to do when I'm older*
> *Every time there's a different response*
> *One minute I wanna do child care*
> *Nother time I wanna do hairdressing*
> *And then I said I wanned to be a counsellor as well*
> (lines 188-197)

The therapist identified the need to support her with this uncertainty:

> *So I suppose one of the agendas for us to think about is how to help you find a way (.) you know to (.) maybe become clearer about what you would like to do? You know a sense of your direction for the future.*
> (lines 199-201).

May's introduction to psychotherapy has arisen at a developmentally-critical stage – the adolescent journey towards adulthood. In session twelve, she and the therapist reflected together on how the therapy came at a much-needed time:

> *May: I've always been (.) quite sensitive*
> *Therapist: ((Quietly)) Yeah*
> *May: But just it's kind of like a process of (.) gettin stronger as I get older*
> *Therapist: ((in overlap)) Yees! Yes I think so yes (.) an I think the work here is probably helped*
> *May: ((in overlap)) Yeah definitely yeah!*
> *Therapist: ((in overlap)) you as well yees yes (.) probly timely....*
> (lines 80-86)

Whilst in their session her parents described May pushing boundaries and keen to engage in typically adolescent pursuits such as going to parties where there will be boys and alcohol, May described feeling upset at night and wanting her parents to sit with her until she went to sleep (lines 734-735). When the therapist reflected, 'You felt you needed looking after like a little (.) child' (line 748), I think she identified the conflict that May found herself in – torn between the desire for her own freedom and the fear and pain of the loss of childhood.

As described, in the first session the main protagonists were May's sister and niece. Little time was given to talking about her relationship with her parents. Given her age, it might be expected that friends would bear a more significant role in her narrative. However, by the tenth session, friends did play a more prominent role. Her relationship with her mother also featured more. The possible reasons for this change will be discussed in the following section.

Narrative themes and stories: Where does the story begin?

After May's mother left the room, the therapist worked sensitively to make May feel comfortable, and she quickly picked up on facts such as May being young in the school year. Perhaps it was the therapist's warmth and close attention or, perhaps,

the absence of her mother that enabled May to feel more comfortable and she quickly identified something problematic:

> *… I stress myself over exams and that like I always end up getting ill around exams.*
> (lines 150-151)

Whilst May identified an area of her life that she found stressful, it soon became apparent that there was something even more difficult to manage – she had witnessed a domestic assault on her adult sister and might have to testify in court. When the therapist asked her if the thought of going to court was also causing her stress, May acknowledged she had tried not to think about it:

> *… I haven't really been thinking about it because I know that if I was to think about it, I'd like it would be worse than stressing out over exams.*
> (lines 319-320)

There was a sense that talking or thinking about this could stir up very strong and overwhelming feelings at risk of becoming uncontainable. We might question this as being counter to the premise of psychotherapy and wonder how this will be navigated in the work. Initially, the therapist accepted May's statement to indicate that she had successfully put this incident out of her mind, but she soon recognised this not to be the case:

> *Therapist: ((in overlap)) Yes so you've put it all to one side*
> *May: ((in overlap)) Yeah*
> *Therapist: Which is appropriate and it's good that you can you know know that it's not popping into the front of your mind all the time because you do really need to concentrate for your exams and it sounds like by and large you've been able to do that*
> *May: Like (.) I can push the court to one side but then when I'll just be just sitting there and all of a sudden I'll get flashbacks to when it happened*
> *Therapist: ((in overlap)) I see so I'm actually wrong there because it does just keep popping to the front of your mind*

May: Yeah
Therapist: And interrupting with your concentration.
(lines 325-333)

May's attempt to manage this traumatic experience, by not thinking about it, clearly had not worked. It is important to remember that this was her first psychotherapy session. As such, perhaps she began by speaking about exam-stress because she was not yet comfortable with the therapist. Exam-stress may have felt like a safer topic than diving straight into talking about an extremely traumatic experience. In this way, May can be seen as a 'defended subject' (Hollway and Jefferson, 2013, p.31 who utilises 'comfortable, well-rehearsed generalisations' (ibid) to ascertain whether the therapist can be trusted or to protect herself from feelings of distress. However, it was interesting to compare May's narrative around the domestic violence with that of her parents. In their session, which came three months later, they tended to focus on external details; for example, how their older daughter's ex-partner repeatedly adjourned the court case and was 'playin' for time' (line 300). They described how their older daughter and children were living in temporary accommodation and were, in effect, doubly ill-treated, firstly by the ex-partner and secondly by the state. Their narrative tended to focus on the exterior rather than the interior. By this I mean that they did not reflect directly on their own emotional response to the situation. They also spoke quickly, often interrupting each other so there were no breaks in dialogue. This appeared to eliminate opportunity for reflection. The parent worker spoke very little and her attempts to gather up and make sense of the material seemed to go unnoticed as the couple doggedly followed their own track:

Mother: Um down there when you think aboud it social services might of (.) actually had someink to do with that becus they might of thought well no she's fleed that flat if he's given it up an she's gonna move back in there (.) then that means I can go round an arrass er
Therapist: So they might have thought
Mother: ((in overlap)) So yeah
Father: ((in overlap)) An Jamie's[5]

[5] 'Jamie' is used as a pseudonym to refer to the parent's grandson.

Therapist: ((in overlap)) it was dangerous for her
Father: ((in overlap)) schools all good cos he's got all gold awards for the attendance and everything
Mother: Yeah oh yeah
(lines 619-629)

I wondered if their tendency to fill the silence rose out of a fear that allowing space for reflection would risk painful, disturbing feelings overwhelming them. I also wondered about the fact that there was lengthy discussion about their daughter's abusive ex-partner and the effect on their grandson, but there was no discussion of the fact that this abuse occurred for nine years without their knowledge:

Mother: But at the end of the day she was too scared to do anything we knew nothink about it
Therapist: Mmm
Mother: But you know she was so rude she said 'No the tenancy's ended'
(lines 387-390)

Here May's mother briefly acknowledged her older daughter's fear but, without any explanation, switched to talk about the council employee who told her daughter that she could not return to her home. Perhaps she switched to talk about the tenancy agreement because it was too painful to stay with thinking about their daughter's suffering or the fact that they had not known anything about the situation. This might indicate a way of trying to avoid painful feeling comparable to May's description of how she tried not to think about the court case.

May's mother continued to mention that May had been called as a witness. In a similar way to how she skirted around her older daughter's terror, she briefly wondered if May's mood swings were related to what had happened:

Mother: You know ((inaudible)) it's just all these mood swings (.) you don't know whether the mood swings are from (.) her being (.) being told no you can't do this or the mood swings from what's happened whether it's all
Therapist: Hmm with the family or the whole family situation
Mother: Yeah

Therapist: That was quite difficult
Mother: Yeah so
Therapist: Yeah (.) How so what is the family situation like at the moment with the court
Father: ((in overlap)) No ((inaudible)) he adjourned it
Mother: ((in overlap)) He adjourned it
(lines 268-271)

From this point onwards, the parents did not discuss anything more to do with how witnessing domestic violence may have impacted May. Though May described trying not to think about this experience, she did spend much of the first and tenth session talking about it. Therefore, in the sessions analysed, there was a contrast between how much time May and her parents spent discussing the emotional impact on May of witnessing domestic violence. Without access to further session-recordings, we cannot know if May's parents spent more time in other sessions discussing how witnessing this abuse might have affected her. I was left wondering if this also felt too painful to spend much time thinking about.

Who am I?

May was confused about what she wanted for herself in the future and what triggered her to feel as she did. This dilemma might be considered normal during this developmental stage when adolescents are typically engaged in a quest of discovery. However, as I heard more about May's difficulties, I learnt that her uncertainty was more complex. This became a little clearer as the first session progressed and she described anxiety about her father dying. She worried about this possibility following the death (by cancer) of her father's brother. She told the therapist:

… everyone says that ((pause)) that they see him in my dad and like it is they are the spitting image of each other.
(lines 640-641)

The therapist replied:

Oh I see so maybe there's a whole question about you know when people are really close (.) um you know in what sense are they like each other and is there a bit of (.) the person in the other person (.) um you know how can you be a separate person? Or are you sort of like so close to other family members that actually you are almost the same as them?
(lines 642-646)

The therapist's response appeared to strike a chord with May who replied, 'That's like me and my niece' (line 647). In this first session, the therapist identified an issue which appeared as a forerunner to a major theme of the psychotherapy as a whole – the sense in which May struggled with key aspects of what makes a person an individual and how people can be close yet separate and unique. In the rest of the session, this theme opened out further as May continued to describe her relationship with her niece:

May: … it's just like we're inseparable
Therapist: ((in overlap)) Hmm
May: And that's really nice for both of us
Therapist: ((in overlap)) Yees yes your niece is the other one that's giving evidence
May: Yeah
Therapist: Yeah are you roughly the same age?
May: Ah yeah she's thirteen I'm fourteen
Therapist: ((in overlap)) I see yes yeah that is obviously really nice to be close and feel that you're really close and that you can share something with someone really
May: ((in overlap)) Yeah
Therapist: ((in overlap)) very well but then (.) I spose the downside is there is a feeling of like where are the boundaries of what's me and what's somebody else do you know what I mean? ((laughs))
May: Yeah
Therapist: It's like (.) are those my problems or are they somebody else's problems and it kind of gets a bit

May: ((in overlap)) Yeah
Therapist: ((in overlap)) confused …
(lines 666-683)

Though May described how nice it was that she and her niece were 'inseparable', she appeared to identify with much of what the therapist said, and went on to explain how she could feel troubled and angered by the way her niece copied her style and hobbies:

Once she dyed her hair the exact same colour as mine
That really did like make me angry and upset
Because we're both individual people
I just felt like she was copying my every move
(lines 690-694)

May appeared to feel suffocated by her cousin's attempts to imitate her, and, as the therapist suggested, was confused about separateness and individuality. In Session Ten, this continued as a strong theme:

… I had a argument with her about (.) like doin' things that I'm doing an like basically like copying everything I do and it started off as a argument but then it started like into like well a big emotional conversation like I explained to her that I don't feel like I can be like my erm own unique individual person and that it doesn't feel like I'm me anymore becus of like the fact that she's doing everything that I'm doing.
(lines 149-154)

She repeated this point later in the session: 'I just feel like when she's doing everything that I'm doing it just feels like I'm not (.) myself?' (lines 280-283). May appeared to feel that her individuality could be drained away from her – that her niece, by imitating her, could rob her of her individualism as if individual characteristics were concrete, finite resources. It appeared that, in her mind, the boundary between self and other was nebulous and could easily be transgressed or destroyed. Given May's confusion about self and identity, I was struck by certain

characteristics of her parents' speech. Often, they repeated the words of the other, for example:

Mother: I know umm yeah cos we wen away on holiday
Father: ((in overlap)) Holiday
(lines 4-5)

And again:

Father: Yeah but I said this when we was on 'oliday all the young girls down there
Mother: Yeah!
Father: ((in overlap)) With babies
Mother: ((in overlap)) With babies
(lines 825-828)

Sometimes they spoke in unison, for example:

Mother: She had to have five days off (.) but she had them on the Saturday so she had um bout ten days off really
Father: Saturday Sunday Monday Tuesday Wednesday Thursday Friday
Mother: ((in overlap)) Yeah
Father: ((in unison)) Saturday Sunday
Mother: ((in unison)) Saturday Sunday
Father: Bout nine days
Mother: Bout nine days yeah so she went back to school on Monday
(lines 21-28)

May's parents' words often overlapped, leaving no space between each other's words. The way they parroted each other or spoke in unison lead to an impression of them operating almost like a conjoined unit. I wondered if, as individuals, they felt ill-equipped to assert their viewpoint and to counteract this experienced deficit they evolved to a symbiotic co-dependence. However, at other times they talked as if the other had no bearing on their thought process or decision making at all. For example, May's father described the decision to forbid their daughter to go to a

sleepover party as *his* decision, claiming, '*I* refused her' (line 91) and, '*I'm* protecting her' (line 118). This seemed inconsistent with the fact that both parents had spent much of the session talking about this decision and concurred unanimously. Similarly, May's mother claimed this decision was based on her morals: '…. that's my morals (.) she's fifteen years old I'm not having her sleeping (.) you know what other parents do' (lines 102-103).

Overall, their way of talking conveyed a sense in which they either appeared to act as one, as if merged or, conversely, they spoke as if separate and detached from each other. In these moments they used the pronoun 'I' rather than 'we'. The way they appeared either merged or completely detached was particularly striking given May's uncertainty regarding identity and the way she appeared to feel that others could steal her individualism. Both the parents' manner of talking and May's preoccupation with her identity being stolen, suggest that identity was not a robust concept for either May or her parents. The therapist's reflection in the first session, '… where are the boundaries of what's me and what's somebody else' seemed equally pertinent to May and her parents. As part of the task of adolescence is to become independent and develop a stronger sense of identity, this was an area that May needed support with, and was identified by her therapist as a focus for the therapy:

> *… I think that's a very important area and maybe quite relevant to why you get low and um um I think that could be an important theme really for for the work is how to help you be your own person you know (.) very friendly and very warm and close to other people fine you know but (.) yourself …*
> (lines 709-713)

Fear of the future

Running alongside the theme of identity was the theme of fear of the future. In Session One, May described feeling unsure of what to do in the future and how sometimes she wished to be treated like a small child. By the tenth session, she was more explicit about how feelings related to her future sometimes overwhelmed her:

May: … this sounds so stup- but it's like I see it as in like a really big ((inaudible)) and then a big scary monster at the end of it like as in my future and just
Therapist: ((in overlap)) Say that again that a little toddle?
May: In like a little tunnel
Therapist: Oh a tunnel! Sorry yeah
May: And like a big a big monster at the end of it being my future an it's like (.) I want I want to (.) like I'd I'd like in this sense I don't wanna rush into my future like only if it could slow down an stop for a little while
(lines 360-368)

Once more she described a wish for time to slow down or 'stop for a little while'. Added to this is the terrifying phantasy that her future involves her navigating through a tunnel with no escape from a monster at the end. When I turned my attention back to her parent's narrative, I observed how a major theme for them was danger. Significantly, both parents concurred that the outside world was fraught with danger. Pertinently, May's mother identified, 'the streets ain't safe' (line 749) and her father backed this up when he described his anxiety about May going out:

Father: If she ain' in at half past nine (.) start panicking
Therapist: Hmm hmm (.) You start panicking?
Father: Oh I would do yeah
(lines 759-761)

The parents identified the external world as the root cause of most things undesirable and dangerous. There was also a strong communication that a chain of negative events potentially leads on from each other, taking young people further and further off track:

Mother: … but you know at the moment it's you get into the drink an then it's the smokin' (.) the smoking's not too bad but (.) well it is it's just as bad but umm it's then the drugs come along (.)
(lines 917-919)

May's mother used her friend's son's addiction and mental health struggle as a further example of potential dangers:

> *… he went down it you know that kind of path (.) started drinkin' then got in with a load of mates then it went to the drugs (.) you know we saw him like nearly kill himself.*
> (lines 925-927)

Following this, she stated, 'I don't want May going down that route' (lines 937-938). Whilst common for parents of adolescents to be anxious about their children's ability to safely traverse the rocky period of adolescence, we might consider May's parents' anxieties more heightened than the average parent. May's mother emphasised her point by drawing on a biblical reference to call alcohol 'the root of all evil' (line 801). She used the words 'path' and 'route' to indicate how one thing leads on from another with alcohol identified as the initiator to this chain reaction. Her language did not reflect any sense in which she believed May could have developed her own sense of agency or internal resources to choose her own path. Added to this, both parents identified May as easily 'led' (line 872).

May's parents' lack of confidence in her capacity to form her own decisions was paralleled in her uncertainty about herself. This was apparent in Session Ten when the therapist encouraged her to 'believe' in herself and she acknowledged, 'I need to start doing that' (lines 638-639). In a further parallel, May's reference to a terrifying monster at the end of the tunnel, suggested she feared that moving forwards inevitably implied moving towards danger with no possible escape. This echoed her mother's concern that she would be easily 'led' down the wrong 'path' or 'route'. We might wonder how much influence her parents' lack of confidence, combined with their communication that the outside world is fraught with danger, had on her sense of identity, belief in self, and ability to conceive of being able to manage as an adult.

Given their older daughter and grandchildren endured domestic violence for nine years, I was interested in how the couple appeared to exclusively locate danger in the external world. I wondered if they found it more comfortable to locate danger

outside rather than to acknowledge that sometimes danger is closer to home. This external focus again paralleled May's attempt to focus on exam-stress rather than think about the trauma of witnessing domestic abuse. By May's tenth session, she and her therapist identified that therapy had come at a time-critical point, offering a crucial space to explore her emotional response to this and other events in her life. Perhaps, equally, the offer of parent sessions came at a critical point for the parents who could be supported to explore the complex task that parents of adolescents face – how to communicate realistic risks whilst not overemphasising the dangers and inadvertently provoking terror in the adolescent. This appeared to be important work because the parents' anxiety appears to have contributed to May's deep-seated fear of the future. Helpfully, May's therapist maintained a strong narrative thread, identifying the dual aspects of adolescence – acknowledgement of development alongside ongoing need for support:

> *… you know you're not a baby anymore but it's a long way off being really thoroughly grown-up … So it is a tricky time and you still need some support.*
> (lines 353-356)

We see the full impact of the therapist's message when her words are presented in stanza form:

> *There's something scary*
> *Kind of horrible*
> *Going through the tunnel*
> *You'd like to get to the end*
> *But there might be something worse*
> *So you need some support*
> *To find your way to something lighter*
> *A feeling of more space*
> *Cos that tunnel doesn't sound*
> *Too nice a place either*
> (lines 383-392)

The therapist showed that she understood what May communicated to her. In this way, she tapped into the ongoing importance for adolescents to feel connected to others and to know they don't have to manage the powerful array of emotions alone. By the tenth session, the experience of connectedness within therapy appeared mirrored in a development in her relationship with her parents: May identified her mother as somebody she could now speak to. She was also in touch with her parents' affection and pride. This was movingly expressed when she described nervously accepting a school award:

> *I walked on stage*
> *And then*
> *Unexpectedly I see my parents*
> *Sitting in the middle of the hall and I'm like*
> *Wow!*
> *They were really proud of me*
> *I wanted to cry*
> (lines 604-609)

Without additional session data, it is not possible to be certain of the origin of this change. It is possible that May's experience of feeling connected within her therapy enabled her to feel better connected with her parents and to perceive a positive aspect to her relationship with them. It may also be that her parents' sessions had supported them to understand and connect with May but, again, this cannot be confirmed without additional data.

Gathering the thread: Development

During May's tenth session, she identified that her mind often went 'blank' (line 293). Her therapist reflected '… sometimes you do lose the thread a bit' (line 301). They continued to explore this further and May recounted how she had been receiving extra maths tuition which had a big impact on her ability to understand the topic:

> *Therapist: Yes and I spose (.) maths umm is a bit like sorting out the logic isn't it*
> *May: Yeah*

> *Therapist: And sometimes you have been quite muddly so maybe the work that we do here to help kind of be a bit clearer might help you have more of a head for maths*
> (lines 515-519)

May agreed with this and continued to describe how she was inspired by a speech heard at school about how ‘you're not born with a special talent it's like practice makes perfect’ (lines 531-532). Here, May identified how nothing is set in stone – change is possible. Contrary to her previous belief – ‘I don't get maths it just it's not something I can do’ (line 538) – she realised that, with the right support, she could understand. As the therapist suggested, from a psychoanalytic perspective, we can also interpret this as a reference to the way in which her therapy had supported her to believe in her ability to develop and begin to make sense of her emotional life. Whilst still sometimes losing the ‘thread’, she expressed her appreciation of the therapeutic work and the fact that together with her therapist, she was supported to ‘steer a path through the muddle’ (line 564) and begin to learn to thread together the disparate events of her life into a more coherent narrative.

Chloe

Chloe was 13 years, 1-month-old at baseline. She identified as white, female. She rated herself as ‘No’ for ‘family medical or mental health problems’ which was interesting as she talked in her sessions about how her mother suffered from both physical and mental-health difficulties during much of Chloe’s life. She lived alone with her mother but had two older brothers. It was identified in her initial therapy session that she had a school counsellor who she did not want to give up working with. For the purpose of confidentiality, I use X to refer to the name of the country that Chloe and her mother moved to, Z to refer to the city where they lived in the UK, and F to refer to Chloe’s father.

Main protagonists and significant turning points

In Chloe's first session, the main characters appeared to be herself, her father, two friends and a girl shunned from her friendship group. Chloe's mother and a collective group of 'gossiping' women appeared as secondary characters. Chloe presented a vivid picture of her father as a villainous character. She used descriptive language, giving many examples of negative characteristics to emphasise her point. In the Parent Session, her mother also spent time describing Chloe's father – how he let them down by not supporting them financially and how he lied to Chloe. As will be described further, by Session Seven, the focus shifted to Chloe's mother. Significant events and turning points included a move to and from another country, multiple incidents of family dispute, the loss of a pet, bullying, and arguing between peers. Chloe also described unsafe living circumstances and multiple moves to seek safety. Alongside this disturbance, she described having to care for her mother who was often unpredictable and angry.

Narrative themes and stories: Where does the story begin?

In the first session, I was immediately struck by the fact that Chloe spoke first, asking in a clear voice, 'Where shall I sit?' (line 1). Her assertive tone, however, was immediately countered by a nervous laugh:

> *Therapist: … How are things?*
> *Chloe: Bad (.) ((Nervous laugh)) I don't really know what to say*
> (lines 3-4)

She continued to describe that her lateness to the session was because she could not get on the bus as police were controlling the number of passengers permitted. She thought the reason for this was because it was Halloween and busier than usual. As the researcher listening in, various connotations arose in my mind from my personal familiarity with this festival. I found myself thinking of 'trick or treaters' in ghoulish costumes traipsing through the dark streets. I found that my mind, in linking Halloween with the police attempts to control public transport, left me with the impression of a tense atmosphere which might turn sour. At this point in the analysis, I did not know that my feeling would reflect Chloe's experience when, much later,

she described relationships in which she was forever uncertain of her position – unable to predict the other's changeable moods and regular outbursts of rage.

Early into the first session, the therapist identified that they were meeting in a different room from that of their initial meeting. Her observation indicated that she attributed meaning to the change of room and, as the therapy progressed, moving was seen to be a central theme in the therapy. The therapist linked the change of room with the multiple moves that Chloe mentioned in the initial meeting, and Chloe acknowledged how unsettling she found the experience:

> *Chloe: I've changed school umm six times an I've moved house ((Pause)) seven times? I've moved quite a bit*
> *Therapist: ((In overlap)) Mm*
> *Chloe: An it's jus' whenever I finally get like whenever I like settle down into one place it's like 'Oh we've got to move again'*
> (lines 200-204)

The therapist's linking of change of clinic-room with Chloe's experience of multiple moves tapped into a potential transference-communication related to how Chloe may anticipate the therapy progressing. When the therapist asked Chloe what she made of the different CAMHS[6] rooms, Chloe described each room as having a doll's house and baby doll. As if in touch with a younger part of herself, she said: '… just crosses your mind like who plays with it an' stuff' (lines 46-47). This feeling was compounded when seeing the doll triggered her to remember first seeing her father in supervised contact. She recounted how she would play with the dolls while she waited for him. He was always late. As if the dolls and the different rooms transported her to a recollection of times past, the story started to unfurl as she recounted her experience of her father. She used a plethora of adjectives including 'creepy', 'weird' (line 62) 'freaky', and 'scary' (line 64), to introduce him to the therapist, thus adding weight to her comment, 'I don't really like my dad like he doesn't feel like my dad he just feels like this (.) anonymous person who I don't even know' (lines 61-62). Re-presented in stanza format, it is easy to identify with how she may have felt as a small child:

[6] Child and Adolescent Mental Health Service

As soon as I saw 'im
I saw his face
I remember the expression and everything
An' then as soon as I
Walked up to 'im
An' just said 'Oh hi'
It was like the first time I'd seen 'im
That I could remember
Yeah I walked up to 'im
An I just said 'Hi'
He literally just got me
An' squeezed me
Which really freaked me out
It was like 'I don't even know you'.
(lines 95-100)

Though talking about supervised contact, the way Chloe described the scene gave a sense of her being alone with her father, scared and overwhelmed by the way he took hold of her without her permission. She repeated the fact that she did not know him – he was like an 'anonymous person'. The concept of the anonymous and potentially disturbing other was raised again when she directly referred to who might be listening to the audio-recordings:

… it's just the fact that someone else could you just like listen to it as well it's kind of (.) freaked me out a bit.
(lines 149-150)

As described, Dallos and Vetere's (2005) suggestion for narrative analysis steps encourage the researcher to: 'Reflectively note how you may be making connections with your own experience, how you have become aware of feelings and images as you read the story' (p.70). At the point of Chloe's direct reference to someone listening to the session-recording, I felt acutely aware of my actions and the ethics of listening. Making use of the psychoanalytic concept of counter-transference, I was

able to register how uncomfortable I felt. Later in the process of transcribing and analysing all three sessions, I would look back to this moment and recognise that it heralded an extremely significant theme – Chloe and her mother's perception that words are often used to harm or coerce. My mind was stirred to think of how *I* would make use of Chloe's words in my doctoral thesis. In the session, the therapist took this up as a possible transference communication which may communicate how, in the context of this very early stage of therapy, this uncertainty might also refer to sharing information with her.

When I analysed the Parent Session, I observed that Chloe's mother spent much of the first part of her session talking about Chloe's father – describing his faults in detail. There were large chunks of speech with very few pauses[7] leaving little space for the therapist to add her thoughts. Chloe's mother described how she had attempted to reunite Chloe with her father because she worried that, should she become seriously ill or die, Chloe would be left alone and helpless. The parent worker expressed surprise that Chloe's father still had parental responsibility. Given the lengths Chloe's mother had gone to describe the deficits of her ex-husband, there seemed to be something incongruous about her attempt to reunite father and daughter. This incongruence was made more explicit when she said:

[7]For example:
Mother: Yeah but you know the court order says supervised contact although we were able to move that forward um and I just as much as I don't even want to be on my own with the man and sit with him in a public place I just felt that maybe that's what we had to do to see if we could try and move it forward a bit because he he he's got a terrible habit of forgetting what he's said and fo before I went to X he'd phone and wanted to know if I could get him a PO box address which I said OK to and din't realise how convoluted it was in terms of it's not organised at the post office I have to go to the sorting office so I said that was something I was going to do when I felt well enough cos I (.) didn't feel well at the time and um I'd said to him 'You know (.) what about you and Chloe' I said to him 'You don't phone or you don't email or' and he said to me 'Um well that's because she's doing what you want her to do' so again he blamed me and I I kept saying I said to him 'Look you know this isn't about what I want this is about your relationship with Chloe' 'Yes but she repeats what you you tell her' and I said 'That isn't the case F, the fact that contact has come to where it is is because I was always supportive of it' I said to him so I said to him 'The issue now is the fact that it's you and the way you behave with your daughter that's stopping your relationship' an he said to me 'No it isn't' an I I felt that we were going in aroun it was just I was beating my head against a brick wall an I said to him 'Look it's you who's said that you wouldn't speak to her unless she apologised to you' and he totally denied that he turned round an said 'No I never! I haven't said any such thing it's you she's she's writing to she wrote to me based on what you were saying' an I said 'She was angry with you because you lied to her' an he carried on denying it an in the end I said 'Look I'm not gonna have this conversation anymore it's (.) doing my head in' an I said 'I'm putting the phone down' an I put the phone down which is why I rarely speak to him because even the judge couldn't even get him to speak directly in the court room so it's not as if it's anything new so in X I thought you know we've got to move forward with this.
(lines 136-162)

> *… as much as I don't even want to be on my own with the man and sit with him in a public place I just felt that maybe that's what we had to do to see if we could try and move it forward a bit.*
> (lines 137-139)

Her subsequent reflection, '… it's almost like a massive burden on me to try and move it forward if indeed it should go forward' (lines 210-211) suggested she felt uncertain about the right path forwards. When the therapist questioned whether Chloe wanted a relationship with her father, the mother replied:

> *Not anymore because she's very angry at the way that he lied to her and how he left us in the lurch last year when we were in X and I wasn't working and he didn't send over the money he said he was going to send over so that's what made her very angry.*
> (lines 223-226)

From a psychoanalytic perspective, we might question how Chloe's mother's attitude towards the father has coloured Chloe's view. Perhaps her description of Chloe's anger was a projection of her own feelings. This possibility was partly considered by Chloe's mother:

> *… she's disappointed and you know sometimes I look back and I think could I have maybe hidden the fact that he wasn't sending the money or whatever but how could I have because we were relying on that for her dental treatment and her school and whatever else so she's disappointed with him she was protective of me she was worried about what was going to happen to us and within all that this whole thing about him lying to her anyway.*
> (lines 228-233)

Chloe's mother considered that knowing certain details about her father was likely to affect how Chloe felt about him. In this session, however, she did not seem to reflect on how her own *feelings* about Chloe's father might be transmitted to Chloe.

Chronicles

… I struggle with telling the story…
(Session One, line 475)

When I moved past the initial discussion about Chloe's father in the first session, I was struck by how hard it was to identify further stories in which Chloe elaborated in detail on a specific event. Her difficulty in telling stories about her life was illustrated when she attempted to describe a situation where she and her friends ostracised another girl. At first, Chloe suggested that the girl was ostracised because she was mean and gossiped about the group, even inciting boys to bully her. However, during the session, Chloe spent time considering who was to blame and wondered if it was necessary to exclude the girl. As she attempted to describe the girl's abusive and unhappy family background, she acknowledged, '… I struggle with telling the story…' (line 475). Whilst her words related to this particular situation, the general scarcity of stories in this session suggested that narrating experience in the form of a story might be challenging for her. In the place of stories, there were what McLeod and Balamoutsou (2001) describe as 'chronicles':

> *... a listing of events … A chronicle is similar to a story in that it supplies information about a specific event sequence rather than a generalised class of events, but it lacks agency, dramatic tension or moral evaluation. Stories are important categories of narrative event from an experiential psychotherapy perspective, because it is through the story that the therapist can gain the most immediate and direct entry into the experiential world of the person.*
> (p.136)

The following example of Chloe describing events in the form of a chronicle rather than a story is taken from her description of living in a different country:

> *... when we moved from our first house like cos (.) my first flat my first house was actually a flat (.) we were stayin there then we moved to a house an then that was Z an it was like oh it's not safe here so we had to move back to our old flat again an then we moved to X (.) an then when we were in a house*

((inaudible)) we moved to another house an then we moved to another flat an then we came back here then we moved to another house no a flat actually.
(Session One, lines 207-214)

Her description of having to leave her dog when she returned to the UK offered a further example of chronicling:

Oh first she was with the (.) vet like cos me and the vet were really close umm like I used to do voluntary work there an then (.) she was at the vet and then she went to to the vet's dad and she went back to the vet an' then she went ta the vet's cousin an' then she went to these other people who she didn't even know so she's moved quite a lot as well
(Session One, lines 241-245)

In a way that echoed her own moves, Chloe recounted a list of moves that her dog made. The account felt superficial and I observed how little emotion was stirred in me. Greater depth, which might be communicated through more elaborate description of feeling or atmosphere, was lacking. I was motivated to consider how a disrupted life, with many moves and broken attachments, might affect someone's ability to form a coherent narrative: the scarcity of stories might result from, and reflect, her experience. A story can be defined as having a clear beginning, middle, and end. Perhaps her tendency to present her experience in the form of chronicles, rather than stories, reflected her experience of life as chaotic: she had little experience of difficulties being resolved (the story's end). In addition, if 'it is through the story that the therapist gains the most immediate and direct entry into the experiential world of the person' (ibid), perhaps, at this early stage of the work, Chloe's reticence to expand on personal information – with, not only a new therapist, but also an unidentified listener/listeners via the audio-recording – inhibited her desire to present her experience as a story. Whether conscious or not, the deficiency of stories may be seen as a self-protective function intended to keep others at a distance. This was in keeping with her assertion:

Loads of people that I've trust before
Have just gone an' thrown it back in my face

So I've put a barrier up
So I can't trust
It takes me a few times for me to see them
Before I can actually properly trust them
(lines 158-163)

I wondered about the impact of trauma on Chloe's ability to communicate her experience in the form of a coherent story. At this point in my analysis, an initial reading of the material offered two possibilities. Firstly, she may not have been equipped with the internal resources to turn personal events into stories – to hold in mind, reflect on, and thread events into a coherent narrative. If her experience of broken and chaotic attachments began in infancy, she would be traumatised, but she would also have missed out on fundamental aspects of development – what Music (2019) calls 'building blocks' (p.10). Lacking this developmental foundation may have left her at huge disadvantage, with a reduced capacity to perform the cognitive dexterity necessary to tell stories about her life**.** A second possibility could be that she did not yet feel comfortable with the new therapist and, to protect herself, narrated life events in the form of chronicles to avoid closer exploration or scrutiny.

As I considered the material, I noticed how hard it was for me to make sense of it. My own thought processes appeared to reflect something of its chaotic nature. I recognised that my questions about the dearth of stories would have to wait until I familiarised myself with material from the later session. When I turned to session seven, the first thing I noticed was a dramatic increase in stories. This led me to consider two possibilities. Firstly, the reason for the dearth of stories in the first session was not due to an impoverished internal world or the effects of trauma but was more likely linked to a protective mechanism in the context of a first session. Or, secondly, by Session Seven, the process of psychotherapy had supported Chloe to begin to develop a different way of looking at and threading experience together. In the latter case, we might consider this a real development due to a process of co-construction occurring with the therapist. This will be explored further. First, I would like to look more closely at what the concept of story and the power of words appeared to mean to Chloe.

Story as propaganda

In Chloe's first session, she quickly raised the concept of story as problematic when she described how her father manipulated the truth. She said, '… he could like tell me different things an' jus' make up a story' (line 68). Here, she highlighted the complexity of what a story is, referring directly to how stories can be used as propaganda – in this case to 'get me to go against my mum' (lines 68-69). In Chloe's view, stories appeared to be used for coercion – to get somebody 'on side'. When the therapist asked if her father's tactic worked, Chloe replied that it put questions into her mind which her mum then refuted saying, 'sometimes it weren't true or that he twist the truth or it was the other way round' (lines 72-73). This left Chloe at a loss to know who could be trusted: 'it was just like (.) dint know who to believe' (lines 73-74). In Session Seven, whilst discussing arguments with her mother, she extended her sense, that a person's words cannot be believed, to her interaction with her therapist – she believed that her therapist would feel similarly:

> *Until you hear both sides of the story*
> *Then there is no side taking*
> *Becos you only see me*
> *I don't think that you do pick sides*
> (lines 543-545)

During the two sessions analysed, Chloe described her family as fraught with tension, where side-taking often appeared almost compulsory. This side-taking was also apparent in her mother's account when she described her family ganging up on, and excluding, her. In Chloe's session, the therapist questioned how this side-taking might be experienced within the therapy. Chloe's response exemplified her deep mistrust of words and her wish for something which she felt as more dependable:

> *Therapist: But you think if I heard a kind of recording of (.) you and your mum in an where an argument is getting stirred up I would very much be on your side*

Chloe: Yeah pretty much ((Laughs)) But that's only cos I had proof I don't really have proof I jus' come here with words (.) which sometimes ((Laughs)) don't help …
(Session Seven, lines 548-551)

For Chloe, words can wreak havoc, but they can also be quite useless in the face of adversity. It was quite striking that, in the Parent Session, her mother also specifically referred to the destructive power of words when she described how her son could be 'vicious in his words' (line 604). She also described how her mother (Chloe's Grandmother) used words to manipulate and coerce others to talk on her behalf: '… my mother manipulates my eldest son as well so a lot of the words that were in the email to me were from my mother' (lines 688-689). The idea that one person can be manipulated to speak another's words was also apparent in the relationship between Chloe's parents: Chloe's mother reported that her ex-husband claimed that Chloe, '… repeats what you you tell her' (lines 147-149). Overall, it appeared that, in this family culture, there was general mistrust of what people say and, indeed, whether their words belonged to them or were actually another person's rhetoric.

Gossip

Words were also perceived to be used by groups to gossip about individuals. There were multiple references to gossip in Chloe's account; for example, when she described how the women of the community would gossip:

It's just gossip
Literally there's no caring whatsoever
It's almost like 'Did you see what she was wearing?'
'Did you see the way she was behaving?'
'Oh my god have you have you seen her?!'
They just gossip
Plain and simple
Just gossip
There's no care in it whatsoever

(Session One, lines 307-311)

When the therapist asked Chloe if she felt gossiped about, she replied, ‘Yeah! I don't care though (.) it's like people would always talk about me and I'd just be like “Yeah and what!”’ (lines 313-314). However, by Session Seven, she disclosed more about how she really felt, describing how she felt scarred by insults and anxious thinking about what people may say about her:

She got these two boys to constantly be on my case
They'd always take the mic out of me
That has kind of scarred me
Now whenever I go ((inaudible)) or whenever I'm at school
I always think ‘Oh what if this certain person says that about me?’
I'm always like worrying about what people think about me
I know that's not really important
I don't really care
I know I don't care
but
I do
I jus’ wish I didn't
But I can't not think about it
It's always in the back of my mind
‘What if this girl or what if this boy says this?’
(lines 443-451)

In a further parallel, illustrating how areas of Chloe and her mother’s narratives overlap, her mother also referred to people talking about her:

… they'd all been talking about me and how the you know I always expected them to (.) be there for me and that I had errrrr I always claimed that I had no money and errr (.) all sorts of (.) anger.
(lines 387-389)

And again:

But that's not been said directly it's what I've heard through the grapevine.
(line 702)

Words that provoke thought

At the end of Session One, Chloe and her therapist discussed how boys bullied her and told her that she had a ‘fat chin’ (line 558):

I don't even know if I have or not ((Laughs)) but (.) I think I have an’ it's just that if they had never said that to me I would never have thought it.
(lines 561-562)

The therapist reflected that Chloe might worry that she might similarly put words into her head. This appeared to resonate with Chloe:

Therapist: The idea that I could put thoughts in your head or say things that make you (.)
Chloe: That make me actually think about it and make me think a different way about (.) something that has happened …
(Session One, lines 573-575)

It would seem that, by Session Seven, Chloe had begun to ‘think a different way’ – whilst the emphasis in Session One had been on her scary, unpredictable father, by Session Seven the focus went quickly to her mother:

The only reason why it was scary
Was cos she'd take all her anger out on me
I wouldn't actually do anything
She'll ask me to do something for her and I'd go and get it
If it was in the slightest way wrong or not enough
She'd scream and shout at me and she'd throw stuff
She'd literally have this whole burst of anger

When I hadn't even done anything wrong
I didn't say anything to her
I was scared of her
I didn't say anything to her for five years
(lines 96-102)

Chloe began to use her therapy to re-examine her relationship with her mother. The sessions analysed suggest that she may have been able to integrate more and move away from a binary split where her father represented bad and her mother good. By this point, she was able to reflect on how her relationship with her mother was also difficult.

Contrasting stories

In my analysis of the material, I followed the suggestion of Dallos and Vetere (2005) to explore the semantic meaning of the data; specifically, to note 'whether the events make sense or whether there are clear contradictions in how events or people are described' (p.70). As Chloe appeared to question and think about her experiences, she was more able to communicate her anger towards her mother. It was interesting to observe clear contradictions between the accounts of Chloe and her mother; for example, there was a contradiction in their accounts of plans for Christmas. In the Parent Session, Chloe's mother described animosity between her extended family and herself. Therefore, she claimed, '… I said to Chloe 'Look you know there's no reason why we can't have Christmas dinner together and then you you can go off and you can see your brother and you can see everybody else that you want to see so I think that's what's going to happen' (lines 406-408).

However, Chloe presented a different story:

I'm jus' gonna go away to my brothers if my mum causes me any trouble (.) cos my mum's jus' said to me anyway that Christmas day I don't believe this right becos somethink will happen and she'll end up being ill again (.) Christmas day she said she's gonna go and help the homeless or something she's gonna go and give them food or something and help them ((inaudible)) in the morning

then (.) iii while she's doing that an' like in the lunch time until the evening I'm gonna be with my brother and my family (.)
(Session Seven, lines 492-497)

I wondered how these contradictions were experienced by Chloe. With only the analysed sessions available, we are left in the dark about how plans for Christmas may have changed in between sessions. What remained clear was the sense of Chloe's deep resentment, communicated in her description of how her mother had decided to spend time helping the homeless rather than with her as initially planned. A further example of incongruence was apparent in mother and daughter's separate accounts of the mother's recent trip away. In the Parent Session, the therapist questioned how Chloe responded to the fact that her mother went away without her:

Mother: … I think she was ok with that because she also knew that I was going back to sort things that hadn't been sorted that needed to be sorted so I don't (.) I didn't sell it to her as me going for a holiday just for me
Therapist: Mmm
Mother: Cos I (.) nmm didn't want her to feel that I was gettin away from her umm but I think that she was ok with that …
(lines 590-595)

Chloe's mother was conscious that Chloe may have felt excluded. Her phrase, 'sell it' suggested that she had thought carefully about her choice of words as if marketing something to appeal rather than to express the full reality. As described, Chloe was deeply uncertain of whether she could trust what people say. As the researcher comparing the narratives of mother and daughter, I was able to use this scenario to explore the sort of situation which compounded Chloe's mistrust. This was an example of how being told one thing did not necessarily represent the full story. The way that Chloe's mother 'sells' her trip may have been an attempt to lessen hurt to Chloe. Nevertheless, she was anxious that her daughter didn't pick up on a deeper layer of meaning – one that she had not spoken directly to Chloe but which she had expressed in her Parent Session where she acknowledged feelings of exhaustion and pressure of being a single-parent: 'I feel very exhausted with it and sometimes I just think I don't want any more responsibilities' (lines 264-265).

In Chloe's seventh session, her therapist observed how feelings stirred up by her mother's trip appeared to have driven a wedge between her and her mother. Chloe replied:

> *… I'm betta off without her (.) I jus' (don't) feel that I need her (.) like cos I've got a taste of what it feels like to actually not have my mum there I know that I don't need her like I didn't miss her once you know when you get that feeling that you miss someone I didn't get that at all (.) like I would a act I actually wish that she would have gone for longer.*
> (lines 141-145)

Though Chloe vehemently claimed not to need her mother, she faltered as she spoke, 'I would a act I actually wish …', leaving the sense that her speech was more bluster than how she truly felt. Perhaps her vehemence was necessary to protect herself from painful feelings of rejection and insecurity. This complicated dynamic was paralleled in the wider family network when Chloe's mother described deeply entrenched animosity between her own mother and herself. This animosity appeared to have spread to further family members, leaving Chloe's mother feeling 'outcast' (line 676) and 'on the fringes' (line 682); for example: '… because my mother's angry with me and err she we've fallen out he [her son] doesn't speak to me and neither does my sister' (lines 699-700). Whilst she has already explained that family members use words viciously, it seemed that words could also be withheld in order to alienate the other. This appeared a family where dispute and grievance festered and were replicated in multiple generations.

Anger transmission

In a further parallel, Chloe's mother's description of how anger passes from one person to another was mirrored in Chloe's perception of how anger is transmitted. In Session Seven, she identified the cause of her angry feelings, claiming they originated with her mother:

… her anger rubbing off has rubbed off on me and like cos I have no cos I haven't had anywhere to like put it for like five years (this year) (.) that's why it's jus' going out to random people even though they have nothing to do with anything that's gone wrong.
(lines 129-131)

When she claimed that her mother's anger had 'rubbed off' on her, it seemed that Chloe believed this quite concretely – as if anger had quite literally permeated her skin. From psychoanalytic, attachment, and neuroscientific perspectives, we understand the serious implications for children living with unpredictable and angry parents. Whilst Chloe acknowledged that 'random people' were on the receiving end of her anger, she appeared to feel powerless to control her outbursts and she did not seem to recognise that her behaviour directly mirrored her mother's when she described that the only way to get rid of anger was to take it out on someone else:

Therapist: How do you find talking about your angry feelings like you have been do you find it
Chloe: ((In overlap)) It jus' makes me worse!
Therapist: Does it?
Chloe: Cos I keep on thinking of someink that's happened
Therapist: ((In overlap)) Mmm
Chloe: Then I feel even more angry and then cos I feel angry I feel like ((Pause)) upset ishs and then cos I feel upset I feel angry again ((Laughs))
Therapist: Hmm
Chloe: So I can't really get rid of it until I can actually take it out on someone
(Session Seven, lines 241-250)

Chloe's therapist was in touch with her experience of angry parents. Simultaneously, however, she also reflected how Chloe appeared to repeat the way of projecting her anger into others. The therapist's reflection provided a supportive space for thinking about anger and, ultimately, an opportunity to break a negative cycle:

I think you describe very vividly this feeling
That anger in this very powerful acute form

Gets passed down generations
Handed down as though there's nothing you can do
Powerless in the face of being on the receiving end
How quickly one goes from feeling frightened
Or on the receiving end of this anger
To being angry themselves
This sort of worrying feeling that mad crazy angry feelings
Just get handed down
You have no choice but to try and get rid of it somehow
(lines 226-235)

Managing strong emotions

When I examined *how* Chloe and her mother spoke, I noticed that they often laughed after acknowledging painful feeling. Examples of this occurred when Chloe's mother laughed immediately after describing anxiety that Chloe had no relationship with her father:

Therapist: … what would you say makes you anxious about her relationship with her father …
M: ((In overlap)) Well the fact that there isn't one ((Laughs))
(lines 119-121)

She laughed again when she described feelings of guilt and exhaustion: '… I sort of fluctuate between feeling really guilty ((Laughs)) and just feeling very tired with it all' (lines 292-293). In Chloe's first session, she laughed when she acknowledged how upset she was when she had to give up her dog:

Therapist: So from being so kind of involved in looking after her and the world of dogs to just having no contact it's quite (.) extreme.
Chloe: Yep and that really upset me ((Laughs))
(lines 269-271)

Similarly, in Session Seven, she laughed when she described overpowering feelings of anger:

> *It's literally really hard for me and then when I do stop I can't breathe cos I really wanna scream (.) so all my friends have to kind of have to pin me down to a chair ((Laughs))*
> (lines 136-138)

Though mother and daughter fleetingly acknowledged feelings of vulnerability, their laughing seemed to illustrate an attempt to disown or belittle their vulnerability. It appeared hard for them to contain and accept these feelings and, instead, they attempted to deny, expel, or project them into others. A further defensive mechanism that was apparent for them both was their tendency to engage in splitting. Splits in the family were numerous, an example of which was apparent in the mother's description of her siblings:

> *They're very different to me*
> *Even when we're gettin on*
> *I don't really relate to them*
> *They're not very intellectual*
> *They're not on my level*
> *My brother is quite racist*
> *He reads The Sun*
> *My sister reads The Daily Mail*
> *Whereas I'm a Guardian reader*
> (lines 709-716)

In Chloe's first session, examples of splitting were plentiful, such as the way that she differentiated between people in X and people in the UK. She passionately described how people in X had poor animal welfare[8], physically abusive teachers,[9] and were

8 *X people they tend to just (.) build a kennel outside and leave their dog on a chain jus' chuck em food and water.*
(Session One, lines 278-280)
9 *… yo can hit children in X no one would do anything about it like te teachers would hit children in our in my primary school my teacher hit me*

preoccupied with appearance[10]. Within the extended family, she appeared as a casualty of the family's tendency to split, and she struggled to know where to place herself. At the beginning of Session Seven, the therapist showed how she understood and held this in mind when she referred to how Chloe had spoken previously about this subject:

> *Chloe: … the thing that most annoys me is that they're both jus' slagging each other behind their backs*
> *Therapist: Mhm*
> *Chloe: An it's jus' annoying ((Pause))*
> *Therapist: In the same way as you talked about last week?*
> *Chloe: Yeah pretty much*
> *Therapist: ((Pause)) An' similar (.) situation for you in the middle*
> *Chloe: Yeah…*
> (lines 6-13)

Both parent worker and Chloe's therapist were conscious of how splits in the family caused difficulty for Chloe as she repeatedly found herself caught in the middle of waring family members. The therapists were also alert to how splits in the family might be enacted between themselves (CAMHS) and the school counsellor. Simultaneously, they were aware of Chloe's need for support to explore internal splits – to be supported to integrate her emotional experience. In the Parent Session, the therapist described splitting between Chloe's mother and *her* mother and extended family:

> *There is a split*

(Session One, lines 383-384)

10 *In X it's like everyone gets (.) they jus' like dress up like literally like really nice dressed nice high heels and loads of make-up just to go to the market and because everyone knows everyone if you didn't dress up a certain way then they'd all be talking about you and there was always this thing about like oh you have to dress a certain way or people will talk about you you can't have people talking about you it's really bad like (.) It's just (.) stupid an then come back here and no one really cares how you dress and you can act the way you want to act like the way you feel like acting on that day one day you could be happy one day you could be sad but in X if you're happy one day and you're sad the next then somethings wrong and everyone knows about it …*
(Session One, lines 291-300)

In a way there's always a separation
It's either between you and dad
Or you and the brother
Or you and mum
One of the things that we want to think about
In terms of deciding whether to continue here or not
Is what it means to her to have two therapists
Because it's a bit of a repetition of something that happens in outside life
So I suppose what we're in the process of thinking is
Can she come here and make use of this space
Can we try and integrate the work that we're doing
So that we help her to put things together
And not always feel that she's in between
(lines 414-434)

Link-making and development

Chloe was determined to continue with both her school counselling and her psychotherapy, despite being advised against it. In Session Seven, she described how it helped 'from both ends' (line 264) and that she had become used to the 'routine'. From a psychoanalytic position, we might consider how her experience of having two reflective and containing therapists might represent a model of a couple that function very differently to anything that she has experienced before. Regardless of the pros and cons of this unusual therapeutic setup, progress appeared to be made even as early as Session Seven; delight could be heard in her voice when she registered that she managed to do something that appeared to have been discussed in the intermediate sessions – making links:

… at the end of the day it's like you ch- you can choose like what side you go on and that's like kind of like me really cos like (.) Oh my god I jus' managed to do the link thing.
(lines 563-564)

Whilst Chloe began therapy with a clear view of the harmful potential of words, she was now beginning to perceive that words could also be used to make sense of, and link together, experience. This conceptual development seemed to have been made possible within the context of the therapeutic relationship. From a psychoanalytic perspective, we understand this process to reflect how Chloe had been able to internalise something of the therapist's capacity to hold and make sense of her experiences. Given Chloe's acknowledgement in her first session that her experience of broken and disturbed attachments had prompted her to put up a 'barrier' (line 161), it was extremely significant that she had been able to learn to trust the therapist and to make use of the therapeutic process in this way.

Discussion

This study used psychoanalytically-informed narrative analysis to explore the narratives of two clinically depressed adolescents alongside their parents' narratives. At the point of writing, I was not aware of any other studies exploring this specific subject. As such, permission to listen to and analyse the sessions of both adolescents and their parents represented a great privilege and offered potential to add original thinking to the field of child and adolescent psychotherapy. My position, like a fly on the wall in both adolescent and parent sessions, was an extremely unusual one. This was specifically so because psychotherapeutic practice with adolescents/children and their parents within a CAMHS setting usually entails two clinicians seeing the parent and adolescent/child separately. In addition, it is important to reflect on the fact that, though parents were offered seven separate sessions, extremely few parent sessions were audio-recorded. I was, therefore, fortunate to find two cases in which I could research both the parent and their adolescent's narratives.

Though the data sample was small, detailed analysis of the psychotherapy sessions provided a wealth of material illustrating thought-provoking points of convergence and divergence between the adolescents and their parent/s. Overarching the whole analysis, it was apparent that there was a close link between how the adolescents and their parent/s understood and experienced the world around them. Analysis of

the data also illustrated convergent themes between the two adolescents. As described in the method section, clinical work and research practice – such as that reported by McLeod and Balamoutsou (2001) – indicates that the first session holds the key to the rest of the case. This was found in both cases analysed for the present study where the first sessions revealed significant themes which later appeared to be central elements of the therapeutic work.

In psychotherapy practice and theory, we recognise the impact that the parent has on their child. As such, we might anticipate seeing markers of this influence in the narratives of the parent-adolescent dyad. However, we also understand from practice and theory that depressed adolescents often feel isolated and detached from their parents. As such, one might hypothesise that the parent-adolescent narratives might reflect this sense of disconnection by their incongruence. What was striking about this study was the marked similarity in narrative themes between adolescent and their parent. Though the sample size was too small to make any certain claims about this correlation, it was apparent that, in these specific cases, shared themes offer possible suggestions about the contributing factors involved in their depression. It would be interesting to carry out further research with a wider population to explore whether these themes are more widely apparent. I will continue to describe these shared themes in more detail.

Talking might be dangerous

Entering into psychotherapy is often experienced as a daunting prospect. In a qualitative study exploring IMPACT participants' expectations of therapy prior to therapy beginning, Midgley, Holmes and colleagues (2014) outline how adolescents commonly feel uncomfortable talking to somebody new, especially about sensitive subjects. This uncomfortable feeling may be exacerbated by the developmental stage of adolescence where individuals are embroiled in the task of individuation and, hence, may find the idea of feeling dependant on a therapist counter-intuitive. Initially, in both cases in the present study, the adolescents appeared anxious talking about emotionally problematic or traumatic experiences. However, this anxiety appeared different to that described by Midgley, Holmes and colleagues: there was a striking similarity for both adolescents where the idea of talking about these

experiences appeared to be considered dangerous and to risk feelings overwhelming them. As such, they were caught in a precarious position – persecuted by painful experience which they felt unable to share with anyone. As described, the research literature indicates that feeling helpless in this way contributes to depression. In consequence, both adolescents began psychotherapy with trepidation about what may arise from talking about feelings.

When I analysed the adolescents' parents' narratives I found similarities in the way that they handled painful subjects. In Chloe and her mother's case, they often both appeared to belittle their experience – for example, by laughing at moments of painful recollection. In May and her parents' case, there was a tendency to avoid painful subjects – May referred to trying not to think about the court case and her parents avoided talking about their emotional response to their older daughter's experience, and May's witnessing of domestic abuse. In these cases, the narratives of parent and adolescent were extremely similar – the inappropriate laughter in Chloe and her mother's case and the attempt to avoid painful material in May and her parent's case. This led me to consider that narratives of parents and their adolescents can be similar both in their repetition of a particular mannerism (for example, inappropriate laughter) and, by their absence of discussion (for example, May and her parents). We can appreciate that experience of parents who find talking about painful subjects so difficult is likely to leave adolescents ill-equipped to build up their own capacity to explore painful subjects whilst also leaving them feeling isolated and alone with their disturbing thoughts and feelings, exacerbating depression.

As well as anxiety about what expressing internal disturbance might evoke within them, both adolescents were also wary of what others might do with their communications. The origin of this fear appeared to be located in prior experience, and they both recounted incidents where expressions of emotional vulnerability left them feeling exposed and intruded upon. May gave an example of this when she described not liking to cry in front of people:

I don't really like (.) like crying in front of people because (.) like (.) this has happened so many times before like when I used to cry every day back in school right like I'd cry there'd be one person that person would go another person would come an' they all wanna know your business.
(Session Ten, lines 818-821)

This statement was strikingly similar to Chloe's: '… in X if you're happy one day and you're sad the next then somethings wrong and everyone knows about it' (Session One, lines 298-300). Painful experiences in the past influenced their willingness to share sensitive feelings in the present. This anxiety was alive in the transference as the adolescents explored whether their expressions of vulnerability could be safely entrusted to the care of their therapists.

Between a rock and a hard place

Both adolescents spoke about feeling caught between quarrelling family members. May described how she could feel stuck between her niece and her sister and how she was recruited to deliver messages on their behalf:

May: … sometimes I'm kind of like the messenger and
Therapist: Yes
May: But it's like it's just like a love triangle in a way
Therapist: It's a love triangle ((laughs)) You're kind of in the middle
(Session One, lines 919-922)

May's feeling of being 'caught in the middle' appeared remarkably like that described by Chloe:

Therapist: When you say slagging each other off (.) to you?
Chloe: Yeah pretty much
Therapist: So you're kind of
Chloe: I'm in the middle
(Session One, lines 13-16)

Both adolescents struggled with the relational dynamic they found themselves in. This appeared a significant factor in their depression: feeling stuck 'in the middle' led to an experience of impotence and helplessness known to exacerbate depression (Bibring, 1953; Sander and Joffe, 1965).

Belief in self

Self-belief was also identified as something both adolescents lacked. In May's case, this was raised by her therapist when encouraging her to: 'Believe in yourself!' to which May replied, 'I need to start doing that' (Session Ten, lines 538-539). In Chloe's case she identified, 'I don't believe in myself' (Session Seven, line 333). In both cases, lack of self-worth was also mirrored in the mothers' narratives – Chloe's mother recounted her experience of feeling rejected from her family and May's mother expressed her regret about not making more of herself professionally. The research literature is clear on the effects of maternal depression on young children, but I would suggest that more research into the effects of a parent's low self-esteem during the critically significant period of adolescence would be helpful.

In the process of analysing the session recordings, I came across narratives specific to the individual and those which related to the wider cultural context. Lack of self-belief might be considered intrinsic to an ego-centric culture privileging advancement of the individual rather than focusing on the larger group or society. Perhaps someone from a more socio-centric culture would not raise this issue. For Chloe and May, living within an ego-centric culture, experiences which led to them not believing in themselves seemed to have left them feeling 'at sea' – disconnected and lost. We can appreciate that constructing a coherent narrative of self would be difficult under these circumstances.

May's parents' belief that she was 'easily led' underscored their anxiety about her future. This was a family where identity appeared a confusing concept – where May's parents often spoke as if one symbiotic entity or, conversely, as if totally detached from one another. Something of this confusion appeared to have been transmitted to May. This was apparent when she communicated anxiety and anger that her niece's imitation of her might result in her not being able to be herself

anymore. In Chloe's case, multiple moves and broken and chaotic attachments appeared to have left her floundering, angry, and confused about her identity and self-worth.

A wish for robust containment

As identified, both adolescents already attended school-counselling which neither wished to give up. The IMPACT team were not aware of this before the onset of the therapy and there was discussion about the risk of this confusing the work. In both cases, the adolescents described feelings of abandonment and were uncertain of emotional support available to them within the context of their family. May acknowledged this as something of a paradox as she described her family as supportive. Yet, in her first session, she communicated a wish that her parents would sit with her until she fell asleep. This seemed to represent a much younger part of her. Adolescence is a conflictual stage of development where individuals are pulled towards adulthood whilst often simultaneously grieving the loss of childhood. In a way that mirrored how she felt caught between family members, she also appeared caught between the opposing forces of childhood and adulthood. Part of her wished to separate from her parents and focus on the wider world, whilst another part wished to revert to a much younger child.

Conversely, Chloe did not voice a wish to revert to a younger child. Her account of childhood indicated a chaotic experience where she often felt frightened. This was reminiscent of Vanheule and Hauser's (2008) study where a major factor in the depression of hospitalised adolescents was the sense of helplessness that arose from their experience of unpredictable, and frightening, significant others. Chloe appeared to have no previous childhood experience to reminisce about or idealise. Instead, she attempted to present the image of a tough young woman who could stick up for herself. However, in her first session, she appeared to be transported to a memory of when she was little, and during the therapy she began to get in touch with more vulnerable feelings. Though engaging in two separate therapies concurrently could risk splitting and confusion, it seems that both adolescents' adamance to continue with school-counselling and psychotherapy might reflect an important communication and appeal for a parental couple to robustly hold them in

mind and reflect on their disturbing thoughts and feelings. Considering how uncertain both adolescents were about so many other issues, I felt that their adamance was noteworthy and depicts the ongoing need for adolescents to be listened to, and to receive robust containment and supportive reflection.

Conclusion: Developing new ways of relating

In psychoanalytic thinking, the understanding of transference enables us to comprehend how individuals transfer their expectations of relationships onto the therapist. These expectations arise from the individual's early relational experience which creates an effectual blueprint for future relationships. This study has focused on a comparison of parent and adolescent narratives. Although exploring aspects of transference apparent in the data in depth was beyond the scope of this study, the material did illustrate how patterns of perceiving the world and relating were often shared between parent and adolescent. Though those in the field of psychotherapy may not find these results surprising, what is striking in this study is the way in which a close analysis of both the adolescent's and parents' narratives indicates the extent to which these similarities arise. This study has explored the ways in which the parents' narratives may have contributed to the adolescent's depression. In May's case, her mother regretted that having children so young meant that she had not 'bettered' (line 847) herself. May's parents articulated how they did not want her going down the wrong track and getting herself into a situation (such as teenage pregnancy or alcohol or drug abuse) whereby she would not be able to achieve her full potential. Clinically, we appreciate that parenting an adolescent involves a certain level of anxiety related to the risks involved as a child navigates the path of individuation. However, May's parents' fears appeared beyond what we might expect. Both parents described their anxiety about dangers May might encounter in the outside world. This message was perhaps most succinctly expressed by May's mother when she said '… the streets ain't safe' (line 749). This presented a striking parallel to their daughter's fear of her future which she described to be like going through a tunnel with a terrifying monster at the end. This sense of unavoidable and terrifying inevitability mirrored her parents' worry that one misstep would automatically lead to the wrong path being taken, with disastrous consequences. The emphasis on external dangers was interesting given that May's sister suffered

long-term domestic violence, indicating that danger was also located inside the home and not only found on the streets. This family appeared to find it easier to locate danger outside rather than to acknowledge that sometimes danger is much closer to home. In this way, any disturbance is projected into the outside world which is then experienced as persecutory. As described, in addition to experiencing the outside world as persecutory, May's parents attempted to avoid exploration of their emotional response. This attempt at avoidance was mirrored by May. However, May's attempts to shut out memories of the domestic abuse she witnessed were unsuccessful and she was left with traumatic flashbacks. We can imagine that the perception of the outside world as a terrifying place, combined with a tendency to avoid talking or thinking about painful experience, is likely to leave an adolescent at a great disadvantage when it comes to navigating the path towards independence. In these circumstances, the adolescent has extremely limited capacity to manage the precarious road to adulthood and, in a persecuted state of mind, depression may arise both as a response to the sense of isolation and overwhelm but also, perhaps, as a retreat from the outside world and progression into adulthood.

In Chloe's case, her mother described unresolved difficulties with her own mother which left her feeling 'outcast' and alienated. In Chloe's seventh session, she described 'hating' Christmas. This year, as with many, her mother had been arguing with family members and, for this reason, Chloe's mother planned to help at a refuge for the homeless rather than spend Christmas with family. Whilst the therapist reflected that sometimes Chloe could feel sorry for her mother, Chloe denied this, saying she would happily leave her mother at Christmas to be with other family members. The tone of her voice and her resolute adamance seemed to belie the sense of abandonment and rejection that she felt towards her mother, mirroring her mother's feeling towards *her* mother. In her 2012 paper, 'Ghostbusting Transgenerational Processes', Moldawsky Silber explored how a parent's unprocessed past is seen to be repeated in the relationship with the child:

> *The past (in all its forms and potentialities) lives on in the present, influencing the affective field of the parent-child intersubjective matrix. In a child's*

> *construction of self, he or she may run up against the confounding presence of ghosts: the dissociated, and thereby unreflected upon past of their parents.* (p.106)

Referring to the work of Roisman and colleagues (2002), Music (2011) describes how the ability to form a coherent narrative of one's experience is pivotal to breaking dysfunctional intergenerational dynamics. This is particularly clear in cases where parents have experienced abuse: 'Those parents abused as children who somehow manage to break the cycle of abuse are those who develop a capacity to form narratives and stories that make sense of their lives' (p.210): with support the 'confounding presence of ghosts' (ibid) can be processed and made sense of so that families may be free of their tyranny. The present study illustrates that both sets of parents found forming narratives of their traumatic experiences very challenging. As described, the parents often appeared to belittle their painful experiences or, deny or expel them completely. These patterns were repeated in their adolescent's narratives. It is important to emphasise that where I refer to the influence of the parental narrative, I also include the lack of parental narrative – where an absence of narrative can result in a void – a missed opportunity to contain and process difficult experience. If we return to the notion of adolescence representing a repetition of the infantile period (where an infant requires the robust containing of their object to help make sense of their persecutory experience), we can appreciate that the adolescent who lacks a parent who is able to contain experience in narrative is likely to flounder in the tumultuous period of adolescence. Potentially, this places the adolescent at greater risk of depression. Clinically, it may be helpful in our work with parents to have this in mind and to consider whether a central task of the work might be to support the parent to develop a narrative to contain their experience.

Alvarez (2012) draws our attention to the fact that some children and young people may never have developed 'mental equipment with which to think about experience' (p.154). Given their parents difficulties in forming narratives, I think that part of the opportunity found in May's and Chloe's therapy was to build up 'mental equipment' (ibid) to make sense of and begin to contain their experiences in narratives co-created with their therapists. For both adolescents, this entailed taking the risk of

trusting the therapist and thinking about painful experience. Though they both openly expressed ambivalence about exploring aspects of their emotional life, the sessions analysed indicated that, even within a relatively short timeframe, they had begun to engage in this process.

This study has reflected on the possible meanings of the narratives of two clinically depressed adolescents and their parents. Previously, Odhammar and colleagues (2011) identified: 'An important task for future child psychotherapy research is to create a better understanding of external factors, such as family and social environment, and their importance for process and treatment outcome' (p.275). As described, there is very limited literature referring to the impact of the parental narrative on the adolescent. It is hoped that through an exploration of narrative, this small study has outlined the ways in which the adolescents were seen to mirror their parents' ways of managing distress. Several narrative themes were seen to overlap between parent and adolescent and, also, between the two adolescents. These overlapping themes included feelings of helplessness, persecution, abandonment, insecurity and low self-esteem, in keeping with a psychoanalytic understanding of depression. The way in which these themes were often mirrored in both the adolescent's and parent's accounts, tentatively support clinical understanding of the effects of intergenerational dynamics. Whilst it is essential to remain sensitive to the adolescent's emerging sense of autonomy, it is hoped that this study has provided evidence of the power of the parental narrative. In conclusion, whilst work with parents of adolescents is often under threat due to pressurised resources and sometimes underestimated clinically, it is argued that adolescence represents a developmentally critical period in which the adolescent brain undergoes dramatic change and potential growth akin to the period during infancy. Given this developmental opportunity, and the fact that, for most individuals, adolescence is the last period in which they will live together with their parents, this time represents a rich opportunity to support parents and adolescents to reflect on, and potentially alter, unhealthy ways of relating and managing emotional disturbance.

References

Abraham, K. (1924). A short study of the development of the libido, viewed in the light of the mental disorders. In: *Selected Papers on Psychoanalysis*. London: Hogarth Press, 1927.

Alvarez, A. (2012) *Live Company: Psychoanalytic Psychotherapy with Autistic, Borderline, Deprived and Abused Children*. Hove: Routledge.

Anderson, R. and Dartington, A. (eds.) (2003). *Facing It Out: Clinical Perspectives on Adolescent Disturbance*. London: Karnac.

Angus, L., Levitt, H. and Hardtke, K. (1999). 'The narrative processes coding system: Research applications and implications for psychotherapy practice', *Journal of Clinical Psychology*, vol. 55, no.10, pp. 1255-1270.

Angus, L. and McLeod, J. (2004). *The Handbook of Narrative and Psychotherapy: Practice, Theory and Research*. Thousand Oaks, CA: Sage Publications, Inc.

Avdi, E. and Georgaca, E. (2007). 'Narrative research in psychotherapy: A critical review', *Psychology and Psychotherapy: Theory, Research and Practice*, vol. 80, pp. 407–419.

Bibring, E. (1953). 'The mechanism of depression'. In: Greenacre, P. (ed.) *Affective Disorders: Psychoanalytic Contributions to Their Study* (pp. 13-48). New York: International Universities Press; reprinted 1961.

Bick, E. (1968). 'The experience of the skin in early object-relations'. *International Journal of Psycho-Analysis*, vol. 49, pp, 484-486.

Bion, W. R. (1962). *Learning from Experience*. London: Heinemann; reprinted London: Karnac, 1984.

Bion, W. R. (1987) 'Attacks on Linking'. In: Bion, W. R. (ed.) (1987) *Second Thoughts: Selected Papers on Psycho-analysis* (pp. 93-109). London: William Heineman Medical Books Ltd.

Boothe, B., von Wyl, A. and Wepfer, R. (1999). 'Narrative dynamics and psychodynamics'. *Psychotherapy Research*, vol. 9, no. 3, pp. 258-273.

Bott Spillius, E. (1994). 'Developments in Kleinian thought: Overview and personal view'. *Psychoanalytic Inquiry*, vol. 14, no. 3, pp. 324-365.

Bowlby, J. (1960). 'Grief and mourning in infancy and early childhood'. *Psychoanalytic Study of the Child*, vol. 15, pp. 9-52.

Braun, V. and Clarke, V. (2013). *Successful Qualitative Research: A Practical Guide for Beginners.* London: Sage Publications.

Bruner, J. (2004) In: Angus, L. and McLeod, J. (2004) Handbook of Narrative and Psychotherapy: Practice, Theory and Research. Sage

Bruner, J. (2006). A Narrative Model of Self-Construction. Annals New York Academy of Sciences.

Byng-Hall, J. (1986). 'Family scripts: A concept which can bridge child psychotherapy and family therapy thinking'. *Journal of Child Psychotherapy*, vol. 12, no. 1, pp. 3-13.

Calderon, A., Midgley, N., Schneider, C. and Target, M. (2013). *Adolescent Psychotherapy Q-Set Coding Manual*. London: University College, Anna Freud Centre.

Calderon, A., Schneider, C. and Midgley, N. (2017). 'The adolescent psychotherapy Q-Set (APQ): A validation study'. *Journal of Infant, Child, and Adolescent Psychotherapy*, vol. 16, no. 1, pp. 106-120.

Clarke, S., and Hoggett, P. (2009). Researching Beneath the Surface: Psycho-Social Research Methods in Practice. London: Karnac.

Cregeen, S., Hughes, C., Midgley, N., Rhode, M. and Rustin, M. (2017). *Short-term Psychoanalytic Psychotherapy for Adolescents with Depression: A Treatment Manual.* London: Karnac.

Dallos, R. and Vetere, A. (2005) *Researching Psychotherapy and Counselling*. Maidenhead: McGraw-Hill Education.

Dana, D. (2018). *The Polyvagal Theory in Therapy: Engaging the Rhythm of Regulation*. New York: W. W. Norton & Company.

Denzin, N. K and Lincoln, Y. S. (1994). 'Introduction: Entering the Field of Qualitative Research'. In Denzin, N. K. and Lincoln, Y. S. (eds.) *Handbook of Qualitative Research* (pp.1-17) Thousand Oaks, CA: Sage.

Denzin, N. K. (2015). 'Narrative's Moment'. In Andrews, M., Sclater, S. D., Squire, C. and Treacher, A. (eds) *Lines of Narrative: Psychosocial Perspectives*. New York: Routledge.

Feldman Barret, L. (2017). *How Emotions Are Made: The Secret Life of the Brain*. London: Macmillan

Fiese, B. H., Sameroff, A. J., Grotevant, H. D., Wamboldt, F. S., Dickstein, S., Fravel, D. L., Marjinsky, K. A. T., Gorall, D., Piper, J., St. Andre, M., Seifer, R. and Schiller, M. (1999). 'The stories that families tell: narrative coherence, narrative interaction, and relationship beliefs'. *Monographs of the Society for Research in Child Development*, vol. 64, no. 2, pp. 1-162.

Fortune, S., Cottrell, D. and Fife, S. (2016). 'Family factors associated with adolescent self-harm: A narrative review', *Journal of Family Therapy*, vol. 38, no. 2, pp. 226-256.

Fraiberg, S. H., Adelson, E. and Shapiro, V. (1980). *Ghosts in the Nursery: A Psychoanalytic Approach to the Problems of Impaired Infant-Mother Relationships*. London, Tavistock Publications.

Freud, A. (1965) *Normality and Pathology in Childhood*. London: Hogarth.

Freud, A. (1974) *Introduction to Psychoanalysis: Lectures for Child Analysts and Teachers (The Writings of Anna Freud, Vol. 1, 1922-1935)*. New York: International Universities Press.

Freud, S. (1905). 'Three Essays on the Theory of Sexuality', *Standard Edition*, vol. 7, London: Hogarth.

Freud, S. (1909). 'Analysis of a Phobia in a Five-Year-Old Boy', *Standard Edition*, vol. 10, pp. 1-149. London: Hogarth.

Freud, S. (1917). 'Mourning and Melancholia', *Standard Edition*, vol. 14, pp. 239-258. London: Hogarth.

Freud, S. (1920). 'Beyond the Pleasure Principle'. *Standard Edition*, vol. 18, pp. 7-64. London: Hogarth.

Gee, J.P. (1986). 'Units in the production of narrative discourse', *Discourse Processes*, vol. 9, pp. 391-422.

Gee, J.P. (1991). 'A linguistic approach to narrative', *Journal of Narrative and Life History*, vol. 1, pp. 15-39.

Gergen, K. J.(1985) 'The social constructionist movement in modern psychology', *American Psychologist*, vol. 40, pp. 266-275.

Gerhardt, S. (2014). *Why Love Matters: How affection shapes a baby's brain*. Second edition. Hove: Routledge.

Goldstein, M. J. and Strachan, A. M. (1987). ‘The family and schizophrenia’. In Jacob, T. (ed.), *Family Interaction and Psychopathology*. New York: Plenum Press.

González-Monteagudo, J. (2011). Jerome Bruner and the Challenges of the Narrative Turn: Then and now. Journal of Narrative Inquiry, 21. 295-302.

Goodyer, I. M., Reynolds, S., Barrett, B., Byford, S., Dubicka, B., Hill, J., Holland, F., Kelvin, R., Midgley, N., Roberts, C., Senior, R., Target, M., Widmer, B., Wilkinson, P. and Fonagy, P. (2017). 'Cognitive behavioural therapy and short-term psychoanalytical psychotherapy versus a brief psychosocial intervention in adolescents with unipolar major depressive disorder (IMPACT): a multicentre, pragmatic, observer-blind, randomised controlled superiority trial', *The Lancet Psychiatry*, vol. 4, no. 2, pp. 109-119.

Henry, G. (1974). ‘Doubly deprived’. *Journal of Child Psychotherapy*, vol. 3, no. 4, pp. 15-28.

Hobson, P. (2002). *The Cradle of Thought*. London: Macmillan.

Hollway, W., and Jefferson, T. (2008). The free association narrative interview method. In: Given, Lisa M. ed. The SAGE Encyclopedia of Qualitative Research Methods. Sevenoaks, California: Sage, pp. 296–315.

Hollway, W. (2009) ‘Applying the “experience-near” principle to research: Psychoanalytically informed methods’. *Journal of Social Work Practice*, vol. 23, no.4 pp. 461–474.

Hollway, W and Jefferson, T. (2013) *Doing Qualitative Research Differently: A Psychosocial Approach.* London: Sage Publications

Hooley, J. M. and Teasdale, J. D. (1989). ‘Predictors of relapse in unipolar depressives: expressed emotion, marital distress and perceived criticism’. *Journal of Abnormal Psychology*, vol. 98, pp. 229-235.

Horne, A. (2000). ‘Keeping the child in mind: thoughts on work with parents of children in therapy’. In: Tsiantis, J., Boethious, S. B., Hallerfors, B., Horne, A. and Tischler, L. (eds.) *Work with Parents: Psychoanalytic Psychotherapy with Children and Adolescents* (pp. 47–63). London: Karnac.

Hustvedt, S. (2014). *The Blazing World*. New York: Simon and Schuster Paperbacks.

Jefferson, G. (2004). ‘Glossary of transcript symbols with an introduction’. In Lerner, G. H. (ed.), *Conversation Analysis: Studies from the first generations*. Philadelphia: John Benjamins.

Jenuwine, M. J. (2001). ‘Narratives of suicidal adolescents’. *Dissertation Abstracts International, Section B: The Sciences and Engineering*, vol. 61, no. 10-B.

Jones, E. (1922). ‘Some Problems of Adolescence’, In: *Papers on Psycho-Analysis*, 5th edition, 1948 (pp. 389-406). London: Baillière, Tindall & Cox.

Kashan A. S., Abel K. M., McNamee, R., Pedersen, M. G., Webb, R. T., Baker, P. N., Kenny, L. C. and Mortensen, P. B. (2008). ‘Higher risk of offspring schizophrenia following antenatal maternal exposure to severe adverse life events’. *Arch Gen Psychiatry*, vol. 65, no. 2, pp. 146-152.

Klauber, T. (1998) ‘The significance of trauma in work with the parents of severely disturbed children, and its implications for work with parents in general’, *Journal of Child Psychotherapy*, vol. 24, no. 1, pp. 85-107.

Klein, J. (1987). *Our Need for Others and its Roots in Infancy*. London: Tavistock Publications

Klein, M. (1933). ‘The Early Development of Conscience in the Child’. In: Lorand, S. (ed.) *Psychoanalysis Today*. New York: Covici-Friede. Reprinted in: *Love, Guilt and Reparation and Other Works, 1921-1945* (pp. 248-257). London: Hogarth Press, 1975.

Klein, M. (1935). ‘A Contribution to the Psychogenesis of Manic-Depressive States’. In: *Love, Guilt and Reparation and Other Works, 1921-1945* (pp. 262-289). London: Hogarth Press, 1975.

Klein, M. (1937). ‘Love, Guilt and Reparation’. In: Klein, M. and Riviere, J. *Love, Hate and Reparation*. London: Hogarth Press. Reprinted in: *Love, Guilt and Reparation and Other Works 1921–1945* (pp. 306–343). London: Hogarth Press, 1975; reprinted London: Karnac, 1992.

Klein, M. (1940). ‘Mourning and its Relation to Manic-Depressive States’. In: *Love, Guilt and Reparation and Other Works, 1921-1945* (pp. 344-369). London: Hogarth Press, 1975.

Klein, M. (1945). ‘The Oedipus Complex in the Light of Early Anxieties’. In: *Love, Guilt and Reparation and Other Works, 1921-1945* (pp. 370-419). London: Hogarth Press, 1975.

Klein, M. (1946). ‘Notes on Some Schizoid Mechanisms’. In: *Envy, Gratitude and Other Works, 1946-1963*. London: Hogarth Press, 1975.

Klein, M. (1948). ‘A contribution to the theory of anxiety and guilt’. *International Journal of Psychoanalysis*, vol. 29, pp. 113-123. Reprinted as ‘On the Theory of

Anxiety and Guilt'. In: *Envy, Gratitude and Other Works, 1946-1963* (pp. 25-42). London: Hogarth Press,1975; reprinted London: Karnac, 1993.

Klein, M. (1957). 'Envy and Gratitude'. London: Tavistock. Reprinted in: *Envy, Gratitude and Other Works, 1946-1963* (pp. 176-235). London: Hogarth Press, 1975; reprinted London: Karnac, 1993.

Krause, K., Midgley, N., Edbrooke-Childs, J. and Wolpert, M. (2020). 'A comprehensive mapping of outcomes following psychotherapy for adolescent depression: the perspectives of young people, their parents and therapists'. *European Child & Adolescent Psychiatry* 2020 Oct 01.

Laurent, H. and Ablow, J. (2012) 'A cry in the dark: depressed mothers show reduced neural activation to their own infant's cry', *Social Cognitive and Affective Neuroscience*, vol. 7, pp. 125-34.

Lawler, S. (2011). 'Narrative in Social Research'. In: May, T. *Qualitative Research in Action*. Los Angeles: Sage Publications Ltd.

Lesser, E. (2020). *Cassandra Speaks: When Women Are the Storytellers, the Human Story Changes*. New York: HarperCollins Publishers.

Luborsky, L., Barber, J. and Diguer, L. (1992). 'The meanings of narratives told during psychotherapy: The fruits of a new observational unit', *Psychotherapy Research*, vol. 2, no. 4, pp. 277-290.

Luborsky, L., Popp, C., Luborsky, E. and Mark, D. (1994). 'The core conflictual relationship theme', *Psychotherapy Research*, vol. 4, no. 3-4, pp. 172-183.

Lupien, S. J., Parent, S., Evans, A. C., Tremblay, R. E., Zelazo, P. D., Corbo, V., Pruessner, J. C. and Séguin, J. R. (2011). 'Larger amygdala but no change in hippocampal volume in 10-year-old children exposed to maternal depressive symptomatology since birth', *The Proceedings of the National Academy of Sciences (PNAS)*, vol. 108, no. 34, pp. 14324-14329.

Mair, M. (1989). *Beyond Psychology and Psychotherapy: A Poetics of Experience*. London: Routledge.

Markham, J. A. and Koenig, J. I. (2011). 'Prenatal stress: Role in psychotic and depressive diseases'. *Psychopharmacology*, vol. 214, no. 1, pp. 89-106.

McCormack, C. (2004). 'Storying stories: A narrative approach to in-depth interview conversations', *International Journal of Social Research Methodology: Theory & Practice*, vol. 7, no. 3, pp. 219-236.

McDougal, J. and Lebovici, S. (1989) *Dialogue with Sammy, A Psychoanalytical Contribution to the Understanding of Child Psychosis*, London: Free Association Books.

McLeod, J. and Balamoutsou, S. (1996). 'Representing narrative process in therapy: qualitative analysis of a single case'. *Counselling Psychology Quarterly*, vol. 9, no.1, pp. 61-76.

McLeod, J. and Balamoutsou, S. (2001). 'A method for qualitative narrative analysis of psychotherapy transcripts'. *Psychologische Beiträge*, vol. 43, no. 3, pp. 128-152.

McLeod, J. (2004) In: Angus, L. and McLeod, J. (2004) Handbook of Narrative and Psychotherapy: Practice, Theory and Research. Sage

Midgley, N. (2006). 'The "inseparable bond between cure and research": clinical case study as a method of psychoanalytic inquiry'. *Journal of Child Psychotherapy,* vol. 32, no. 2, pp.122-147.

Midgley, N., Ansaldo, F. and Target, M. (2014). 'The meaningful assessment of therapy outcomes: Incorporating a qualitative study into a randomized controlled trial evaluating the treatment of adolescent depression'. *Psychotherapy*, vol. 51, pp.128-137.

Moldawsky Silber, L. (2012). 'Ghostbusting Transgenerational Processes'. *Psychoanalytic Dialogues: The International Journal of Relational Perspectives*, vol. 22, no. 1.

Murray, L., Halligan, S., Goodyer, I. & Herbert, J. (2010). 'Disturbances in early parenting of depressed mothers and cortisol secretion in offspring: a preliminary study', *Journal of Affective Disorders,* vol. 122, no. 3, pp. 218-223.

Murray, L., Arteche, A., Fearon, P., Halligan, S., Goodyer, I. & Cooper, P. (2011). 'Maternal post-natal depression and the development of depression in offspring up to 16 years of age', *Journal of the American Academy of Child and Adolescent Psychiatry*, vol. 50, no. 5, pp. 431-434.

Music, G. (2009). 'Neglecting neglect: some thoughts about children who have lacked good input, and are "undrawn" and "unenjoyed"'. *Journal of Child Psychotherapy,* vol. 35. no. 2, pp. 142-156.

Music, G. (2011) *Nurturing Natures: Attachment and Children's Emotional, Sociocultural and Brain Development*. Hove: Psychology Press.

Music, G. (2014) ‘Top down and bottom up: trauma, executive functioning, emotional regulation, the brain and child psychotherapy’. *Journal of* Child Psychotherapy, vol. 40, no. 1, pp. 3-19.

Music, G. (2015) ‘Bringing up the bodies: Psyche-soma, body awareness and feeling at ease’, *British Journal of Psychotherapy,* 2015; vol. 31, no. 1. pp. 4-19.

Music, G. (2019). *Nurturing Children: From Trauma to Growth Using Attachment Theory, Psychoanalysis and Neurobiology*. Oxon: Routledge.

Novick, K. K. & Novick, J. (2005). *Working with Parents Makes Therapy Work*. Lanham, MD: Jason Aronson.

Odhammar, F. Sundin, E. C. Jonson, M. Carlberg, G. (2011). ‘Children in psychodynamic psychotherapy: changes in global functioning’. *Journal of Child Psychotherapy*, vol. 37, no. 3, pp. 261–279.

Polkinghorne, D. E. (1992). ‘Postmodern Epistemology of Practice’. In Kvale, S. (ed.), *Psychology and Postmodernism* (pp.146-165). London: Sage.

Porges, S. W, (2004). ‘Neuroception: A Subconscious System for Detecting Threats and Safety’. Retrieved from: https://static1.squarespace.com/static/5c1d025fb27e390a78569537/t/5ccdff181905f41dbcb689e3/1557004058168/Neuroception.pdf.

Ratnarajah, D. & Schofield, M (2008). ‘Survivors’ narratives of the impact of parental suicide’. *Suicide and Life-Threatening Behavior*, vol. 38, no. 5, pp. 618-630.

Roisman, G. I., Padrón, E., Sroufe, L. A., and Egeland, B. (2002). Earned-secure attachment status in retrospect and prospect’. *Child Development*, vol. 73, no. 4, pp. 1204-1219.

Rosenbaum, A. (1994). ‘The assessment of parental functioning: a critical process in the evaluation of children for psychoanalysis’. *Psychoanalytic Quarterly*, vol. 58, pp. 466–490.

Rosenfeld, H. (1987). *Impasse and Interpretation: Therapeutic and Anti-Therapeutic Factors in the Psychoanalytic Treatment of Psychotic, Borderline, and Neurotic Patients*. London: Routledge.

Rustin, M. (2003). ‘Research in the consulting room’. *Journal of Child Psychotherapy*, vol. 29, no. 2, pp. 137-145.

Rustin, M. (2009). ‘Work with parents’. In: Lanyado, M. and Horne, A. (eds.) *The Handbook of Child & Adolescent Psychotherapy: Psychoanalytic Approaches. Second Edition*. (pp. 206–219). London: Routledge.

Sander, J., & Joffe, W. (1965). ‘Notes on childhood depression’. *International Journal of Psychoanalysis*, vol. 46, pp. 88-96.

Schafer, R. (1980). ‘Narration in the psychoanalytic dialogue’. *Critical Inquiry*, vol. 7, no. 1, pp. 29-53.

Schafer, R. (1980). ‘Narration in the psychoanalytic dialogue.’ Critical Inquiry, vol. 7, no. 1, pp. 29-53.

Schore, A. (2003). *Affect Dysregulation and Disorders of the Self*. New York: Norton.

Siegel, D. J. (2014). *Brainstorm: The Power and Purpose of the Teenage Brain*. London: Scribe.

Sutton, A. and Hughes, L (2005). ‘The psychotherapy of parenthood: Towards a formulation and valuation of concurrent work with parents’. *Journal of Child Psychotherapy*, vol. 31, no. 2, pp. 169-188.

Talge, N. M., Neal, C., Glover, V., and the Early Stress, Translational Research and Prevention Science Network: Fetal and Neonatal Experience on Child and Adolescent Mental Health (2007). ‘Antenatal maternal stress and long-term effects on child neurodevelopment: how and why?’. *Journal of Child Psychology and Psychiatry,* vol. 48, no. 3-4, pp. 245-261.

Tischler, S. (1979) ‘Being with a psychotic child: A psychoanalytical approach to the problems of parents of psychotic children’, *International Journal of Psycho-Analysis*, vol. 60, pp.29-38.

Trowell, J., Joffe, I., Campbell, J., Clemente, C., Almqvist, F., Soininen, M., Koskenranta-Aalto, U., Weintraub, S., Kolaitis, G., Tomaras, V., Anastasopoulos, D., Grayson, K., Barnes, J, and Tsiantis, J. (2007). ‘Childhood depression: a place for psychotherapy. An outcome study comparing individual psychodynamic psychotherapy and family therapy’. *European Child and Adolescent Psychiatry*, vol. 16, no. 3, pp.157-167.

Trowell, J. and Dowling, E. (2011). ‘Reflections and thoughts: Learning from the study’. In: Trowell, J. and Miles, G. (eds.) *Childhood depression: A Place for Psychotherapy*, (pp. 241-252). London: Karnac.

Tustin, F. (1972). *Psychotic Depression in Autism and Childhood Psychosis*. London: Hogarth, reprinted London: Karnac, 1995.

Vanheule, S. and Hauser, S. T. (2008). 'A narrative analysis of helplessness in depression', *Journal of the American Psychoanalytic Association*, vol. 56, no. 4, pp. 1309-1330.

Waddell, M. (2018). *On Adolescence*. Oxon: Routledge.

Weissman, M. M., Wolk, S., Goldstein, R. B., Moreau, D., Adams, P., Greenwald, S., Klier, C. M., Ryan, N. D., Dahl, R. E. and Wickramaratne, P. (1999). 'Depressed adolescents grown up'. *Journal of the American Medical Association*, vol. 281, no. 18, pp. 1707-1713.

Whitefield, C. and Midgley, N. (2015). ' "And when you were a child?": How therapists working with parents alongside individual child psychotherapy bring the past into their work'. *Journal of Child Psychotherapy*, vol. 41, no. 3, pp. 272-292.

Winnicott, D. W. (1948). 'Reparation in respect of the mother's organised defence against depression'. In: *Through Paediatrics to Psychoanalysis* (pp. 91-96). London: Tavistock, 1958; reprinted London: Hogarth Press, 1975.

Winnicott, D.W. (1960). 'Ego distortion in terms of true and false self'. In: *The Maturational Processes and the Facilitating Environment*. (pp. 140-152). London: Hogarth Press, 1965; reprinted London: Karnac, 1990.

Winnicott, D. W. (1963). 'Psychiatric Disorder in Terms of Infantile Maturational Processes'. In: *The Maturational Processes and the Facilitating Environment* (pp. 140-152). London: Hogarth Press, 1965; reprinted London: Karnac, 1990.

Winnicott, D. W. (1967). 'Mirror-role of Mother and Family in Child Development'. In: Raphael-Leff, J. (ed), *Parent-Infant Psychodynamics: Wild Things, Mirrors and Ghosts*.; pp. 18-24; Philadelphia, PA: Whurr Publishers; 2003.

Winnicott. D. W. (1973) *The Child, the Family, and the Outside World*. London: Penguin.

Bibliography

American Psychiatric Association (2013): *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Arlington, VA.

Bamberg, M. G. W. (1997). *Narrative Development: Six Approaches*. Mahwah, NJ: Lawrence Erlbaum Associates Publishers.

Boothe, B., Grimm, M. L. and Hermann, M. L. (2010). 'JAKOB narrative analysis: The psychodynamic conflict as a narrative model'. *Psychotherapy Research*, vol. 20, no. 5, pp. 511-525.

Boulard, A. (2015). 'Exploratory study of depressed adolescents' life narratives', *Psychologica Belgica*, vol. 55, no. 2, pp. 87-100.

Burr, V. (1995). 'What does it mean to be a person? The self as constructed in language'. In: *An Introduction to Social Constructionism*. London: Routledge.

Connolly, A. (2011). 'Healing the wounds of our fathers: Intergenerational trauma, memory, symbolization and narrative'. *The Journal of Analytical Psychology*, vol. 56, no. 5, pp. 607-626.

Cowan, P. A. (1999). 'What we talk about when we talk about families'. *Monographs of the Society for Research in Child Development,* vol. 64, no. 2, pp. 163-176.

Crouch, W., Lemma, A. and Briggs, S. (2008). *Relating to Self-Harm and Suicide: Psychoanalytic Perspectives on Practice, Theory and Prevention*. London: Routledge.

Dean, A. L., Malik, M. M., Richards, W. and Stringer, S. A. (1986). 'Effects of parental maltreatment on children's conceptions of interpersonal relationships'. *Developmental Psychology*, vol. 22, no. 5, pp. 617-626.

Edelson, M. (1993). 'Telling and Enacting Stories in Psychoanalysis and Psychotherapy: Implications for Teaching Psychotherapy'. In: *The Psychoanalytic Study of the Child*, 48, pp. 293-325.

Emmanuel, L. (2011). 'Brief interventions with parents, infants, and young children: A framework for thinking', *Infant Mental Health Journal*, vol. 32, no. 6, pp. 673-686.

Freud, S. (1915). 'Mourning and Melancholia', *Standard Edition*, vol. 14, pp. 237-258. London: Hogarth.

Hänninen, V. (2004). 'A model of narrative circulation', *Narrative Inquiry*, vol. 14, no. 1, pp. 69-85.

Issakainen, M. and Hänninen, V. (2016). 'Young people's narratives of depression'. *Journal of Youth Studies*, vol. 19, no. 2, pp. 237-250.

Labov, W. (1977). *Therapeutic Discourse: Psychotherapy as Conversation*. New York: Academic Press.

Lloyd, L. (2017). *The Transgenerational Perspective*. Accessed on 19/11/2020 at https://www.bacp.co.uk/bacp-journals/bacp-children-young-people-and-families-journal/march-2017/the-transgenerational-perspective/

Luborsky, L. and Crits-Christoph, P. (eds) (1990). *Understanding Transference: The CCRT Method*. New York: Basic Books.

Midgley, N., Ansaldo, F. and Target, M. (2014). 'The meaningful assessment of therapy outcomes: Incorporating a qualitative study into a randomized controlled trial evaluating the treatment of adolescent depression'. *Psychotherapy*, vol. 51, pp. 128-137.

Midgley, N., Holmes, J., Parkinson, S., Stapley, E., Eatough, V. and Target, M. (2014). '"Just like talking to someone about like shit in your life and stuff, and they help you": Hopes and expectations for therapy among depressed adolescents'. *Psychotherapy Research*, vol. 26, no. 1, Jan. 2016. pp. 11-21.

Midgley, N., O'Keeffe, S., French, L. and Kennedy, E. (2017). 'Psychodynamic psychotherapy for children and adolescents: an updated narrative review of the evidence base'. *Journal of Child Psychotherapy*, vol. 43, no. 3, pp. 307-329.

Milton, J., Polmear, C. and Fabricius, J. (2011). *A Short Introduction to Psychoanalysis*. London: Sage.

Mishler, E. G. (1995). 'Models of narrative analysis: A typology', *Journal of Narrative & Life History*, vol. 5, no. 2, pp. 87-123.

Monteagudo, José González. (2011) 'Jerome Bruner and the challenges of the narrative turn: Then and now', *Narrative Inquiry*, vol 21, no. 2, pp. 295-302.

Murphy, S. A. and Johnson, L. C. (2003). 'Finding meaning in a child's violent death: a five-year prospective analysis of parents' personal narratives and empirical data'. *Death Studies,* vol. 27, no. 5, pp. 381-404.

Omer, H. (1993a). 'Quasi-literary elements in psychotherapy', *Psychotherapy*, vol. 30, no. 1, pp. 59-66.

Omer, H. (1993b). ‘Short-term psychotherapy and rise of the life-sketch’, *Psychotherapy*, vol. 30, no. 4, pp. 668-673.

Owens, C., Lambert, H., Lloyd, K. and Donovan, J. (2008). ‘Tales of biographical disintegration: How parents make sense of their sons’ suicides’. *Sociology of Health & Illness*, vol. 30, no. 2, pp. 237-254.

Parry, A. and Doan, R. E. (1994). *Story Re-Visions: Narrative Therapy in the Post-Modern World*. New York: Guilford Press.

Penn, P. and Frankfurt, M. (1994). ‘Creating a participant text: writing, multiple voices, narrative multiplicity’, *Family Process*, vol. 33, pp. 217-231.

Polkinghorne, D. E. (1995). ‘Narrative configuration in qualitative analysis’. *Qualitative Studies in Education*, vol. 8, no. 1, pp. 5-23.

Riessman, C. K. (1993). *Narrative analysis*. London: Sage.

Riessman, C. K. and Speedy, J. (2007). 'Narrative Inquiry in the Psychotherapy Professions: A Critical Review'. In Clandinin, D.J. (ed.) Handbook of Narrative Inquiry: Mapping a Methodology. Thousand Oaks, CA: Sage Publications, Inc, pp. 426-456

Russell, R. L. (1991). ‘Narrative in views of humanity, science and action: lessons for cognitive therapy’, *Journal of Cognitive Psychotherapy*, vol. 5, pp. 241-256.

Russell, R. L. and Van den Broek, P. (1992). ‘Changing narrative schemas in psychotherapy’, *Psychotherapy: Theory, Research, Practice, Training*, vol. 29, no. 3, pp. 344-354.

Rustin, M. (2003). ‘Research in the consulting room’. *Journal of Child Psychotherapy*, vol. 29, no. 2, pp. 137-145.

Schafer, R. (1992). *Retelling a Life*. New York: Basic Books.

Tellides Jaffee, C., Fitzpatrick, M., Drapeau, M,, Bracewell, R., Chamodraka, M. and Marini, N. (2012). ‘The manifestation of transference during early psychotherapy sessions: Exploring an alternate data source for therapist narratives in transference research’. *Counselling and Psychotherapy Research*, vol. 12, no. 4, pp. 257-266.

White, M. and Epston, D. (1990). *Narrative Means to Therapeutic Ends*. New York: Norton.

Appendices

1: Session extract with colour coding

Below is an extract from Session Ten with May. The colour coding refers to the narrative analysis steps as defined by Dallos and Vetere (2005, p.70), outlined in my Procedure and Analysis section (pp.39-41). 'YP' refers to 'Young Person'. In this case, 'May' was used as a pseudonym.

278 Therapist: So I was just wondering whether the kind of thing that irritated you was
279 her wanting to copy you?
280 YP: Yeah erm that's basically what it is like (.) like as I said I just feel like when she's
281 doing everything that I'm doing it just feels like
282 Therapist: Mmm
283 YP: I'm not (.) myself?
284 Therapist: ((in overlap)) Yes
285 YP: And that I can't be an individual person
286 Therapist: Yes yes
287 YP: Be (.) an like I forgot who I said it to but a friend at school like most of them know
288 my niece and um I was talking having a conversation about it sayin that I don't think I
289 could be my individual person
290 Therapist: Yes
291 YP: And like they had been in the same position before
292 Therapist: Yes
293 YP: An they basically said that *erm ((pause)) my m*ind's gone blank ((short laugh))
294 erm
295 Therapist: ((short laugh)) Your mind's gone blank?
296 YP: Yeah that happens often
297 Therapist: Yes maybe it's because you're a bit full of a cold
298 YP: ((short laugh))
299 Therapist: Yeah
300 YP: Um
301 Therapist: But sometimes you do loose the thread a bit
302 YP: ((Laughs)) Oh gosh

303 Therapist: Yeah it's something about being your own individual person as opposed to
304 being really close to somebody (.) else how there are nice bits it's quite there are
305 pros and cons aren't there?
306 YP: Yeah
307 Therapist: Cos on the good side if you're really really close to someone else you
308 never have to feel (.) alone
309 YP: Yeah!
310 Therapist: But on the other hand if somebody is totally twinning up with you all the
311 time you kind of feel constricted and you can't actually venture out into the world and
312 experiment and find things out for yourself and that's part of the challenge of life isn't
313 it?
314 YP: Yeah
315 Therapist: Mmmm (.) So it sounds like maybe it's a kind of growing up thing that you
316 don't want to be kind of tied up with someone all the time you want to discover who
317 you are
318 YP: Yeah

2: Session extract with stanza example

Below is an example of a section from Chloe's first session where I felt my analysis benefitted from re-presenting the material into stanza format.

Here is the material in the original transcript format:

95.YP: Like as soon as I saw im like I saw his face an ((inaudible)) his face now but I
96.remember the expression and everything an then as soon as I (.) like walked up to im he
97.an just said 'Oh hi' and stuff it was like the first time I'd seen im like that I could remember
98.Therapist: Mmm
99.YP: (.) So like yeah I walked up to im an I just said hi an he just literally just got me an
100.squeased me which really freaked me out an it was like 'I don't even know you'

And here it is re-presented in stanza format:

As soon as I saw 'im
I saw his face
I remember the expression and everything
An' then as soon as I
Walked up to 'im
An' just said 'Oh hi'
It was like the first time I'd seen 'im
That I could remember
Yeah I walked up to 'im
An I just said 'Hi'
He literally just got me
An' squeezed me
Which really freaked me out
It was like 'I don't even know you'.
(lines 95-100)

3: Summary of session example

McLeod and Balamoutsou (2001) describe how 'Strategies are needed to enable a sensible degree of reduction of the text, without loosing too many important nuances of meaning' (p.139). In order to retain a manageable hold on each session whilst comparing and contrasting it with other sessions, I have summarised each session. Below is an example from Chloe's first session:

There is an air of strain at the beginning of the session; Chloe is late and describes a stressful journey. Though the therapist refers to an initial meeting held last week, Chloe claims not to have thought about the therapy. She takes in the room, noticing details which remind her of a supervised contact in a similar room with her father. This introduces the subject of her relationship with her father and we hear how traumatic her meetings with him have been. Her language is evocative as she describes him as 'creepy', 'weird', 'freaky', and 'scary' whilst simultaneously thinking back to how she was 'littler' and 'vunerable'. She describes clearly how she felt that she did not know her father and that he was like an 'anonymous person', making his sudden, uninvited physical contact with her feel threatening.

The therapist, referring to the initial meeting, describes Chloe's ambivalence about the sessions being audio-recorded for the IMPACT Study. This raises the subject of trust as Chloe describes the idea of sharing personal information which could then be listened to by a stranger as unsettling. The therapist suggests that, in the context of this very early stage of the therapy, this uncertainty might also refer to sharing information with her as she is akin to a stranger. Chloe then appears to take this up and explains that she has tried to trust people before who have subsequently let her down and that, consequently, she has put up a 'barrier' to protect herself.

The therapist, again referring to the initial meeting, reflects on how many moves Chloe has experienced. Chloe then lists these moves, including a move abroad and back again. In this story, she speaks of her dog which had to be left behind when she returned to the UK. She describes how, following giving up the dog, the dog also experienced multiple moves. Though Chloe describes being happy to move back to the UK, it is clear that she is very sad about leaving her dog behind. In describing

how important it was to make sure that the dog was left with people who would take good care of her, Chloe raises the subject of cultural difference. She describes how the women in the country in which they lived were preoccupied by physical appearance and that a culture of gossiping was prevalent. Though Chloe describes that she did not care that people gossiped about her, later in the session she contradicts herself and describes how 'scarred' she has been by an experience where two boys bullied her and said that she had a 'fat chin', leaving her to worry what people say about her. She also describes how the boys' comments put an idea into her head which would not have been there if they hadn't made these comments. The therapist links this to an idea that Chloe might worry about what sort of ideas might be evoked by the therapy and Chloe agrees quite adamantly with this suggestion.

Chloe describes peer relationships – both good and bad with regular ups and downs as might be expected in adolescence. Within this context, she brings up the subject of a girl who she and her friends shunned. At first it appears that this was because the girl was mean and gossiped about the friends, even inciting the boys to bully Chloe. But during the session Chloe spends quite some time musing over who was to blame for the girl being shunned and wondering if her expulsion was necessary, especially given the girl experienced an unhappy and abusive family life. The session seems to end quite abruptly.

4: Ethics Approval Letter

The Tavistock and Portman NHS
NHS Foundation Trust

Quality Assurance & Enhancement
Directorate of Education & Training
Tavistock Centre
120 Belsize Lane
London
NW3 5BA

Tel: 020 8938 2699
https://tavistockandportman.nhs.uk/

Jessica Maliphant

By Email

14 May 2019

Dear Jessica,

Re: Trust Research Ethics Application

Title: What stories do depressed adolescents tell about their relationships with their parents?

Thank you for submitting your updated Research Ethics documentation. I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee your application has been approved. This means you can proceed with your research.

If you have any further questions or require any clarification do not hesitate to contact me.

I am copying this communication to your supervisor.

May I take this opportunity of wishing you every success with your research.

Yours sincerely,

Best regards,

Paru Jeram
Secretary to the Trust Research Degrees Subcommittee
T: 020 938 2699
E: academicquality@tavi-Port.nhs.uk

cc. Course Lead, Supervisor, research Lead

5: Turnitin Receipt

Digital Receipt

This receipt acknowledges that Turnitin received your paper. Below you will find the receipt information regarding your submission.

Submission Author	JESSICA MALIPHANT
Turnitin Paper ID (Ref. ID)	86519210
Submission Title	M80 Final Thesis
Assignment Title	Check your draft essay with Turnitin
Submission Date	15/03/21, 14:26