Exploration of the process of implementing Short Term Psychoanalytic Psychotherapy (STPP) within a Child and Adolescent Psychotherapy team working in an NHS Trust: An Interpretative Phenomenological Analysis.

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Abstract

This study aims to explore the implementation of Short-Term Psychoanalytic Psychotherapy (STPP) in Children and Young People's mental health services (CYPS) in an NHS Trust. It focuses on the perspectives of the Child and Adolescent Psychotherapists (CAPTs), investigating their thoughts and feelings as they implemented STPP. Particular focus is given to how these thoughts and feelings changed over the year of this process.

The participants were four qualified CAPTs working across three CYPS within one NHS Trust. This constituted the majority of the Trust's CAPT team. Data was gathered via transcription of audio recordings of the participant's interviews at two time points: Time 1 as CAPTs were beginning to use STPP and Time 2 a year into its implementation.

Interpretative Phenomenological Analysis was then used to elicit themes from the data. Particular attention was paid to how these themes changed or did not change over the two interview time points. Three relevant superordinate themes were found:

Theme 1- Is STPP '*psychotherapy-light*'[1]? Existential questions.

Theme 2- The '*hard reality*'[2] of time, could there be '*enough*'[3]?

Theme 3- '*People are very depleted*'[4] - the need for organisational holding and containment.

[1] Participant D, Time 1, Line 425
[2] Participant D, Time 1, Line 392
[3] Participant C, Time 2, Line 314
[4] Participant C, Time 1, Line 314

The findings are explored and discussed in relation to relevant research and psychoanalytic theory. Reflexivity and the countertransference of the researcher are also used to further embed and illuminate the findings.

The fantasies, thoughts and feelings CAPTs have in relation to STPP are central when introducing this way of working. The importance of organisational culture, and a holding and containing environment in allowing space for innovation is highlighted.

Word count: 282 words

Declaration

I declare that the content of this study is my own work and that ethical approval for it was granted by TREC (see Appendix A).

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1. Introduction

This study sought to explore the process of a Child and Adolescent Psychotherapy (CAP) team implementing Short Term Psychoanalytic Psychotherapy (STPP) within their services in a National Health Service (NHS) Trust. It focused on the perspectives of four Child and Adolescent Psychotherapists (CAPTs), the majority of the CAP team, who were starting to use STPP in their services, which for most of them was a new way of working.

STPP is a time-limited, manualised psychoanalytic therapy recently developed by CAPTs to treat adolescents with depression, in recognition of the need for effective and timely treatment for this population and the need for the profession to engage with and undertake research interrogating whether the treatments we can offer provide benefits for patients (Cregeen et al., 2017). The model was designed to be used in the manualised psychoanalytic treatment arm included in the Improving Mood with Psychoanalytic and Cognitive Therapies (IMPACT) study (Goodyer et al., 2017), which compared the efficacy of this treatment compared to Cognitive Behaviour Therapy and a brief psychosocial intervention in reducing depressive symptoms in adolescents. This was a landmark study for the CAP profession. It was the largest RCT of its kind that CAP had been included in, and its findings importantly showed parity between the treatment models-all significantly reduced depressive symptoms in the participants and there was no significant difference in cost between treatments.

On the basis on the IMPACT study, the National Institute for Health and Care Excellence (NICE) guidelines included psychodynamic psychotherapy as one of their recommended treatment options for adolescents with moderate to severe depression

(NICE, 2019). NICE explicitly highlight that their guidelines are based on empirical evidence and the need for more good quality research showing the efficacy of psychodynamic psychotherapy and other psychological therapies, to inform future treatment guidelines. NHS mental health services are expected to take account of NICE guidelines in developing their provision of care. Therefore, being part of research that might provide a basis for increased CAP inclusion in these guidelines is vital if CAP is to continue to be part of the picture of NHS commissioning, training, and recruitment processes and thus ultimately widely available to patients accessing the NHS.

As a profession, CAP can seem to find itself grappling with how to adapt, develop, survive or even thrive as it strives to find its place within pressurised modern NHS children and adolescent mental health services (Holmes, 2000). CAP involvement in the NHS has long, complicated roots. CAP training and practice has been a part of the NHS since it was founded in 1948 (Pedder, 1996) and it continues to be one of the 12 core NHS psychological professions (The Association of Child Psychotherapists, 2020). However, CAPTs in the NHS are working in services that are having to respond to increased patient demand and limited resources resulting in a pressure for patient throughput, alongside a need to increase their evidence-based treatment provision and undergo service transformation in line with the NHS Long Term Plan (NHS, 2016).

Following the development of STPP and the IMACT study, the CAP profession has now included STPP, alongside other time-limited models, in its core training alongside longer, intensive ways of working (The Association of Child Psychotherapists, 2020). Given the wider service drivers, pressures and context

described, there is a rationale to implement STPP as a time-limited, evidence based treatment in CAP more widely.

However, this drive for more CAPTs to offer STPP and other evidence-based, manualised, time-limited work in general is not without controversy. There is a recognition that, since its inception, there have been disagreements between psychoanalytic thinkers about the optimal duration of treatment, and how time-limited, short-term models are viewed (Briggs, 2019).

Within this context, in 2017, the CAPTs I was working alongside in my training post decided to start to implement STPP into their services. I was interested in how this process would develop, and in my search of the literature could not find any papers that investigated this process from the perspectives of CAPTs. In my subsequent reading, I noticed literature regarding STPP and other psychoanalytic time-limited models anecdotally reported that clinicians can find the implementation of these models challenging (e.g. Mann, 1982, p. 78). It appeared that an in-depth study of this process could therefore be an interesting, fruitful and timely area of research.

I therefore interviewed CAPTs in the Trust where I was working as they began to implement STPP (2017), and again a year in to this process (2018). During this year, the CAPT group focused on STPP work during their monthly peer supervision to support themselves in starting to learn about and use this model of therapy. I used Interpretative Phenomenological Analysis to analyse the interview data, identifying subordinate and superordinate themes, paying particular attention to how these themes did or did not change over the year at the two interview time points. This gave an indication as to the processes of implementing STPP and gave rise to three superordinate themes of particular relevance to the field of study. These themes

focused on existential questions about STPP; the experience of the limitation of time in STPP and whether STPP could offer enough for some adolescent patients; and the difficulty of implementing STPP within pressured services, highlighting the need for organisational holding and containment.

While STPP was being implemented, the service I was working in, as so vividly described by CAPT participants (see Findings: Superordinate Theme 3), was under huge pressure: high staff sickness, ongoing and incessant changes of managers, pathways, protocols and the imperative to treat high numbers of patients in an effective and timely manner. Navigating the process of instigating new effective models of working successfully was therefore an important challenge.

The decision to base this study in the Trust I was training in, was reflective of the aim of producing research that closely reflected and examined real-world experiences in the profession that could improve patient care and professional experiences. On a personal level, I was invested in the development of services within the Trust where I was training, and where I hoped to continue future work once qualified. I had long been interested in how decisions are made about the duration of psychotherapy and particularly in the ending dynamic, so STPP was a model I was curious about and wanted to understand better. I hoped this research would help me and my colleagues understand the process of implementing STPP within the Trust more deeply and that this understanding might support this endeavour, as well as any future innovations in our working practise. This was for both my own development and that of the services and the Trust more widely. I also hoped that this research might more broadly support other CAP colleagues thinking about innovation and implementing STPP where they worked.

2. Literature Review

This research study was an investigation of the first year of implementing Short Term Psychoanalytic Psychotherapy (STPP) in Children and Young People's Mental Health Services within an NHS Trust. STPP was developed as a psychoanalytic treatment for adolescents with depression (Cregeen et al, 2017). Depression is a significant mental health issue for this age group (World Health Organisation [WHO], 2019) and effective treatment within the NHS is therefore vital. The IMPACT study (Goodyer et al., 2017) was a major Randomised Control Trial (RCT) which provided evidence of the efficacy of STPP, and this model is now specifically included in the Child and Adolescent Psychotherapy (CAP) training. The use of STPP has been a significant development in the CAP profession, with a rationale for it to be further rolled out into NHS Trust services. This study focused on the perspectives of the Child and Adolescent Psychotherapists (CAPTs) who decided to start using STPP, most of whom did so for the first time.

A literature review was undertaken in four main areas to examine the field under study and add weight and context to the research findings. The areas focused on were adolescence, depression in adolescents, psychotherapeutic time-limited work with adolescents, and further psychoanalytic theories relevant to the scope of the study. The RAMESES protocol (Greenhalgh et al., 2011), identifies the essentials in a literature review: 1) identifying seminal papers with the help of supervisors, colleagues and assessors; 2) pursuing references and citations; and 3) database search (including 'grey' literature such as PhD theses and unpublished reports, see also Noble and Smith, 2018). In following this protocol, psychological and psychoanalytic databases (including PsycINFO, PEP Web, Psychology and

Behavioural Sciences Collection, PsychARTICLEs, Cochrane Library) were individually searched using key words, truncated words and synonyms. Results were then narrowed down to select papers relevant to this study.

In deciding the scope and focus of the literature review, it was important to understand the context. STPP is a treatment developed for adolescents with depression, which has shown good results (Goodyer et al., 2017). It is a short-term, time-limited, manualised treatment model. Therefore, these three areas (adolescence, depression in adolescence and psychotherapeutic time-limited work with adolescents) were focused on in the literature search and review. The psychoanalytic theory base included related to the scope of the study as important context. As the data analysis proceeded, the particular psychoanalytic concepts that emerged relevant to the findings were related to data regarding the difficulties participants described in their working environments. These seemed key to their feelings about implementing new ways of working in starting STPP. Further literature was thus sought and included which looks at this issue. There is, inevitably, a huge body of literature which came to light in some of the areas highlighted that could not be included in this thesis, given the limitations of space.

Adolescence

Much has been written in the fields of psychology and psychoanalysis regarding adolescence, the following is a brief overview of key facts and thinking regarding this stage of life. The World Health Organisation (WHO) states that an ‘adolescent’ is a person aged between 10-19 years old, a ‘young person’ between 10-24 years old (WHO, n.d.). Adolescence is the transitional period of maturation and development between childhood and adulthood, related to the onset of puberty, when it

commences and its duration can vary between individuals. Adolescence includes physical, neurological, psychological and social changes, how it is, or has been, understood differs across time and between cultures (Lesko, 2012).

As mood disruption, risk-taking and parental conflict have become seen as more common as a natural part of adolescence, particularly in Western culture (Arnett, 1999), it can be difficult to distinguish what is normal developmental turbulence within the adolescent context and what is symptomatic of pathological illness (Hilt and Nolen-Hoeksema, 2009). Whilst there can be social stigmatisation of adolescence (Briggs, 2009), most people successfully navigate it (Graham, 2004); it is often a time of 'much disturbance, change *and* (emphasis added) potential for growth' (Wise, 2000, p.7).

Depression in Adolescence

What Is Depression in Adolescence?

Until the 1970s and 1980s symptoms relating to depression were often seen as ordinary emotional turmoil associated with adolescent development (Bhardwaj and Goodyer, 2009; Stein and Fazel, 2015). Indeed, the Diagnostic and Statistical Manual of Mental Disorders (DSM) only extended the diagnostic criteria of depression to include children and adolescents in 1980 (Cregeen et al, 2017). Much has changed in our understanding since this time; the WHO now recognise depression in this age group as a significant issue, globally understood as the ninth leading cause of disability and illness in adolescents (WHO, 2019).

In the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) the criteria for depression included specific criteria for children and adolescents, including that 'depressed mood' may present as 'irritability' in this

age group (see Appendix B for full criteria). Depressed adolescents and children may present with differing symptoms to adults (Birmaher et al, 1996), for example, adolescents may describe ‘low mood’ as ‘boredom’ (Bhardwaj and Goodyer, 2009). Symptomatic criteria of depression (as detailed in the DSM-5) can support the diagnosis of depression. However, it is important this does not become a barrier to adolescents accessing services and treatment when they are suffering with the impact of symptoms of depression but do not meet diagnostic thresholds (Bertha and Balázs, 2013; Bhardwaj and Goodyer, 2009).

The picture of adolescent depression is complicated by the likelihood of comorbid disorders. In particular, research shows there is often comorbidity between depression and anxiety in adolescence and early adulthood (Waszczuk et al, 2015). As many as 25-50% of depressed adolescents have been found to have comorbid anxiety disorders (Axelson and Birmaher, 2001). Recent research by Cohen et al. (2018) and Finsaas et al. (2018) added texture to this picture as they considered the trajectory of symptoms; both studies found that there was heterotypic continuity between childhood anxiety and adolescent depression (i.e. that children with anxiety are more likely to develop depression later in adolescence). Additionally, McLaughlin et al. (2015) found that adolescents with high levels of depressive symptoms had associated statistically significant higher levels of physical, social and separation anxiety over a period of a year than adolescents with lower levels of depressive symptoms, although the mechanism through which this association develops remains unknown.

Prevalence of Depression in Adolescents.

Costello et al.’s (2006) substantial meta-analysis of 26 epidemiologic studies considered the prevalence of depression. This research considered data from

59,703 observations of children and adolescents born between the years of 1965-1996. They found that 5.6% (standard error 0.3%) of 13-18 year olds had diagnosable depression. This study looked at data collected globally rather than the prevalence of depression in adolescents in the United Kingdom specifically.

At the time of writing, the most recent data published by National Health Service [NHS] Digital (2018) collated survey responses sent to 18,029 children and adolescents (as well as their parents and teachers) living in England who were registered with a General Practitioner, using a stratified probability sample. This survey considered the prevalence of children and adolescents who met the threshold of a diagnosable emotional disorder (including anxiety disorders, depressive disorders and bipolar affective disorder). They found 9.0% of 11-16 year olds and 14.9% (95% confidence intervals) of 17-19 year olds had an emotional disorder. Depression and anxiety disorders were found to be the most prevalent emotional disorders in this sample: 7.9% of 11–16 year olds had anxiety disorders and 2.7% of the same age group had depressive disorders. The prevalence rose for 17–19 year olds, with 13.1% found to have anxiety disorders and 4.8% depressive disorders. This research had a large sample size designed to be representative, but a modest response rate of 52% may have introduced bias into the sample and reduced the quality of the data collected (Rindfuss et al., 2015). Whilst the survey relied upon self-report measures, data was taken from more than one respondent (child/ young person, parent and teacher) which is likely to have increased the validity of the findings.

In consideration of the prevalence of depression in adolescents, gender appears to be an important factor, with research finding a statistically higher prevalence in females than males (Birmaher et al., 2007; Costello et al, 2006; NHS Digital, 2018).

It appears that these gender differences emerge during adolescence, as it is not found in younger children (Angold et al., 2002), and the gender difference in adolescence is comparable to that in the adult population (see Fonagy et al., 2015 for a full overview of the literature). Whist there is not one clear explanation for this gender discrepancy, it may be due to a complex interplay of biological and social mechanisms (Cyranowski et al., 2000).

There has been controversy over whether there has been an increase in the prevalence of emotional and behavioural problems in the adolescent population over time (Briggs, 2009). Whilst Costello et al. (2006) did not find that an increase in the prevalence of depression in adolescents between the years of 1965 and 1996, the more recent NHS Digital study in 2018 did find a statistically significant increase in the prevalence of emotional disorders in children and adolescents, aged 5-15 years, of 4.3% in 1999 to 5.8% in 2017. Collishaw's (2015) literature review of the distribution and prevalence of mental health problems globally also found that diagnosis and treatment of affective disorders in children and adolescents has significantly increased over recent decades in high income countries.

Certainly, in the UK, there has been a recognition of the need to increase the general mental health provision available to children and adolescents. In the NHS Long Term Plan (NHS, 2016) created in 2015/6 there was a commitment for significant additional funding and resources for Children and Adolescent mental health services to increase the numbers of children and young people that could access treatment and support by 2021/22.

Risks Associated with Adolescent Depression.

NHS Digital (2018) found that adolescents with mental health disorders were significantly more likely to also drink alcohol, smoke and use illicit drugs compared to adolescents who did not have a mental health disorder. Whilst a correlational finding, this study, and other research (Aalto-Setala et al., 2002; Eaton et al, 2012), has found that adolescents with depression and other mental health disorders are more likely to self-harm and attempt suicide than those who do not have such illnesses. It is of concern that Morgan et al. (2017) found a 68% increase of 13-16 year old girls presenting in English primary care settings with self-harm injuries between 2011 and 2014. Further research is needed to illuminate the underlying reasons for such an increase.

Kessler et al. (2001) found that at least 50% of children and adolescents diagnosed with depression would experience depression again in adulthood, though this was based upon retrospective reports of adult patients and therefore subject to recall bias. However, a recent meta-analysis of longitudinal cohort studies by Johnson et al. (2018) added weight to this finding, they pooled data from eleven separate cohorts and found adolescents with depression were 2.78 times more likely to go on to experience depression in adulthood than those who did not experience depression as adolescents.

These parts of the literature review underline the serious nature of adolescent depression, the prevalence and impact of it on individual's lives during their adolescence and the potential of this illness continuing into adulthood. Research (Ferrari et al, 2013) has shown that worldwide, depression was the second highest cause of years lived with a disability, and in 26 countries it was the primary cause of adult disability. Effective and timely treatment is therefore vital in trying to alleviate

adolescents' current suffering, and to support them to move towards living healthy adult lives.

Current Available Treatment in the United Kingdom for Adolescents with Depression.

The National Institute for Health and Care Excellence (NICE) provides formal health care guidance in England, as well as in Scotland, Wales and Northern Ireland through their devolved administrations. The NICE guidelines (NICE, 2019) recommend children and adolescents who have moderate to severe depression should be thoroughly assessed and treated in Children and Adolescent Mental Health Services (CAMHS) (also known as Children and Young People's Services, CYPS) with particular attention given to understanding the relational, family and environmental context and risks associated with the child or young person. NICE highlight the need to establish a therapeutic alliance and to undertake shared decision-making, taking account of the preferences and values of the patient and their carers. For young people (aged 12-18 years old) with moderate to severe depression, NICE recommends offering individual cognitive behavioural therapy (CBT), for at least three months with or without fluoxetine medication as a first line intervention. If CBT is not considered effective or suitable in meeting clinical need, then interpersonal therapy for adolescents (IPT- A), family therapy, brief psychosocial intervention (BPI) or psychodynamic psychotherapy should be offered, again with or without fluoxetine. This is a significant inclusion for the CAP profession, as these guidelines influence commissioning, the professional make-up of services and therefore treatments available to patients. It is also important to note that within this guidance, NICE highlight that CBT is recommended as a first line treatment due to there being more good quality research involving CBT, which demonstrates its efficacy. They emphasis the need for further high quality studies to fully understand

the efficacy of psychotherapy, as well as other treatments such as family therapy and IPT-A to inform future treatment guidelines.

CBT has a focus on ‘affective education, coping skills, problem solving and cognitive restructuring’ (Hilt and Nolen-Hoeksema, 2009, p476). IPT-A focuses on resolving relationship problems relating to the adolescent’s depression (Kirpatrick et al., 2017). BPI involves psychoeducation and building up healthy habits and activities (NICE, 2019) and family therapists work with an adolescent and their family together, focusing on issues within family life (Larner, 2009). Meanwhile psychodynamic psychotherapy (like psychoanalytic psychotherapy) aims to work with the individual to ‘understand and resolve … problems by increasing awareness of their inner world and its influence over relationships both past and present. It differs from most other therapies in aiming for deep seated change in personality and emotional development’ (British Psychoanalytic Council, n. d.).

The NICE guidelines further suggest offering antidepressant medication (fluoxetine) to treat adolescents with depression, in conjunction with a psychological therapy, unless the child or adolescent has refused therapy. There are concerns about whether these drugs are an effective treatment for depression in this age group (Jureidini et al., 2004) and associated increased risk of suicidality (Hammad et al., 2006) requiring careful ongoing review. This highlights the need for effective, accessible psychological treatment for this age group.

Psychoanalytic Understanding of Depression in Adolescence.

The ‘psychic agenda’ of adolescence is a full one, which has been extensively written about in psychoanalytic literature (Waddell, 2002 and 2018). Changing hormones and physical maturation of the body relate to an increase in sexual and

aggressive drives, which can feel disturbing, and overwhelming (Evans, 1982; Waddell, 2002). Adolescents have to navigate moving from a child-like state, dependent on parental care, to becoming an individual who is expected to manage their own separate, sexually mature body (Laufer, 1987), which can provoke ‘intense anxiety’ (Laufer, 1996, p.348). Peer group relationships appear to have particular importance to an adolescent’s psychic development and emotional health (Jarvis, 1999).

Psychoanalytic thinking has also considered how the course of the adolescent processes of separation and individuation may relate to how such processes were navigated earlier in life (Blos,1983). In adolescence, emotional change and transition is often not linear, and this period is typically thought of as a struggle, with a simultaneous pull toward, and flight away, from increasing separation from parents or carers and the independence of adulthood, which ‘increase[s] the potential for both internal and external conflict’ (Hilt and Nolen-Hoeksema, 2009, p4).

In their book ‘Short-Term Psychoanalytic Psychotherapy for Adolescents with Depression: A Treatment Manual’, Cregeen (2017) and colleagues give a succinct and thorough overview of the major psychoanalytic theories and ideas relating to adolescent depression (see chapter ‘Psychoanalytic Views of Adolescent Depression’, p. 11-35). They emphasise that psychoanalytic psychotherapy focuses on the ‘underlying psychodynamic and developmental issues, rather than on manifest symptoms of depression’ (p. 11). Highlighting that it is crucial that the understanding and treatment of an adolescent experiencing depression must incorporate the understanding of their adolescent developmental process.

Time-Limited Psychotherapeutic Work with Adolescents

Whilst all psychotherapy is in a sense time-limited and has an ending, this phrase is most often used in relation to brief or short-term psychotherapy. Briggs (2019) gives an overview of the history and development of psychoanalytic time-limited ways of working, the genesis of which was in Freud's, at times, extremely brief intensive analyses. Briggs highlights that there has been controversy surrounding the duration of psychoanalytic treatments from the early days of development (as later further explored), and a sense that the idea of delivering time-limited, shorter forms of psychoanalytic therapy with adults and children keeps 'disappearing' (p15). Briggs details how brief, time-limited psychotherapeutic models came back to the fore of the psychoanalytic profession from the 1950's with the development of several time-limited psychoanalytic treatment models.

Malan (1979) was a significant figure in re-establishing the role of time-limited psychotherapy with children and adults. He developed a model with a 40-session limit, calling it 'short-term dynamic psychotherapy'. Mann (1982), another prominent figure, wrote 'Time-Limited Psychotherapy' outlining a 12-session model with different tasks at the beginning, middle and end of the work. He described time as both maternal and paternal, and said that paternal time is essential and demonstrated, in his model, by the adherence to the 12 sessions. He saw the final phase of this work as the most important part, with the hope of 'mastery of separation' in which the patient's ego and self-esteem may be 'fortified by the internalization of the therapist' (p46). Whilst there are differences in technique between these and other forms of time-limited work, both suggest that in these models the reality of the ending has a greater presence than is often felt in open-

ended work, the feeling of loss may therefore be present from the beginning and available to be worked with.

There has been on-going development of psychoanalytic models for working with children and adolescents in a time-limited way. For example, the Tavistock Under 5 model (as described in Bradley & Emmanuel, 2008; Wylde, 2009) is a well-established five session psychoanalytic treatment model for working with infants and their parents/carers. There has been a development of an idea that psychoanalytic brief, time-limited work can be beneficial in treating a wider range of patients than traditionally thought (Binder et al., 1983; Davenloo, 1995; Shefler, 2000; Strupp et al., 1984).

Time-limited work with a psychoanalytic basis for adolescents in particular has been an area of development within the CAP profession. For example, there has been a development of treatments such as Dynamic Interpersonal Therapy (Lemma et al., 2011) and Mentalisation Based Therapy (Rossouw & Fonagy, 2012). Briggs (2015) developed Time-limited Adolescent Psychodynamic Psychotherapy (TAPP) alongside Louise Lyon, based on Malan's work earlier described. This is (usually) a 20-session, manualised, model which has a focus of psychoanalytically understanding an adolescent's difficulty and focusing on these issues to re-establish developmental processes and progress. Briggs highlights that such work requires a focused approach rather than trying to resolve or cure all the difficulties a patient might bring with them in to therapy.

Although traditionally seen as requiring long term work, Trowell and Kolvin (1999) found that girls (aged 6-14 years) who had been sexually abused showed improvement when treated in a time-limited way via either 30 individual

psychotherapy sessions, or 12-18 sessions of group work. Trowell and colleagues (Trowell et al., 2007) went on to develop Focused Individual Psychodynamic Psychotherapy (FIPP), which was a 30-session treatment model (with concurrent parent work) to be used with adolescents with depression. When compared to family therapy in this RCT, both treatments were shown to be effective in treating moderate to severe depression in children and adolescents (9-15 years old). It was the on the basis of the FIPP model that STPP was developed for inclusion in the IMPACT trial (Goodyer et al., 2017).

Short Term Psychoanalytic Psychotherapy (STPP)

Whilst the term 'Short Term Psychoanalytic Psychotherapy' (STPP) can be used to describe many different ways of working which appear in a search of the literature, in this context it refers specifically to the model described in 'Short-Term Psychoanalytic Psychotherapy for Adolescents with Depression: A Treatment Manual' (Cregeen et al., 2017). STPP is a model developed and used by CAPTs to treat adolescents with depression, based on psychoanalytic understanding of the particular processes and challenges of this stage of development earlier described. It includes 28 psychotherapy sessions for adolescents alongside 7 sessions for their parents or carers.

STPP is a manualised model of treatment that was developed for inclusion in the Improving Mood with Psychoanalytic and Cognitive Therapies (IMPACT) study (Goodyer et al., 2017). This study was a naturalistic, multi-centre RCT and the largest trial of psychoanalytic psychotherapy with children and young people as yet undertaken. As such, it marked an important milestone for psychoanalytic psychotherapy research and the CAP profession. The study included 465 adolescent participants who had moderate-severe depression, and compared three treatment

arms: STPP, CBT and a brief psychosocial intervention (BPI). STPP was found to be as effective as CBT and BPI in a reduction of symptoms of depression at the end of treatment, and a year on there was a continued reduction in these symptoms as well as co-morbid symptoms such as anxiety. This parity of treatment efficacy was particularly significant in the context of CBT having often been seen by services as the treatment of choice, given its extensive evidence base (Fennell, 2012), and highlighted the importance of the availability of a range of treatment options for patients including STPP.

With the development of STPP and its inclusion in the IMPACT trial showing its efficacy in treating adolescents with depression, there is currently an increased rollout of this model within services. Training in STPP, or other equivalent manualised time-limited models, is now specifically included in the Quality Assurance Framework of The Association of Child Psychotherapists (ACP), who accredit CAP training programmes (The Association of Child Psychotherapists, 2020). Whilst the ability to offer brief work and assessments has long been part of CAP training (alongside the capacity to offer long-term, intensive work), the inclusion of time-limited manualised models such as STPP is of particular importance, relevant to this study.

Controversy surrounding time-limited and manualised models of psychotherapy

Briggs (2019, p.15) describes the way in which explicitly time-limited, short-term work has provoked ‘crucial and long-contested issues in psychoanalysis’ (see also Hallett 2012; Nyberg 2011; Wilson 1992). Briggs (2019) draws our attention to Freud’s writings in the early 20th century regarding the value of brief psychoanalytic work, and this being held in contrast with an understanding of his technique whereby

the analyst gives time and attends to developments as they come in open-ended work.

Into this discussion, restrictions on funding for psychological treatment of any sort, and a pressure on services to meet increased demand for treatment, has intensified the debate. CAPTs who have been largely trained to work long term in an open-ended way, and whose personal training therapy or analysis is also long term, may not feel comfortable with this time-limited model.

In his development of Time Limited Adolescent Psychodynamic Psychotherapy (TAPP), Briggs (2010 and 2019) asserts that the time-limited nature of the work is helpful to the adolescent patient who is able to use this structure developmentally and not be overwhelmed by an open-ended commitment. Whist the perspectives of the adolescents and their parents taking part in the IMPACT study has been well researched (Midgley et al., 2016; Midgley et al., 2017; Stapley et al., 2016), less is known through research about how CAPTs view undertaking such time-limited, manualised work.

Whilst I did not find any specific research that focused on the views of CAPTs undertaking time-limited work, their responses and difficulties with it have been anecdotally reported in the literature. In their study, Trowell and Kolvin (1999) highlighted the need for careful management and supervision in the face of the pressure and pain involved for both patients and clinicians in having to accept the limitation of time in the psychotherapy and group work treatments they were researching.

Cregeen et al. (2017, p. 54) emphasised that CAPTs can experience the time-limitation of STPP ‘like a cruel imposition on both patient and therapist, especially

when working with adolescents with particularly severe depression or with long histories of loss and abandonment'. Mann (1982) wrote that when introducing any innovative model of brief work, one must be aware of the 'emotional resistances to it', that these could include 'an exuberance and enthusiasm…in the hope that it will make possible the fulfilment of a preciously held fantasy' or an 'objection…derive[d] from the personal need to avoid the undoing of a fantasy' (p78). He warns that unless the resistances of clinicians are explored and discussed then they 'are apt to foreclose a fair trial' of the model (p79). Psychoanalytic ideas regarding resistance are further explored in the following section.

The relationship between STPP and other time-limited, manualised treatments and research is also an important consideration and possible source of controversy. Henton and Midgely (2012) outlined the impassioned nature of the debate and split within CAP about engagement in research, and the value of it, particularly in regards to Randomised Control Trials (RCTs) with the focus on outcome research. This study focused on the thoughts and feelings CAPTs had about being involved in the IMPACT study as an RCT. They described, in participants, a gradual shift moving from a position of resistance and distance from such research endeavour to becoming more actively involved and engaged and sharing hopes that the outcomes of the study could be helpful to CAP development and position in NHS services.

Manualisation of psychotherapeutic work allows its greater inclusion in robust clinical studies, as it allows adherence to the treatment to be measured and confirmed. Midgely et al. (2013, 2017 and 2021) highlight that historically psychodynamic treatments have not had as robust an evidence-base as other forms of treatment for children and adolescents, and give an important overview of the increasing body of

research regarding its efficacy in treating a wide range of mental health difficulties that does now exist.

The importance of the development of ‘academic, clinical and research skills’ is highlighted in the Quality Assurance Framework for CAP training (ACP, 2020, section 3.3). The inclusion of research skills speaks to the public sector requirement for greater provision of evidence-based treatment, as set out in the NHS Long Term Plan (NHS, 2016). Thus, there is an emphasis on the need for the CAP profession to develop its evidence-base to continue to be valued and funded as a core profession in mental health services. This represents a shift in the training and profession, with a move to an increased research-mindedness in the core training, which now includes research doctoral studies within the four-year programme.

Further Psychoanalytic Theory and Concepts Relevant to the Area of Study and Findings

Holding and Containment

In psychoanalytic theory, the concepts of holding and containment overlap: both are part of what the infant needs from the parent or carer in order to thrive. However, there are differences that are pertinent to some of the findings from this research. ‘Holding’ is more of a way of being than a particular process: as described by Winnicott, (1965[1960]) it is complex and involves the whole of daily care, taking account of the infant’s body and emotions and following ‘the minute day-to-day changes belonging to the infant’s growth and development, both physical and psychological’ (p. 162). The care-giver enables the child in this way to have a sense of time and what Winnicott (1956) termed ‘going on being’ (p303). ‘Containment’ is more of a process: some internal activity with a beginning, middle and end wherein

the container takes in the desperate and inchoate feelings from the infant and is able to metabolise them sufficiently for the infant to be able to receive them back and not be overwhelmed by them, a process described by Bion (1962). Caldwell and Joyce (2011) and Ogden (2004) elaborate on the differences and connections between holding and containment, suggesting that they are not mutually exclusive activities - each offer a perspective.

As will be discussed in the following section on how workers engage with new models of working, what enables workers to engage with change is also complex and multi-layered. However, as the developmental process involves constant change, it is reasonable to assume that some of what is essential to the developmental process in life will be necessary for a process of change in any human activity. It could be argued that to translate the ideas about what an infant needs to develop into what a worker needs to embrace change is stretching the concepts too far. However, as will be further discussed later, the literature search in the area of psychoanalytic understanding of organisations indicates that workers need to feel secure in their organisation (similar to being ‘held’), and they need to feel part of a process which takes account of their ideas and their feelings (similar to ‘containment’). These are prerequisites for successful development and worker engagement.

Resistance

In psychoanalytic theory, resistance has a specific meaning. As described by Rycroft (1968), it is ‘the opposition encountered during psychoanalytic treatment to the process of making UNCONSCIOUS processes CONSCIOUS’ (p.142, author’s emphasis). Freud wrote about resistance as early as 1909 (Freud, 1910[1909],

SE11), noting that ‘some force’ (p.23) prevented an idea or memory becoming conscious. He said that this force was called into being by the need to repress a conflict which ‘would have produced a high degree of unpleasure’ if it were to reach consciousness (p.24). Klein understood resistance as ‘an expression of anxiety and negative transference’ (Spillius et al., 2011, p.474).

In modern psychoanalytic theory, resistance continues to be written about. The PEPWEB has over 800 references and papers on the subject (for example, Bernstein 2013; Lentz, 2016). The general point is that resistance is a clinical challenge that if unprocessed, leads to difficulties in the patient being able to change. As noted by Hurst (2016), looking at the concept of resistance first requires thinking about the concept of change. Many of the comments in the literature regarding the need for resistance relate to the idea that it is a defensive activity, because the required change produces anxiety.

In thinking about the subject of this research, the concept of resistance offers a possible lens with which to view the data: humans resist change when they are unsure or anxious about what the change will involve or what its outcome might be. This has particular relevance in thinking about how workers engage with change, discussed below.

How Workers Engage with New Models of Working

A psychoanalytic literature search of this topic has not produced much material specific to introducing new models of working within psychotherapy services. However, given one of the findings (See Findings and Discussion: Superordinate Theme 3), it was important to try and understand how clinician’s feelings and perspectives might impact on their ability to implement innovative ways of working. A

search through the Pepweb (which contains many psychoanalytic papers) for ‘employee’ produced 18 papers that refer to a psychoanalytic understanding of organisations; the search for ‘organisation’ together with ‘change’ produced 28.

The use of psychoanalytic understanding to help organisations deal with problems is an area of psychoanalytic practice that is well established. For example, Cooper and Dartington (2004), De Board (1978), and Hinshelwood and Skogstad (2002) have all written and researched in this area. What emerges relevant to this study is that for staff to work co-operatively they need to feel both supported and valued, and not under too much pressure.

Rao (2013) highlights the importance of organisational culture in their case study regarding psychoanalytic consultancy work in a physical health team within the NHS. She describes how when under significant pressures, organisational cultures can become stuck, hostile and ‘unthinking’ (p3). This can result in staff employing unconscious psychic defences to avoid overwhelming anxiety, resulting in resistance to thinking about how change can be possible. She emphasises the need for containment within such organisations to allow creative thinking to emerge.

Obholzer (1986) writes that resistance to change in organisations is fundamentally based on institutional dynamics, and what anxieties are being defended against at an institutional level. He particularly highlights the role of leadership in bringing in change, that those instigating change need to be seen as having the accepted authority to do so, and to have an inner conviction about the change for such a process to be possible.

The way in which research-based evidence translates to making policy and a drive to change practice within the fields of social care and mental health has been explored

by Cooper and Wren (2012), based on their own professional experiences. They highlight that treatment models with a research evidence-base, which are cost-effective and used to treat specific problems, are increasingly promoted by commissioners and managers of public services. However, these can stall when the imperative to implement such models reaches frontline services. They detail their concern that such a process can place too much emphasis on the implementation of what they view as often unsound research and drive change that does not take in to account the complexity of individuals, and the range of knowledge workers have in their work with these people. Although this paper was based on experiential knowledge and case study examples, it is relevant to the implementation of STPP, which is part of the professional response to the agenda of increased focus and funding on evidence-based treatment models. These concerns could therefore be seen as part of the context in which STPP arrived, despite STPP's strengths of having been developed within the CAP profession with the complexity of individuals and the knowledge CAPTs have about their patients at its core.

Change management and worker engagement is a much-researched area in the field of psychology, employer/employee relationships and human resources departments, as a search of wider, less psychoanalytically focused databases found. For example, Di Fabio et al. (2016) found that workplace relationship civility was positively associated with the acceptance of change in their research involving 261 participants working in public and private institutions. Other research by Vakola et al. (2004) has highlighted how differences in individual's personality traits and 'emotional intelligence' play in to their attitudes toward change, as measured by self-report inventories. Holbeche and Matthews (2012) and Macey et al. (2009), writing about the essential nature of employee engagement, stress the need for the

employees to be consulted about changes and managed supportively. The psychoanalytic theories that might illuminate these findings are discussed in the previous section.

This section of the literature review identifies and reinforces the importance of staff feeling valued and supported in their work. In the matter of implementing innovations, an understanding of individual and institutional resistance is vital, the role of leadership important but potentially contentious, belief in the efficacy of the new requirements needed, and consultation before changes are implemented are all key to increasing the likelihood of successful outcomes.

In conclusion, what can be understood from this literature review is that adolescence is an incredibly important developmental stage, during which a sizable minority of individuals experience depression that can have significant and ongoing detrimental impacts on their lives and thus requires timely and effective treatment. There has been a development of time-limited psychotherapeutic work to treat adolescents, within this context STPP has been developed by CAPTs (Cregeen et al., 2017) and shown to have successful outcomes in treating depressive symptoms (Goodyer et al., 2017). Thus, CAP training has developed to include STPP, and other time-limited models (alongside open-ended, long-term, intensive work) and there is a drive to roll out delivery of STPP within services.

Whilst the IMPACT study has shown the efficacy of STPP (Goodyer et al., 2017) and there is research regarding the perspectives of patients and their families taking part in this study (Midgley et al., 2016; Midgley et at., 2017; Stapley et al., 2016), and how CAPTs viewed taking part of it as an RCT (Henton and Midgley, 2012) less is

known about CAPTs perspectives of delivering STPP and implementing it into their services. In the context of a history of controversy surrounding time-limited work in the CAP profession (Briggs, 2019), and what is known about resistance to thinking and change in organisations, particularly when they are under pressure, this felt a gap in the literature and an area worthy of further investigation.

3. Methodology

The aim of this research project was to explore the process of implementing Short Term Psychoanalytic Psychotherapy (STPP) within a Child and Adolescent Psychotherapy (CAP) team working in an NHS Trust.

Specifically, I aimed to do this via the following avenues of investigation:

- To capture and explore Child and Adolescent Psychotherapists' (CAPTs) thoughts and feelings about STPP at the beginning of the process of implementation within the Trust.
- To capture and explore CAPT's thoughts and feelings about STPP after a year of implementation of STPP within the Trust, examining changes and consistencies over time.

This project used Interpretative Phenomenological Analysis (IPA) as a methodological basis to design data collection and analysis procedures, focusing on the following sources of data:

- A total of eight interviews with four CAPT participants working in the same NHS Trust. The interviews were undertaken at two time points:

Time 1- At the beginning of implementation of STPP in the NHS Trust (2017)

Time 2- A year in to the implementation of STPP in the NHS Trust (2018)

<u>Context of the research</u>

Short Term Psychoanalytic Psychotherapy (STPP) has been a significant development in the Child and Adolescent Psychotherapy (CAP) profession, with robust research from the IMPACT study showing its efficacy as a treatment for

adolescents with depression (Goodyer et al., 2017), and its inclusion in the CAP training alongside open-ended, longer-term work, as described in the Literature Review. In short, there has been a commitment and growing national interest in using STPP within the CAP profession.

CAPT colleagues in the Trust within which I was training agreed to start to learn about STPP together and implement this model in their work. This decision process and how I was or was not involved, was later subject to differing interpretations from the point of view of the participants (see 'Findings and Discussion, Superordinate Theme 1'). From my perspective, it was a decision made by the group of CAPTs, independently from me, and I was told about the decision by my service supervisor, following a peer supervision where I had not been present. At the time, and subsequently, I understood that the decision was born out of colleague's interest and awareness of a drive within the profession to use STPP given its part in the IMPACT study. When I heard of this idea, I saw it as giving a timely opportunity to investigate the process of implementing STPP in real time, in real community mental health services and to find out what might arise in these processes from the point of view of CAPTs.

The CAPTs in the NHS Trust where I worked were based across three distinct children's mental health services (CYPS). They met once a month for peer supervision in which they presented and explored clinical work. These peer supervision meetings were the forum in which starting to learn about and use STPP had been originally discussed and in subsequent meetings I clarified with colleagues that this had been my understanding and introduced the idea that I would develop a research project to run alongside the endeavour to start using STPP. A firm plan developed in the group, where peer supervision would be used for a year for CAPTs

to focus on STPP work and thus give themselves professional support in starting to use this model. During this year of STPP focused peer supervision meetings, CAPTs read and discussed the STPP Treatment Manual (Cregeen et al., 2017) and qualified members took it in turns to present their clinical STPP work.

The decision to undertake research within the Trust where I was a trainee was partly in order to find out more about implementing STPP within the context of usual CAP work, and to produce findings with direct relevance to the Trust. It was also in order to try to reduce the variables in the research. For such an intersubjective process as implementing a new model of working in CAP, I thought it would be useful and offer another perspective if I aimed to use the embedded nature of my position and my experience in the process of the research and in extrapolating findings. Selecting participants from another Trust, as well as having large practical implications, would not remove any possible problem of the researcher being known as having an investment in the outcomes, particularly within the context of a comparatively small and interconnected profession. Working in my own Trust enabled me to use my knowledge and reactions as part of the evidence (as further explored in the Findings and Discussion).

Participants

At the beginning point of data collection in 2017, the NHS Trust in this research employed five qualified CAPTs and myself, a trainee CAPT. We worked in three distinct CYPS services in different localities, with our own separate teams, clinical managers, clinic buildings and patient populations.

I wanted to explore the process of establishing STPP work across the Trust including, if I could, perspectives from CAPTs working in the three different Trust

services, to explore what emerged in this process across the different service environments. I hoped this would add richness to the data, about what might be similar or different about starting STPP work in these slightly different contexts. I therefore invited all five qualified CAPTs working in the Trust to be participants and take part in the study and four agreed to do so.

This resulted in representation of at least one CAPT from each of the three CYPS services within the overarching Trust, and inclusion of the majority of the CAPT team. Attempts were made to creatively include the CAPT who did not want to be interviewed and understand something of their perspective, but ultimately their decision not to take part had to be respected. It would be interesting for future research to explore the views of CAPTs who chose not to take up the STPP model.

My final sample size of four participants was thus largely governed by the number of CAPTs in the Trust who agreed to participate in the interviews, which fitted with the suggested sample size of IPA, my chosen methodology, as later discussed. The participants in this study were a homogenous group in that they were all qualified CAPTs working in the same Trust. Smith et al. (2009) suggest that when using IPA, data from a homogenous group enables the research to thoroughly examine the phenomena of a particular experience, in this case the experience of implementing STPP. There were however, some important differences between the participants, which are important to expand upon as far as is possible whilst maintaining confidentiality.

I have given much consideration through supervision and throughout the process of conducting and writing this study up, about how much detail to give regarding the participants involved in this study. Whilst such information is helpful to readers and

fellow researchers in understanding this research, caution about this is necessary as the CAP profession is a small one and individual demographic descriptors would increase the likelihood of participants in this study being identifiable. However, the following information relating to participants as a group seems particularly pertinent to giving context to the findings and less likely to identify participants as particular individuals.

The participants, as a group, had trained in a variety of training schools across the United Kingdom and all had trained at a time before STPP was developed or taught on clinical training courses. They were experienced clinicians, at different stages of their careers. Whilst for the majority of participants this was their first experience of using STPP, one participant had been involved in the IMPACT study and had prior experience of using the model. Participants worked in the same Trust, but were based in three different services with their own cultures, geographical and social contexts. These individual differences and variety in circumstances reflects some of the real-world differences within CAP teams that might be starting to use STPP and adds depth and rich complexity to the data and findings about this process of implementation.

Research Methodology

Interpretative Phenomenological Analysis (IPA)

I was looking for a qualitative research methodology that would allow the embedding of the researcher in the co-construction of the making of meaning and exploration of CAPTs ideas and feelings underlying the process of implementing STPP. I chose IPA, which is a qualitative research method Smith developed in response to what was seen as the limitations of the dominant positivist paradigm in health psychology

research, and the wish to instead take an idiographic approach to more fully take account of and understand the rich complexity of human experience (Smith et al., 1995). Much has now been written regarding IPA's methodology and applications in social science research (Dhanak et al., 2019; Pietkiewicz and Smith, 2014; Roebuck and Reid, 2019; Smith et al., 2009).

IPA has at its foundation the phenomenological concern of understanding an individual's subjective, personal perception of an event, phenomenon or experience (Smith et al., 2009). It takes in to account the reality of its limitations - that the understanding of another is affected by the researcher's own conceptions and subjectivity. Making sense of another's inner world and thoughts is understood as an interpretative endeavour, which requires a double hermeneutic process. Participants are invited to make sense of their own experience and communicate this verbally through interviews, and the researcher must then make sense of what the participant is communicating through what they say, how they say it and what they do not say (Smith et al., 1999; Smith et al., 2009). This double hermeneutic is central to the IPA model of making and understanding the meaning of the subject being researched to the participants. It is a research and analytic method, which has been increasingly used to give insight into aspects of patient and therapists experiences of therapeutic processes (for example, Friel, 2016; Whitefield and Midgley, 2015).

Consideration of the nature of co-constructed meaning and the role of interpretation was important in the context of this study. Whilst supervision was used to check for bias in the interview questions, process and analysis, the researching interviewer had particular professional relationships with all the CAPT participants that needed to be held in mind and examined. Beyond my personal characteristics, at the time of these interviews, I was a CAPT trainee in the Trust and as such met the participants

as part of peer supervision once a month throughout my training. I was also a supervisee of one of the participants and thus had a closer professional relationship with them. I considered whether this relationship was too close to allow for their inclusion in the research project, but on balance, their unique perspective into the process of implementing STPP felt important. Furthermore, I was someone who was in the midst of a training that for the first time incorporated the research doctorate in the clinical training, and also included specific training in STPP and time-limited manualised work. All of this needed to be considered as part of the co-constructed meaning of the interviews, as explored further in the Findings and Discussion chapter.

Psychoanalytic Theory and IPA

The nature of IPA, in valuing the exercise of detailed examination of the experiences of one, or a limited number, of individuals in order to better understand the complex meanings of a particular phenomenon, felt familiar from my learning about psychoanalytic thinking through my training. Psychoanalysis has a long history of theory being derived, evolved and adapted from rich clinical case histories and work (Lingiardi et al., 2016) which, as with qualitative research more generally, at times has left it open to criticism regarding its validity and replicability, but also offers important insight to human experience and what we might understand of ourselves and each other (Eagle, 2007; Yin, 2009).

The nature of double hermeneutics allows a process of rich interpretations, including thinking about what meaning might be communicated unintentionally, or unconsciously. The psychoanalytic stance used in psychotherapy helped me in my interviewing skills. In mind was Bion's (1967) idea of being present with patients

without 'memory or desire' (p.136), being careful not to put one's own theoretical understanding, past experiences, or hopes on to what the patient is trying to express. Instead, to have centrally in mind, the importance of attentive listening and attention to verbal, non-verbal, conscious and unconscious communication. In the interviews, this was precisely the position I tried to hold. Being alert to times before, during and after interviews in which I could feel a pull away in to my own memory or desires for STPP, or for the research project, and to use my reflexivity and supervision to interrogate these and the interplay with what I understood in my communications with the participants.

Researcher reflexivity is a requirement for all researchers, particularly in qualitative research (e.g. Lyons and Coyle, 2011). It includes the researcher's critical evaluation of both the research and of the theoretical concepts used, as well as internal work to remain open-minded about the subject of research and possible findings. Reflexivity does not explicitly incorporate the unconscious, but there are many areas of discussion where there is an implicit acceptance of it. For example, Langdridge (2007) offers ten 'fairly basic questions' (p.59) for the reflexive researcher, which include questions about the researcher's feelings and motivations. What reflexivity does not explicitly embrace is countertransference, which is important in psychoanalytic work and understanding. This is the process whereby the feelings and preoccupations of the subject are communicated unconsciously to another (Rycroft, 1968), in this case the researcher. Being alert to this intersubjective experience could indicate an area of interest or concern to the participant.

Research Design

Smith et al. (2009) suggest that for professional doctorates the number of interviews best used in an IPA study is usually in the range of four to ten, they note that the aim is 'quality not quantity' (p.51). Although at the higher end of this range, the eight interviews I conducted in total therefore fitted well with my chosen data collection and analysis model.

The four CAPT participants were interviewed at two time points. The first time point (in 2017) was a couple of months in to the year of using peer supervision to think about the STPP model and clinical work. At this time, all participants had had a chance to read about the STPP model in the Treatment Manual and begin to think about using STPP. The aim was that they would have begun to have their own thoughts, feelings and expectations about STPP, which I might capture and explore via interviews.

The second interview time point was a year later, in 2018, once the process of using the peer supervision meetings to think about STPP had just ended. The aim was that participants would have had by this time an opportunity to undertake STPP work. I hoped to capture and explore how their thoughts and feelings about STPP might have changed, or stayed the same, and capture some of their experiences of implementing STPP within the context of NHS CYPS services.

Following the IPA recommendations for interviewing participants (Smith et al, 2009), for each time point, I created interview schedules with 6-8 main questions and optional supplementary prompts to aid exploration of thoughts and reflections (see Appendix C and D). These interview schedules were discussed with supervisors and revised to ensure questions were open-ended and neutral. The aim was to ensure

we kept to the topic of STPP, participant's views, thoughts and feelings about the model and how it would be or had been implemented in their service, but to allow enough space for free and natural expression. Questions and prompts were used to jump off from and return to, and the interviewer was free to change the order of questions if it better followed the natural flow of the discussion, to ask participants to expand on their specific comments and to allow novel thoughts and ideas to come into the conversation.

CAPT participants were invited to choose the location of their interview in a confidential, quiet, comfortable and safe space. All participants chose to conduct interviews on the NHS Trust property where they worked, in private rooms where we could not be overheard or disturbed. Interviews lasted about an hour and were audio recorded.

Interview recordings were formally transcribed using a trusted provider to ensure confidentiality and security, and were anonymised. The transcriptions were then analysed using the IPA procedure as described in Smith et al. (2009). That is, I first familiarised myself with the text, reading the transcripts multiple times, in conjunction with the original audio recordings. I added descriptive, conceptual and linguistic comments, looking for repeated words and clusters of words. I then noted emerging themes, 'which speak to the psychological essence of the piece' (Smith et al., 2009, p.92). I undertook this procedure for each interview before moving on to the task of identifying and developing superordinate themes.

Once I had found emerging themes in the data, I began to build up layers, developing and organising subordinate themes in to a preliminary structure, which began to coagulate around likely superordinate themes. An example of this process

of developing a superordinate theme can be found below, in Table 1. Interrelationships between subordinate themes were identified and compared for concurrence, convergence and divergence, to develop strong over-arching superordinate themes.

Table 1: Example of the process of developing emerging themes in to subordinate and superordinate themes

Emerging themes (examples)	**Subordinate Themes**	**Superordinate Theme**
Split, divided team Pressure to do more Overstretched Difficulty putting context of service in to words Fighting for resources Feeling of persecution Traumatised workforce Changes imposed/force Coping with ongoing change and restructuring CAP is an overstretched resource	The wider context of pressurised services	'People are very depleted' -the need for organisational holding and containment
Importance of service stability for innovation Change is uncomfortable Peer supervision- 'precious' space and time STPP focus -opportunity to learn Work to protect CAPT peer supervision space Role of supervision in containing CAPT anxiety Peer supervision containing anxiety Peer supervision - learning	The need for organisational holding and containment.	

Once I had found superordinate themes for Time 1 interviews, I then undertook the same process for the Time 2 interviews. Whilst I tried to approach these with an open mind to new significant themes arising at this time, I also wanted to notice how the superordinate themes from Time 1 might or might not be present a year on; how ideas and feelings about STPP might have evolved over time. In the event, I did not

find any new superordinate themes in the Time 2 data, and could focus on how themes from Time 1 had or had not changed over this period. For the data from the Time 2 interviews, as well as looking at how the superordinate themes had changed or remained consistent from Time 1, I also remained alert to what was the same or different between the participants within these themes.

I had considered an alternative methodology of focusing on following the findings for each participant through Time 1 and then Time 2, noting more specifically what had changed or had not changed for each individual. However, whilst handling the data, it quickly became apparent that such a methodology would be too cumbersome with such extensive data. Furthermore, it would be more exposing for the participants as it would make them far more identifiable within the data. I therefore persisted with the plan of primarily taking the themes more generally and as a group as a whole, highlighting where there were important differences between participants, inconsistencies within interviews, and changes or stability of themes generally as a group across the time points.

At each stage of this process I engaged in thorough supervision in which I shared with my supervisor the detail of my analysis through marked up transcripts, emerging themes and then superordinate themes – evidencing how these had been derived, in order to crosscheck that the themes were congruent with the data. This process was integral to ensuring my data analysis was credible. To do this, my natural way of working using paper, pens, colours to add layers of analysis and find the best fit for the data into themes, had to adapt and find expression instead through the computer in documents that I could share via secure email for online supervisions. This was a way of working and process that was difficult at first but I found increasingly useful, as it provided space for creative, lively analysis. For example, using ‘copy and paste’

to find the best constellation of emerging and subordinate themes that then gave wider superordinate themes that best made sense of the data, and communicating this as a process that could be followed by my supervisor in the evolution of drafts of these documents.

Using researcher reflexivity and my countertransference, I also used my research diary to try and monitor both any biases and any possible counter-transference reactions. This will be explored further in the sections of reflexivity and countertransference in the Findings and Discussion section and in the Further Discussion section. I worked at keeping the possibility of being surprised by my findings as I went along to avoid confirmation bias, and indeed there were themes I was surprised to find, as later discussed.

This was a complex process and elicited a huge amount of data, which needed to be pared down to focus on what was of most existential import to the research aim of exploring the process of implementing STPP in a CAP team. This led to me not including one superordinate theme from my findings: '*'Parent work I think is still a big issue'*[5]- The importance and challenges of delivering parent work'. This superordinate theme featured in all interviews across the two time points. However, as these findings were related to wider, more general challenges in delivering parent work in CAP, rather than specifically related to STPP, this theme was not expanded upon or included in the findings and discussion. Interested readers can see the findings related to it in Appendix H.

[5] Participant A, Time 2, Line 92

This process led me to find the following three superordinate themes:

Theme 1: Is STPP '*psychotherapy-light*'[6]? Existential questions.

Theme 2: The '*hard reality*'[7] of time- could there be *'enough'*[8]*?*

Theme 3: '*People are very depleted*'[9] -the need for organisational holding and containment.

Adaptations to the Research Design

The design of my study evolved during the course of data collection and analysis, in response to pragmatic concerns and in discussion with my supervisor.

I had originally planned a mixed methods design, and included the collection of data regarding STPP patient participants. This was to investigate the uptake and delivery of STPP within the Trust over this initial year of implementation. The original aim was to collect descriptive data regarding the number of patients seen for STPP, their demographics, number of sessions offered and taken up, and outcomes of therapy (were goals reached, symptoms reduced) and the views of patients and their parents or carers.

I became concerned during the year of STPP implementation that the expectation of CAPT participants using outcome measures with their patients might be becoming obstructive to them starting STPP work, as they were, anecdotally, not felt to be a usual part of their CAP work. As it was imperative that this did not prevent participants starting STPP, I made it clear that use of outcome measures was not a

[6] Participant D, Time 1, Line 425
[7] Participant D, Time 1, Line 392
[8] Participant C, Time 2, Line 314
[9] Participant C, Time 1, Line 314

prerequisite to them using the model or taking part in the research, with the idea concerns relating to this could be explored in the Time 2 interviews.

In the event, outcome measurements were not consistently used, and so would have been difficult to compare. There was a low return in patient and parent/carer participant questionnaires. Some relevant patient demographics, such as age, were reflected upon in interview data and so already part of the findings from another avenue of evidence.

More pressingly, once I had collected all of the data, I found that I had a prolific amount of interview data from CAPT participants and pragmatically would struggle to fully examine and explore this if I also tried to fully examine and explore the patient data within the limitations of this research project. I had in mind Smith (2011) and his assessment of what makes a ‘good’ IPA study, in particular the need for space to present and discuss at least two themes that are well evidenced with interesting and detailed discussion. On balance, as less is known about CAPT’s views on STPP and their experiences in beginning to use this model in their usual practice within the NHS, I felt this was the most important area on which to focus my research.

As earlier discussed in my literature review, there is already substantial evidence of the efficacy of STPP from the IMPACT trial (Goodyer et al., 2017) and a body of research concerning adolescent and parents’ perspectives, via the IMPACT - My Experience study (for example see Midgley et al., 2016; Midgley et al., 2017 and Stapley et al., 2016). The data elicited from the patient participants was still useful in later reflections within the CAPT team of the research, and readers who might be interested I have appended the methodology I used and my findings from this part of the research (Appendix E).

Ethics

Ethical issues were a particularly important consideration in this study and were thought about thoroughly and frequently through the supervisory process. Ethical approval was sought and obtained from the NHS Trust and the University of Essex.

CAPT participants were initially invited to be interviewed via email and discussions about participation in the research study were kept outside of the STPP-focused peer supervision to ensure CAPTs were not put under undue pressure to participate. Participants were given a written explanation of how their data would be gathered and used and gave written consent (Appendix F).

It was made clear that although every effort would be made to anonymise data, as this was a small CAP team and verbatim extracts would be used, there was a chance participants might recognise themselves and colleagues in the findings. Consent was considered an ongoing process, discussed before interviews and revisited during and after interviews where appropriate. Indeed, this led to some specific patient related data being withdrawn from an interview transcript and a discussion within another interview about how one comment might be represented in a way the participant felt was generalised enough that they would not be recognised.

Through supervision, thorough thought was given to presenting findings in a way that both represented and protected the anonymity of the CAPT participants as far as possible.

All data was held on a Trust laptop following Trust Data Protection Policies and, once anonymised, held in secure locked cabinets.

In conclusion, this naturalistic study aimed to explore the process of implementing STPP within the context of a CAP team working in an NHS Trust. The scope of my initial research design meant that I was able to respond to the pragmatic need to adapt this project to focus solely on qualitative data. Qualitative data was elicited from interviews with four CAPT participants at two time points - as they began to think about using STPP and a year into implementing this model into services. These interviews garnered rich qualitative data, which could offer insight in to how CAPTs think and feel about using STPP in their busy practice, and how these thoughts and feelings might evolve, or remain the same, over time.

4. Findings and Discussion

The three relevant superordinate themes that emerged from the interview data encapsulated the thoughts and feelings that the idea of implementing Short-Term Psychoanalytic Psychotherapy (STPP), and the experience of doing this, evoked in Child and Adolescent Psychotherapist (CAPT) participants. Table 2, below, is a summary of these superordinate themes and their corresponding subordinate themes:

Table 2: Superordinate and Subordinate Themes

Superordinate Theme	**Subordinate Theme**
1: Is STPP '*psychotherapy-light'*[10]? Existential questions.	A: How STPP fits with or is in opposition to what CAP is and how CAPTs are trained to work B: What, or who, is driving the decision to implement STPP C: STPP as a part CAP work, concern that it does not take over.
2: The *'hard reality'*[11] of time- could there be *'enough'*[12]?	A: Worries about time, loss and being in the position of a bad, withholding, depriving object. B: Psychological avoidance of the ending, having longer in mind. C: Could STPP focus the work and be enough for what some adolescents need?
3: *'People are very depleted'*[13] -the need for organisational holding and containment.	A: The wider context of pressurised services B: The need for organisational holding and containment.

In illustrating the findings of each subordinate theme, I have used verbatim extracts that appeared to be typical examples. All verbatim examples can be found in Appendix

[10] Participant D, Time 1, Line 425
[11] Participant D, Time 1, Line 392
[12] Participant C, Time 2, Line 314
[13] Participant C, Time 1, Line 314

G. Findings have been organised into what was found from the Time 1 interview data, as STPP was beginning to be implemented, and then what was found a year later in the Time 2 interviews, showing what had changed or not changed. At both time points, I have represented the different voices of the participants – the similarities and divergence of their ideas and feelings.

Taking each superordinate theme as a whole, I have then discussed this in relation to relevant research and psychoanalytic theory, to see what theoretical constructs might assist with the process of making meaning of the findings. I have also examined my own researcher reflexivity and counter-transference experience, to further explore and embed the findings.

4.1 Superordinate Theme 1: Is STPP '*psychotherapy-light*'[14]? Existential questions.

This superordinate theme encompassed the existential questions about STPP that came out of the interview data in relation to the Child and Adolescent Psychotherapy (CAP) profession. It consisted of three subordinate themes, as illustrated in Table 2, and these have been used as subheadings to present the findings.

A. How STPP fits with or is in opposition to what CAP is and how CAPTs are trained to work.

Findings from Time 1 Interviews

During the beginning stages of implementing STPP within the Trust, the three participants who had not previously used STPP wondered how STPP might fit within or perhaps be in opposition to what they felt CAP was. There was a repetition across

[14] Participant D, Time 1, Line 425

some of the interviews in comparing STPP to what was repeatedly termed more *'traditional'* forms of open-ended and long-term CAP work, pointing to this being the form of work that colleagues, patients and families would usually expect when coming to see them. This was strongly raised as an area of concern in the following extracts:

'I think some people might think it's psychotherapy- light. Erm, and sometimes the sugar-free versions, or the caffeine-free versions aren't, you know, there's, they're not considered the real thing. So, I don't know if, erm, I think for some there may be a feeling that what they're getting, or if they're offered this- I don't, I mean they might feel it's that, you know, they're not getting the whole, the, the full deal.' -Participant D, Time 1, Lines 425-430

'I suppose there is something about li-limiting sessions- that is a, it's not against everything that we do but it does feel, kind of, anti-child psychotherapy' -Participant C, Time 1, Lines 790-792

These two extracts vividly demonstrate the idea of STPP being in opposition to something fundamental in CAP, or being seen to represent a watering down of it.

In the first extract, Participant D puts these thoughts out into what *'some people might think'* rather than presenting this as what they themselves think. This could straightforwardly be an expression of how they thought colleagues and patients might respond to STPP in comparison to usual CAP work, and therefore part of the challenges of implementing it in the service. Alternatively, or additionally, this might have been a more palatable or unconscious way of bringing in a concern they also had about STPP. In the interview, their hesitant language seemed to convey that this idea was difficult to put into words. The phrase that STPP could be considered '*psychotherapy-light'* seemed key, and was a motif that was repeated in this extract, as they go on to say that people may feel they're not getting *'the real thing'*, *'the full*

deal'. In the second extract, Participant C remarked on the one hand, *'it's not against everything we do'* and added *'but it does feel, kind of, anti-child psychotherapy'*. This similarly felt very stark.

Participants brought up how it felt to deliver STPP, when they had had *'training in traditionally long-term psychotherapy'* (Participant B, Time 1, Line 98), where the *'training is very much about long-term intensive, erm, cases'* (Participant C, Time 1, Line 794). There was a sense that STPP was '*such a different way of working'* (Participant D, Time 1, Line 207).

Another participant, when discussing a change they had made to their STPP patient's session time remarked, *'maybe traditionally a, a psychotherapist might not have wanted to be perhaps as pliable as I was.'* (Participant B, Time 1, Lines 429-430). This seemed related to the more general idea already described about STPP being in comparison to *'traditional'* CAPT, or a *'traditional'* psychotherapist- someone in mind less *'pliable'*, who would not adapt so much.

There were however differing thoughts: that STPP might be *'business as usual, in, in, in many respects'* (Participant B, Time 1, Line 177) and important as part of the *'wide répertoire'* (Participant B, Time 2, Line 634) of what CAP could provide. There were thoughts that STPP offered a helpful way to work with some adolescents, particularly those nearing the transition to adult services (as explored further in Superordinate Theme 2). Participants linked STPP to more familiar forms of brief CAP work, mentioning previous time-limited work they had undertaken due to external time-limiting factors such as patients moving away, or when using the Under 5 Tavistock model, for example:

'Well, it reminded me in a way about, er, under-five work and, er, the five-session model, erm, introduced by the Tavistock. And my service supervisor initially helping me to think, think about that, and, and that you kind of have to, to work at a, a faster pace, in a way' –Participant B, Time 1, Lines 151-153

These links to other time-limited work seemed to support the participants in finding in their minds a grounding for STPP, a way in which to think about this way of working that fitted with what they already understood and used in their practice. However in this interview there also remained a feeling that the specificity of the 28 sessions for patients, and 7 parent or carer sessions in STPP brought in *'a new dimension'* (Participant B, Time 1, Line 99) which required a '*kind of learning curve'* (Participant B, Time 1, Line 103).

Findings from Time 2 Interviews

In general, thoughts about whether STPP was in opposition to *'traditional'* CAP had reduced a year in to the implementation of STPP in the Trust, in the Time 2 interviews. One participant reflected on the initial feelings about implementing STPP, stating:

'I guess there's been a bit of resistance to it, I think, a little bit, I think it's felt a bit out of what we know, which is silly in lots of ways. That fear of, "We can't do it differently".' – Participant C, Time 2, Lines 16-21

There seemed, in this participant, a reflection regarding the shift of their feelings from the Time 1 interviews in how they saw STPP and from the use of the collective word *'*we', the change they saw of this more widely in their CAPT colleagues. In this extract, the *'resistance'* to doing something *'differently'* like STPP now felt reduced, and on reflection even a *'silly'* fear. There seemed to remain an idea that STPP is doing something *'differently'*.

There continued across the interviews, and in the interview with this participant, a consistent sense that long-term, open-ended psychotherapy was at the core of how participants viewed CAP work:

'You know, the absolute core of what we do is, is long-term, open-ended psychotherapy, and that's not gonna change, that's, that's what we do.' – Participant C, Time 2, Lines 136-137

The idea that STPP brought a challenge to the fundamental ways in which participants were trained to work was also less prominent within the Time 2 interviews, however ideas about this were still present in some interviews and felt important:

'I think it's got appeal to the service. Erm, I think for, for me, although I, I kind of, enjoyed learning and thinking about it, erm, my- one of my, er, intensive case supervisors always sits on my shoulder and, er, and she always used to say, "Don't mess with the method.". Erm, and, erm, we're already reducing what we do, you know. People already just coming once a week as opposed to twice or three times a week. And, erm, I suppose sort of something about holding on to what we do and holding on to something that we've been trained to do and that we're good at.' – Participant B, Time 2, Lines 389-395

In this interview, the participant later repeated this idea of *'don't mess with the method'* (Line 402) and considered this in relation to how colleagues may have experienced implementing STPP:

'Maybe like me, they've got a supervisor on their shoulder of "don't mess with the method".' -Participant B, Time 2, Lines 507-508.

The repetition of the phrase *'don't mess with the method'* seemed to indicate its importance to this participant. It linked to ideas present in Time 1 interviews that STPP had not been part of participant's training, and might in fact be opposed to, or dilute, core CAP principles. The phrase had a superego quality to it, which could be

considered to have persecutory or perhaps conversely, guiding qualities. The participant linked their own feeling to that which might be present throughout the group and perhaps underlying reticence about implementing STPP, offering a helpful insight to what some of these processes in the group might have been.

Conversely, this participant continued (as in their Time 1 interview) to have other time-limited work in mind, talking about the Under 5 Tavistock model and saying about this, *'so why not trust that you know, this could be equally valuable'* (Participant B, Time 2, Line 413). The presentation of this as a question raises the idea that there was something about the STPP model that remained difficult for this participant to *'trust'*, but that they were interrogating why this was in their own mind.

B. What, or who, is driving the decision to implement STPP

Findings from Time 1 Interviews

Participants spoke about STPP being a model that might benefit some of their adolescent patients (as explored in more detail in Superordinate Theme 2). They said that depression was a major issue within the adolescent patient population, and highlighted the research in to STPP and that the model had parity with other treatments from this research perspective. There were, therefore, clinical reasons presented as to why STPP might be a positive development in CAP and patient centered drivers for implementing it. However, there appeared to remain a question about what external forces might also be driving the implementation of STPP and a sense of concern regarding this.

There were repeated comments about *'ethics'* in the interviews. This was raised more widely in the context of thinking about CAP work in general, for example

regarding parent work. It was also raised once in relation to STPP, and the duration of the model specifically:

'ethically, I think you kind of, just your, your clinical decision making has to - your patient has to be at the centre of it.' –Participant D, Time 1, Lines 499-500.

In this extract, patients being at the *'centre'* of decision-making was explicitly linked to being an ethical stance, showing the importance to participants that consideration regarding STPP should be primarily led by patient need and what was of benefit to them. This may be illuminative of why the presence of external drivers of STPP might cause a pause for thought. The repeated use of words relating to *'ethics'* in other interviews, even when not directly linked to STPP work, brought to mind the level at which participants were thinking about CAP work and STPP - that decisions they made in their work were important at a fundamental values level, and required careful consideration.

There were repeated comments in the interviews about STPP and short or time limited work being *'liked'* by managers and services as a whole.

'the service is very interested in it as a model, partly because it seems to offer a far shorter intervention timescale than psychotherapy is historically known for. That's attractive to the service. Erm, er, so I think the service are going to be, erm, pressing more, really, for us to be working, providing more short-term intervention, or short-term treatment, if and where possible.' -Participant D, Time 1, Lines 182-186.

This extract highlights what felt in the quality of the interview a worry about the pressure that there might be on them within services to offer more short-term treatments like STPP. This raised what felt implicit in the interviews – whether the decision to implement STPP was based on offering a model that might benefit patients, or linked to more elusive agendas in services concerned about resources. This was more explicitly raised in the following example:

'so much is driven nowadays, by cost savings and things like that, of course you think then, you know, are we losing our thinking about, you know, you introduce a patient, and it, its really up to the patient and you, in the therapy, when an ending will happen, you know, and are you just going along that you are accepted for longer in the NHS, you know, or in general, you know. But still from my experience I would say, you know, there are benefits, you know, and I can see some advantages.' - Participant A, Time 1, Lines 238-244

Whilst acknowledging '*benefits'* and *'<u>some</u> advantages*' (emphasis added) of STPP, this second extract again highlights the loss that STPP seemed to be linked to in participant's minds - that of greater freedom within the therapy to decide an ending with the patients. This participant also raised whether a decision to '*go… along'* with this was linked to being *'accepted for longer in the NHS',* and highlights the driver of *'cost savings'*, whether this leads to loss of *'thinking'*. This extract contextualises the implementation of STPP within systemic issues (further explored in Superordinate Theme 3) and brings in some concerns that felt consistent in the interviews at this point, about what drove the implementation of STPP beyond clinical considerations of it as a model that might benefit this patient group.

<u>Findings from Time 2 Interviews</u>

Consideration of potential external, service level, drivers for implementing STPP continued to be an important theme in the Time 2 interviews.

One participant, speaking about the attraction of STPP to the service said, *'I think it's about quality and quantity'* (Participant B, Time 2, Line 111), indicating that they felt services might be driven by throughput and quantity of patients that could be seen, and also by the wish to provide a *'quality'* therapy. The idea of quality seemed related to STPP's standing as a model that had been researched and shown to be

an effective treatment. Ideas of how STPP was seen by managers and the service as a whole were present in all interviews, for example:

'it was very, very welcomed on the more manager side… when we say we do short term, short term always, I think, sounds good to them (laughter)'. –Participant A, Time 2, Lines 5-16

'The service were very attracted to the option'- Participant D, Time 2, Line 23

Managerial support and service enthusiasm for the STPP model could be seen as a positive factor, supportive of its implementation within the service. However, in the quality of the tone, laughter and nonverbal communication during these interviews at these points, it felt that there was a more complex communication underlying these seemingly positive statements. Across the interviews, I felt there was an implicit continued underlying suspicion about why services might support the implementation of STPP.

The idea of *'strategic benefit'* being a cause of concern and potentially at odds with benefits for patients was raised explicitly by one participant, after talking about STPP adding to the range of work CAPTs could offer in services they said:

Interviewee: 'It's interesting I'm thinking about a strategic benefit, and not necessarily a, a benefit for the patient.

Interviewer: Why do you think that might be?

Interviewee: I suppose the obvious answer is that, do I see any benefit for the patient? And I don't know. I suppose I haven't had enough experience.' –Participant C, Time 2, Lines 415-419

Implicitly, in this extract, there felt a question as to whether these two drivers for implementation of STPP (strategic benefit for CAP and benefit for the patient) might be at odds with one another. In general, it felt participants were interrogating in their

own minds what the drivers for implementing STPP in services were- within the CAP profession, the Trust and within themselves, and whether this threw up ethical issues that might need consideration.

Through my experience with the CAPT peer supervision group over this first year of implementing STPP within the Trust, I had become alert to differing ideas within the group about where the idea of implementing STPP in the Trust had originated. In discussion with my supervisor, I decided to openly ask participants their ideas about this in the Time 2 interviews so this could be explored further. Whilst I tried to ask this in a neutral and open way, one participant initially responded with *'Didn't you ask me that question last time?'* (Participant C, Time 2, Line 8), which felt in the interview unexpectedly prickly, making me think it was a difficult question and had hit a nerve, or perhaps I was not managing to hold as neutral position as I had hoped.

Participants responded to this question with a variety of views as to whether the decision to implement STPP was made internally and driven by the CAPT group, or whether it came from outside the group and felt more *'forced'* upon members:

'In terms of how it started is that, as a small group of psychotherapists, we've discussed it and we've agreed amongst ourselves that we will go to begin to implement it as one of the range of treatments that we provide.' - Participant D, Time 2, Lines 12-15.

'I think there was resistance about implementing STPP, I'm sure it's not gone unnoticed, kind of, the, "Why are we doing this?" like, almost like people being forced into, into it, and that's –there's been some quite strong opinions on that within the psychotherapy group, and I think that's caused some resistance.' – Participant C, Time 2, Lines 108-113

These extracts show the diversity of thought within the participants, whether they felt they had ownership of the decision to implement STPP, or whether it was felt to

come from an external driver and *'forced'* upon the group, causing *'resistance'* to the idea. In the second extract the question of *'why are we doing this?*' felt critical, potentially linked to the earlier ideas about external, service level, drivers of implementing STPP and their view of my role in this.

The role of research in driving the implementation of STPP was also spoken about in interviews. One interviewee linked the initial driver of implementing STPP in the Trust to colleagues outside of the Trust who had been involved with the IMPACT study and were actively '*looking for people...to then spread it out in the country.'* (Participant A, Time 2, Line 39).

Some participants also saw this research project as having a role in the implementation of STPP, which was viewed by different participants as helpful and as resulting in resistance to the process:

'*the idea that you might erm, evaluate it, or do some research on it, which I think also helped, you know, that we take it seriously'* -Participant A, Time 2, Line 51.

'I wonder if that caused some of the resistance as well, though, that, you know, we're doing this just 'cause of the research, rather than thinking we're doing this because it's a, it's of value to us. But, also I think that, once I got over myself a bit, and, you know, thought "This is better", it, it is actually helpful. I also think it was because of the research we got all the support, you know, the peer supervision, and everything.'- Participant C, Time 2, Lines 507-511

From these extracts there was both an idea that the research project had brought protection and support to implementing STPP, and that the thought that it drove the decision to implement STPP *'caused some resistance'*. In the second extract, there was reflection on the idea of implementing STPP *'cause of research'* was initially felt as in opposition to something of *'value'* to the CAPT group, although there was a reflection that this feeling had dissipated and changed during the process of

implementing STPP. As explored in the discussion, ideas about where the idea and drive for implementing STPP came from were important to how participants experienced this process, and perhaps inevitably, in the minds of some participants I did not remain an impartial observer in this process.

C. STPP as a part CAP work, concern that it does not take over.

Findings from Time 1 Interviews

In the first interviews, held in the beginning stages of the process of implementing STPP in their services, two participants had started working with patients using the STPP model and two had not. The two participants that were not already using STPP, spoke about their plans to start this work and the difficulty they had in finding a first patient who they felt they could use the model with. There were repeated comments across the interviews about whether STPP was a suitable model for the patients they had on their CAP waiting list.

In these Time 1 interviews, there was an idea that STPP might be used to a small extent in participants future work, and a concern of it not taking over as the predominant way of working raised in two interviews:

'I'm not sure if I'll see a handful in the future, you know, ongoing. So, it will be a very small amount of my caseload, and therefore I think, you know, it will not be something which completely changes our picture or our profession, being here, you know? Perhaps I'm more, it's, it's more of a challenge within our profession, you know? To think, or to allow this thinking, of having a short-term model as well.' – Participant A, Time 1, Lines 282-286.

'I would hope there would continue to be scope for the different models, you know, well those patients that we know we're going to need to see longer term' -Participant D, Time 1, Lines 519-521

'I'd be concerned if this became the only model for working with adolescents.' – Participant D, Time 1, Line 523

'I suppose I sometimes wonder whether this, this might get extended to younger, to latency age children. I just know there's such an emphasis upon us, on, on throughput.' -Participant D, Time 1, Lines 527-530.

From the above extract from Participant A, it seemed important to them that STPP would be a *'very small'* part of their future work, that it *'will not be something which completely changes our…profession'*, importantly STPP was described as a model CAP could have *'as well'*, rather than be solely reliant upon. Whilst this was said with confidence, it brought to my mind whether this was a concern for the participant, or if they had an awareness of this being a concern in the CAPT peer group, that time-limited or brief work could take over and eclipse open-ended, longer-term ways of working. As shown, this concern about whether STPP would take over CAP work was repeated in the extracts from Participant D's interview, indicating it was an important consideration for them.

Findings from Time 2 Interviews

After this first year of STPP implementation, at the point of the Time 2 interviews, there was a sense that participants were '*up and running'* (Participant D, Time 2, Lines 117-118) with STPP work. All participants had started to use STPP; two were mid-way through such work and two had completed STPP work with a patient. The three participants who had less prior experience with STPP all spoke about an idea of needing or wanting to have more STPP experiences to understand the model better, although for some this felt more a cautious thought than a definite plan.

Whilst all participants spoke about the idea of offering more STPP work in the future there remained, as had emerged in Time 1 interviews, an idea that it was important to participants that STPP would not become the dominant model of CAP work:

'I think I am quite confident that people will use it, perhaps in the same way I am, you know, it's just something on the periphery really.'– Participant A, Time 2, Lines 298-300

'I think it has a place. I wondered if some of the anxiety about implementing it would be that, that we would be expected to do all of this, you know? It would take over, kind of, what we do, but it's not. You know, it's very clear that it's not at all, and it's helpful to have, erm, an alternative, really. Because sometimes we have young people who don't want to, that won't manage that open-endedness' -Participant C, Time 2, Lines 205-210

In the second extract, this participant explicitly said that they had shared the concern presented in Time 1 findings that STPP could take over CAP work, but that this concern had abated for them over the year. In the Time 2 interviews generally, there was less talk of a concern that STPP might dominate over other types of CAP work, suggesting there was a reduction in this anxiety.

Discussion of Superordinate Theme 1 in relation to relevant research, psychoanalytic theory, reflexivity and counter-transference.

The concerns raised in Time 1 interviews that STPP might be seen as *'psychotherapy-light'* (Participant D, Time 1, Line 425), or *'kind of, anti-child psychotherapy'* (Participant C, Time 1, Line 793) vividly encapsulated a fundamental concern about what STPP's place within CAP was, or should be, and whether it fitted with the way in which participants were trained to work. Whilst this sentiment was less prominent in Time 2 interviews, it seemed important in understanding initial

concerns and possibly part of why it took some participants several months to start STPP work during this year of implementation.

CAP training involves learning about underpinning psychoanalytic theories and how to apply this thinking in undertaking psychoanalytic work. This includes training in how to make a therapeutic space for the patient (e.g. the setting, number and length of sessions) often called 'the frame' (Rogers, 2014; Tabakin, 2018; Will, 2018). Examination of the elements of this concept and the many discussions about it are beyond the scope of this research. However, the thought that STPP brings a challenge to the profession - whether it could *'allow this thinking*' (Participant A, Time 1, Line 286) - was present implicitly in all the interviews, particularly at Time 1. There was an implication that what STPP represented felt like a movement away from the usual frame, how participants viewed CAP work should be, or at least how they thought it had traditionally been done.

In the interview data, there was an acknowledgement of the research into STPP finding it to be considered effective in treating depression in adolescents (Goodyer et al, 2017). STPP was not developed and therefore not part of CAP training when participants of this study were training, though other models of brief work would have been. Indeed, participants related STPP to their other experiences of time-limited work due to external circumstances, or another brief model of work, the Tavistock Under 5 model (Bradley & Emmanuel, 2008; Wylde, 2009). Having other such brief work in mind, appeared to support participants in thinking about STPP, possible adaptations to technique required and the need to have the ending firmly in mind (see Superordinate Theme 2 for further exploration of this). However, there still seemed to be initial worries about whether STPP might be too much of a departure from CAP work despite, as outlined in the literature review, STPP arriving in the professional

context of there also being other reputable and researched time-limited psychoanalytic treatment models (Briggs 2019, Trowell and Kolvin 1999, Lemma et al., 2013).

The additional aspect of STPP being a manualised model was interestingly less prominent in the interview data (further explored in Superordinate Theme 3) despite the interviewer asking about how interviewees found using the STPP Treatment Manual (Cregeen et al., 2017) directly. Two participants commented on the manual being very useful and supporting them in the work whilst another said they did not really have it in mind. Given that using a manual is a key innovation of STPP, I had expected this question to elicit more detailed and complex thoughts or feelings in the responses. Psychoanalytic theory considers silence, what is not said, to be of import and that the feeling of a silence, or minimal verbal response can alert us to complex unconscious feelings that are difficult to put into words (Bravesmith, 2012; Sabbadini, 2004). As well as bringing in a supportive function, I think using a manual for STPP might have added another aspect to the *'challenge'* (Participant A, Time 1, Line 285) STPP was felt to bring to the profession and CAPTs. The manualisation of psychotherapeutic work supports the possibility of research in to its efficacy as well as a resource for professional development. However, concerns have been noted that therapists may feel that using a manual restricts their professional freedom and space for spontaneity (Kächele, 2013; Garfield, 1996). Further, more detailed exploration of how participants felt about using the manual when starting to implement STPP may therefore be an interesting area for future research.

In terms of training and practice, the CAP profession, like that of psychoanalysis and psychotherapy generally, has changed and adapted over the years to incorporate new ideas and adaptations to technique (Arkowitz, 1992). For instance, Alvarez (1992) and Tustin (1990) have been in the forefront of thinking about adaptations required to work

with children presenting in autistic states. The work of these senior child psychotherapists is well known to CAPTs and participants would likely have incorporated these and other adaptations and additions to psychoanalytic thinking and technique during their professional careers. However, this seemingly did not completely ameliorate their anxiety and resistances to the adaptation that STPP requires, at least at the beginning of the process of its implementation into Trust services.

The concern raised as to whether a *'traditional'* psychotherapist might have been as *'pliable'* (Participant B, Time 1, Line 430) felt an important one in the context of the adaptations the profession has incorporated. Lanyado (2009) details these and the additional adaptations a CAPT often has to make to take in to account the context of a child's family and social situation, as well as service circumstances. I wondered if, in practice, that might feel compromising to CAPTs and, where there are often pressures to adapt, whether the prospect of another adaptation of technique as required by STPP might have felt emotionally difficult.

The finding regarding the level of apparent concern about what the drivers to implementing STPP were was a surprise to me. These centred on whether this was entirely based on patient need, or driven by the service imperative for throughput, or *'strategic'* (Participant C, Time 2, Line 415) for the CAP profession to be *'accepted for longer in the NHS'* (Participant A, Time 1, Line 241). These drivers could be seen to be aligned: that the patient might benefit as STPP is suited to their developmental stage and nature of their difficulty, and the opportunity to offer short-term work might help increase the numbers of patients seen and thus meet wider service interests, and thus be helpful for the position of CAP in public services. Meeting the need to see increasing numbers of patients awaiting treatment in a timely manner by offering a

range of short and long-term treatment options has long been a concern and consideration for the CAP profession (Lanyado, 1999; Lanyado, 2009). Indeed, research following another Children and Adolescent Mental Health service's decision to implement Time-Limited Adolescent Psychodynamic Psychotherapy (TAPP), explicitly detailed that this decision was made with an aim of meeting the demands of long waiting lists and enabling them to treat patients more quickly (Briggs et al., 2015). However, the driver of the service and patient throughput was felt in most of the interviews as something viewed with caution, it seemed that there was an implicit concern that a focus on this might, in the end, be at odds with what best benefitted individual patients. This could be related to findings presented and discussed in Superordinate Theme 3, in that the service context may have been experienced at times as persecutory rather than benign, and thus viewed with caution.

This issue may also have been linked to the findings, present to some extent at both interview time points, that there was concern that STPP should not take over and eclipse long-term open-ended work, which was seen as '*the absolute core of what we do'* (Participant C, Time 2, Line 136). It seemed vital to participants to ensure they could continue to offer patients long-term open-ended work as well as STPP, which by Time 2 interviews they seemed more reassured would remain possible, indeed some feeling at this time point that STPP might offer a *'helpful…alternative'* (Participant C, Time 2, Line 209). Whilst this could be about participants ensuring they could continue the type of work they felt trained to do and most confident in, it could also be related to a wish to protect an option for patients to access longer-term pieces of work if required, and perhaps a feeling that this option could be under threat. Patient choice has been shown to be an important factor in the outcomes of different treatment models (Swift and Callahan, 2009; Winter and Barber, 2013), however more research

is required to fully understand which individuals might most benefit from different forms and timeframes of therapy and why this is. In the absence of this, it is understandable that participants were mindful of the need to also be able to offer some patients longer, or more intensive, psychotherapy and therefore have some concern about the place short-term work, like STPP, might take up within services, and the preference or pressure there could be in services for this.

A year into the process of implementing STPP, at Time 2 interviews, all participants were *'up and running'* with STPP work (Participant D, Time 2, Lines 117-118). However, this had taken longer than I had expected and fewer patients (five) were seen (or had begun to be seen) for STPP during this year than I had envisaged. This might have been because I had unrealistic expectations and had been naive to the impact of the service context (further explored in Superordinate Theme 3). It could also be due to the *'resistance'* that was identified by Participant C to the experience of doing something *'differently'* (Time 2, Line 21), to questioning why they were implementing STPP and at first feeling *'forced'* in to it (Time 2, Line 110) and the linked feeling of whether it was *''cause of the research'* (Time 2, Line 508).

Reflecting on my own experience of the research process, I think some of the difficulties I experienced were reflective of some of the issues I was researching. I was part of the first cohort of the new CAP training programme, which fully integrated research as part of the four-year clinical training and included STPP in the training. I became interested in the research topic following learning of a decision that I had understood to have already been made by my colleagues to implement STPP in the Trust. It seemed that the participants and other colleagues were at first enthusiastic and wanted to be helpful to me in my research endeavour, and largely this feeling continued throughout the project. However, the totality of what happened in this

process was more complex. I had an experience in the peer supervision group that I was seen to be driving the STPP agenda despite consciously trying not to take up any such position or role and there was a marked reticence in participants using the outcome measures that I had originally designed as part of the methodology. When asked specifically about where the idea to implement STPP had originated in the Time 2 interviews, amongst a range of responses, one participant reflected on their initial feeling that '*we're doing this just 'because of the research, rather than thinking we're doing this because it's a, it's of value to us'* (Participant C, Time 2, Line 508). This indicated that this had been an issue for at least one of the participants at the start of the process of implementing STPP. Another participant, when comparing STPP to working with adolescents for a year, said that this experience (of STPP) would be different because *'your, y- the timescale's shorter'* (Participant D, Time 1, Line 244). Although they corrected the word *'your'* to *'the'*, this again implied that I had become identified in the participant's minds with STPP, perhaps inevitably.

In doing the project as part of my core training, I was doing something different from what the participants had done in their training, and it seemed that some of the feelings they had towards being asked to do something new and different when under pressure, became part of how they felt about me as the researcher. In psychoanalytic theory, this would be a displacement - *'the process by which the individual shifts interest from one object or an activity to another'* (Rycroft, 1968, p35). Thus, I think I became imbued with feelings participants had about implementing STPP, that it had been forced on them and represented something different to what they had experienced of CAP training and practice. Further research in to how CAPTs view the role of research in the profession and their feelings about undertaking it and being involved in it would be an interesting area of future study.

4.2 Superordinate Theme 2: The '*hard reality*'[15] of time, could there be *'enough'*[16]?

This superordinate theme detailed the difficulty in the experience of time in STPP for CAPTs, and their thoughts about whether this offered enough to patients that might be of use and benefit. It was comprised of three interlinking subordinate themes as outlined in Table 2. The prominence of these different subordinate themes changed over the time-period of the two interviews as explored and discussed in this section.

A: Worries about time, loss and being in the position of a bad, withholding, depriving object.

Findings from Time 1 Interviews

The words *'loss'*, *'ending'* and *'not enough'* were repeated several times by three of the four participants during the Time 1 interviews (as detailed in following extracts) when talking about STPP work, or how they imagined this work would be. The time-limited nature of STPP was said to be a *'hard reality'* (Participant D, Time 1, Line 392), that seemed to feel harsh and painful for both STPP patients (or imagined prospective patients) and the CAPT participants, for example:

'I brought the dates and the numbers…I think there's been a, probably a, a hard swallow. To kind of think, "Golly, we've, we've already done X number of appointments, and I've got this many left". I think it does bring, erm themes around loss, and that, that process very, very much to the core.' -Participant B, Time 1, Lines 145-148

'You can lose, you could lose time or, before you know it, you're at mid-point and…(silence).' Participant D, Time 1, Line 219

[15] Participant D, Time 1, Line 392
[16] Participant C, Time 2, Line 314

The sense given in these extracts was of the reality of time (the *'dates and numbers'*) being a '*hard swallow'*, where one may suddenly feel they are losing time, and hurtling toward an ending. The petering out to silence in the second extract felt it had a deathly quality in the interview.

This state was seen in contrast to how participants talked about open-ended work, as in the following extracts:

'I wonder how rich it makes the sessions? Because, you've got, you have to bring stuff, almost, you have to work through it, it, it's there. You know, if you've got that longer and open-ended, sometimes it feels like you just float through, though sessions.' - Participant C, Time 1, Lines 883-886

'if it were a longer piece, I think we've got longer to, to work through it or go back to it and, erm…But, but maybe it is rather like wh-when I mentioned the under-five work, you've ki-you, you do have to go at double speed…. You can't sort of, erm allow something to kind of, erm, settle or…That's the wrong word, or float and feel it in perhaps the way that you might if it were open-ended.' - Participant B, Time 1, Lines 495-502

In these extracts there was an idea of the more explicit time-limit in STPP, in comparison to open-ended work, as something that might make the material more *'rich'*, or the therapist have to work at *'double speed'*. The repetition of the verb *'float'* felt important in relation to ideas of the reality of time, which is explored further in the discussion of this superordinate theme.

Participants spoke of alternating between feeling curious and interested about using STPP, where *'the ending's there from the start'* (Participant C, Time 1, Line 856), whilst also feeling *'personally, it's going to be a, it will be a struggle, because I think, erm, I think endings are difficult'* (Participant D, Time 1, Line 250). These two participants particularly raised a concern that setting the ending from the beginning

might increase the negative transference and change the position they were put in, in relation to their patients:

'from a very personal point of view, about not wanting to put myself into that bad objects kind of place, And, you know, hearing other people talk about it, that's not always the case, but, I suppose that's a, maybe fear of mine - That stops me, kind of, you know, three years now and I still haven't done one [an STPP case]' Participant C, Time 1, Lines 813-818

'From a personal perspective, is about managing feelings it provokes in me as being wearing the shoes, the shoes of the withholding object…I, I find it hard to occupy that space of, of being withholding, or not giving enough. Erm, of being in the position of seemingly depriving, and so, for me, this raises major anxieties.' -Participant D, Time 1, Lines 382-389

In these interviews the phrases *'bad object'*, *'withholding object'* and *'depriving'* were repeated and felt central to concerns about starting STPP work, indeed Participant C explicitly linked this *'fear'* to having been a barrier to them starting STPP. Both participants were thoughtful of this being a very '*personal'* concern, linked to their own personalities and what they felt they needed to *'struggle'* or *'wrestle'* (Participant D, Time 1, Lines 250 and 260) with to initiate STPP.

<u>Findings from Time 2 Interviews</u>

Overall concerns about ending, loss and being in the position of a bad, withholding or depriving object were much less prominent a year on in the Time 2 interviews.

In these interviews, participants highlighted how the time-limitation might be experienced as a positive aspect for some STPP patients (explored further in Subordinate Theme C). However, they remained in touch with how for other patients this might feel cruel or limiting - that a patient might think:

"If I was important enough you wouldn't be offering me something that was short-term."" -Participant D, Time 2, Line 65

Participants continued to be aware of the emotional pressure this elicited within themselves, for example:

'I might have felt a little bit of a push of, "Are you going to offer me more, will you offer me more? I'm already saying it's not enough." Erm, so I think those dynamics were a little more acute than there might have been for a usual practice.' – Participant B, Time 2, Lines 238-242

Whilst this was described as still leaving participants with a feeling that *'there's no time to waste…it's now or it may be never'* (Participant D, Time 2, Line 261), there was also a sense that this feeling was *'more manageable now'* (Participant C, Time 2, Line 310). When reflecting on the process of implementing STPP, the participant with greater previous STPP experience put the anxiety about the limitation of time and whether this would be enough for the patient as, '*normal, you know, for everybody who does STPP for the first time.'* (Participant A, Time 2, Lines 206-211).

Two participants elaborated further on this change in managing their own anxieties about STPP and the limitation of time, as shown in the following extracts:

'it's almost like holding your nerve, not giving in to my own anxieties about not giving enough. And, and, kind of, being able to, "This is enough," you know, "There's enough here".' – Participant C, Time 2, Lines 312-314

'I suppose it's trying to understand what we're being in touch with there, what is that deprivation? Why do we feel that we've got to fill it with, with endless sessions, when it, it might be able to be worked through in a timely way, really, a time-limited way.' – Participant C, Time 2, Lines 271-274

'at the onset I had to think about my anxieties and doubts and fears associated with the task. I think, you know, it's very given to worrying about the limited time available, what happens if pro- things prove too complicated or…You know, the patient doesn't

seem to be gaining any benefit. I think, erm… I think it was quite useful to do that thinking because I was just aware of things that would be provoking resistance within myself.'- Participant D, Time 2, Lines 619-623

In these extracts, participants seemed more able to think about what they might be on the receiving end of within their counter-transference with patients, and where this might meet anxiety within themselves and thus have particular traction.

B: Psychological avoidance of the ending, having longer in mind.

Findings from Time 1 Interviews

It was notable that the majority of patients who were seen for STPP during this first year of implementation within the Trust were 17 years old, and 18 years old when STPP ended. As well as thinking about clinical suitability, participants reflected on their selection of prospective patients where *'the timeframe around it would fit in terms of either discharge from this service or a transfer onto, to adult services.'* (Participant B, Time 1, Lines 114-115). They also related STPP to previous work they had undertaken with adolescents where again time had been limited due to external factors (or age or transfer out of area) rather than as a treatment of choice.

Participants were alert to the prominence of older adolescents in their minds when considering STPP, for example saying *'I should be thinking about younger adolescents, really.'* (Participant D, Time 1, Line 289). They also considered how this might be an avoidance of the anxiety related to time, as seen in the following extract:

'I wonder if I might feel differently about it if the young person wasn't the age that they are. So, I know that we're going to have to stop. So, it feels like, er, a very appropriate intervention. Perhaps if they were 14 or they were 15 and, erm, it was a finite number. I wonder if, as somebody who's traditionally done longer-term work, I might have other questions or other thoughts or other feelings in my mind about, "Is this actually going to, erm, be enough?". –Participant B, Time 1, Lines 190-199

Participants often found ways to have longer in mind. Whilst they were only at the beginning or yet to start STPP work, some talked about the idea of being able to refer people in to adult psychotherapy following completion of STPP, if needed:

'*I could support a referral to say, "This is what we've done, actually a longer term or more intensive therapy might be indicated."*' -Participant B, Time 1, Lines 219-221

At this time, some participants held in mind their freedom to offer more sessions if they felt, after careful consideration, this was what the patient needed. For example:

Interviewee: 'I can see an advantage for young people, to know that it has an ending, but I also, I guess I'm someone who, if it turns out that it's not really good to end it after the 28 sessions, I'm not hesitant to do so, you know, so…

Interviewer: 'So you would keep it going if it felt that actually ending it now, wasn't...'

Interviewee: Yeah. Yeah, and I think that was also always said in the, in the study, you know, that if there is a clinical need, it overrides whatever the research says' - Participant A, Time 1, Lines 229-236

It seemed important to participants in the process of starting STPP to be able to think that they could offer more sessions if that met '*clinical need*'.

<u>Findings from Time 2 Interviews</u>

This subordinate theme was much less prominent in Time 2 interviews, however participants did still reflect on their choice to see patients for STPP where it *'fitted in terms of what the service was going to be able to offer anyway.'* (Participant B, Time 2, Line 63). As in Time 1, some participants elaborated on why they had made this decision:

'I think if they were younger and they weren't turning 18, I think it would be, I think if there's… You know… I think, you know, facing the dilemma of ending… It will be difficult. Ending, where the therapy is the, you know, would end, I think, because there'll always be that sense of, erm… The possibility to be able to continue on and

do other things, or, or new problems that might manifest, that might feel to need to be dealt with or worked with. So, I think it's just working with that internal dilemma of-being able to end and manage the feelings associated with that. Withdrawing something where you think, well, maybe they could gain from continuing. – Participant D, Time 2, Lines 449-458

It is clear from this extract that the participant was aware that by working with older patients they had avoided part of '*the dilemma of ending'*. The hesitant language seemed in the interview to indicate that the participant was trying to put in to words something that was emotionally difficult to describe, perhaps indicating how difficult the feelings relating to endings were.

Half of the participants did not count assessment sessions as part of STPP, as set out in the STPP Treatment Manual (Cregeen et al., 2017), instead offering three assessment sessions and then the 28 STPP sessions. This meant on a practical level the patients had more sessions overall, it also meant the participants had more time to explore whether STPP was the model they wanted to offer, whether it best suited their patients, which in the interviews felt important to them.

Whilst STPP was seen as potentially being *'a gateway experience'* (Participant D, Time 2, Line 294) to adult psychotherapy for one of the participant's patients, they also expressed feeling that STPP had been beneficial in its own right. Thoughts about subsequent referrals for adult psychotherapy were not present in the Time 2 interviews more generally. This perhaps indicates that thinking about further work at this time point was individual to the patient's needs, rather than a sign that the participants were struggling with the pull to offer patients more in an indiscriminate manner as was felt in Time 1 interviews.

C: Could STPP focus the work and be '*enough*'[17] for what some adolescents need?

Findings from Time 1 Interviews

During interviews at both time points, participants spoke at length about which patients they thought STPP might benefit and which patients they thought it would not be suitable for. There was a repeated idea that STPP offered less time than the patients usually referred for CAP needed, or was not suitable for them. One participant, in talking about referrals said more *'straightforward cases'* (Participant C, Time 1, Line 36) did not get referred for CAP. There was concern about whether short-term work in general was suitable for the majority of patients referred to the service:

'we're working with very complex families with intergenerational, multi-layered trauma. And, and actually, erm, six sessions and out doesn't, doesn't cut the mustard. And, erm…We're often battling trying to, kind of, find a, a way to help these, these families.'
-Participant C, Time 1, Lines 65-70

This participant was not talking about STPP explicitly in this extract, but the idea of *'six sessions and out'* raised an idea that a blanket decision of very short-term work did not meet the need of patents and their families accessing the service, and indeed felt in the interview the antithesis of this *'battle'* to help such families.

Participants identified that they thought STPP was likely to be less beneficial, or more difficult to undertake, with patients who were cared for children and where there were higher risk of self-harm or risk taking behaviours. There were also concerns repeatedly raised about whether STPP could be effective where patients had more *'entrenched'* difficulties (Participant B, Time 1, Line 627). A patient's capacity to introject was also

[17] Participant C, Time 2, Line 314

felt to be of central importance, *'it requires quite a bit of ego strength'* (Participant D, Time 1, Line 414).

For most participants it seemed they felt they were at the beginning of understanding what kinds of patients might benefit from STPP and across the majority of interviews, they indicated that this was a decision they would make collaboratively, in supervision, with colleagues. There was also a sense that it was only by the experience of trying STPP that they might understand what patients it could help, for example:

'We'll all learn, won't we, through this process of who's able to use it? Who, who can really use it?' –Participant B, Time 1, Line 651.

Whilst participants seemed unsure in their own minds of which patients STPP might best suit, they saw the time-limitation of STPP as being potentially attractive to some adolescent patients:

'And it might be that, you know, I get an adolescent that's very clear that they don't want long-term work. And that would be, I suppose the other way, they don't want to come forever and ever, but they actually do want an intervention. And that might be a way to offer STPP. They don't want that over-dependence. Because, you know, in lots of ways that's very appropriate, because it's, they're adolescents.' -Participant C, Time 1, Lines 1211-1215

Whilst the participant in this extract brought up the developmental appropriateness of a time-limit which did not encourage or demand too much dependency in adolescent patients, this idea felt in the hesitant language of *'it might be'*, and *'I suppose'*, difficult for them to really imagine. Similarly, another participant said:

*'I've got some positive feelings though…this idea, adolescents, they hate commitment, they can't stand it…adolescents balk at the idea [of longer treatment]…For some reason I don't think I see lots of adolescents balk at that, that idea, and I've seen quite a lot that, erm, er, have responded very positively at the idea of, of something substantial'***. -**Participant D, Time 1, Lines 399-405.

These participants had an idea that some adolescents might want and need a time-limited treatment, but felt their professional experience was of seeing patients they felt needed and wanted longer. In the second extract, it seemed that *'something substantial'* meant longer, open-ended work, linking to ideas in Superordinate Theme 1 of STPP being seen as *'psychotherapy-light'* (Participant D, Time 1, Line 425).

Conversely, at this time point, the participant who had previous STPP experience seemed more confident in the idea that STPP would benefit some adolescent patients, and suit their developmental stage of life:

'I think, especially for adolescents, I think it, it is a good model, because you often don't get them for much longer, you know? They develop, and they want to go off, and so I think that fits them, somehow.' – Participant A, Time 1, Lines 223-226

'I guess that's something like bringing the adolescents in, going, or, or, or, stirring up adolescent, an adolescent process. Which is separation process, so, helping the parents and the young person to move on and be not stuck in this, kind of, "I don't want to move between childhood and adulthood", you know? I think that is something, I guess, which STPP fits very well.' –Participant A, Time 1, Lines 474-478

Additionally, there was an idea in other interviews that STPP might bring a different aim, or focus to the work with patients:

'I suppose it comes down to this stuff Monica Lanyado draws upon, where the question of having done enough, you know…reaching a point of having, having, having done enough to enable a young person to, erm, progress, or recover. And perhaps that's an inner struggle for me, is about, erm, feeling okay with having done enough' - Participant D, Time 1, Lines 252-256

Louise Emanuel I think wrote a nice paper on, er, moving slowly, but at double pace. And it feels a little bit like, like that…You've got time, but you're also conscious that you haven't got time. A-and maybe it does concentrate everybody's minds and brings something in a different way into the room which is valuable as well as anxiety provoking. - Participant B, Time 1, Lines 155-162

In the first extract the idea of *'having done enough'* felt important, linked to an idea that the aim of STPP might be more specific and '*enough*' to support recovery and development rather than encompassing all that there might be to understand and work on. In the second extract, the idea of STPP *'concentrate[ing] everybody's minds'* was seen as *'different'* and *'anxiety provoking'* but also *'valuable'*. That both participants reached in mind for papers by psychoanalytic thinkers (Lanyado, 2009 and Emanuel, 2008 respectively) perhaps indicated that they were seeking steadying objects to help them think about what the aim might be in STPP for patients, and how the work might be different in this model.

Findings from Time 2 Interviews

At the point of Time 2 interviews, participants continued to wrestle with which patients might benefit from STPP, and when this model would not be suitable; there was an emerging idea that what had been considered contraindications to STPP in Time 1 interviews might be re-considered. There was an increased sense in some interviews that some adolescent patients really benefitted from STPP as it suited their developmental task.

'I think it's still a, er, battle, really. Not a battle, but, er, a, kind of consideration that I don't, I don't have, like, a tick list of criteria that I think, "Oh this sounds like STPP."'. – Participant C, Time 2, Line 86.

In this extract the *'consideration'* of which patients might benefit from STPP was initially described as a *'battle'*, although the participant changed this more combative word, its initial use perhaps indicated that this was an issue that they still struggled with. Whilst this participant said they did not have a *'tick list of criteria'* for STPP, throughout the interviews there remained ideas that *'complexity… would*

contraindicate using the STPP model' (Participant D, Time 2, Line 34), or STPP would be better suited where *'there isn't so much of the early, kind of, trauma stuff'* (Participant C, Time 2, Line 424).

Whilst another participant initially described something similar to these two extracts when describing the kind of patient they would think of offering STPP to, they went on to say:

'I think maybe there's a myth or an idea, of, "Oh, oh that case it too complicated". Er, or, "My cases are too complicated." When actually it might be that, erm, this would kind of be helpful recognising it may or may not meet all of the needs , but it can, kind of, erm, address something of value within that time frame.' –Participant B, Time 2, Lines 148-151

In this extract, the participant seemed to be cautiously exploring the idea that complexity might not contraindicate STPP, that the aim of this therapy might offer something of *'value'* whilst not addressing '*all of the needs'.* They went on to say that they thought it would be helpful to revisit the STPP Treatment Manual to re-read what was said in order to:

'learn something more, is it a defence or, you know, what is it that's kind of in our own mind shaping a decision about yay or no [to offer STPP]' – Participant B, Time 2, Lines 496-498.

The idea therefore emerged that considering which patients might or might not helpfully make use of STPP was important, and a valid concern, but might also be related at times to CAPTs defences, and consideration was required about why they were making these decisions.

At this second time point, the majority of participants gave detailed descriptions of adolescents who they thought would benefit from STPP and why this model might suit them at this stage of life:

'with adolescents, there are benefits, you know, because they are usually not inclined to have open-ended psychotherapy. You know, they're usually scared by this idea, and especially for those who, their main problem focuses around adolescence and they're stuck somewhere. This model kind of gives them, really, this kind of, push or the opportunity to go into it or go out of it. (Laughter).' – Participant A, Time 2, Lines 131-135

The idea that STPP might give a developmental *'push'* to adolescents who were otherwise anxiously stuck and depressed was repeated across the interviews, along with the idea that long-term work might be felt by such patients to be *'claustrophobic'* (Participant D, Time 2, Line 379).

Thus, there was a developing sense that STPP might provide some adolescent patients with what they needed to progress and develop, to bring the patients difficulties to the fore, for example:

'The end is there. It's just there. It's in, it's such an interesting - because the end should be there all the time anyway, but it's not, where here it is, and, and actually, all of her material is about death and endings anyway.' – Participant C, Time 2, Lines 159-161

'they gain from the sense that there's the opportunity and space for them to bring their own concerns and preoccupations. And there's enough space for those things to be able to be thought about.' – Participant D, Time 2, Lines 472-474

From their experience of using STPP, it seemed that the majority of participants felt that there was *'opportunity and space'* for their patients to bring and think about the material that they needed to. There was a growing sense that STPP might indeed offer *'enough'* (Participant C, Time 2, Line 314) for some patients.

Discussion of Superordinate Theme 2 in relation to relevant research, psychoanalytic theory, reflexivity and counter-transference.

Overall, there was a general reduction in concerns about the limitation of time, loss, and the connected potential increase of being in the position of a bad, withholding or depriving object between the two interview time points. The, likely related, apparent need to have more time in mind by thinking about further psychotherapy after STPP, also decreased by the Time 2 interviews. However, participants continued throughout the interviews at both time points to reflect on their decisions to mostly use STPP with older adolescents, where there was a service dictated ending due to age. In contrast, participants spoke positively about STPP and the potential it had in providing adolescents with *'enough'* (Participant C, Time 2, Line 314) that they might find beneficial in helping them become less *'stuck'* (Participant A, Time 1, Line 476), freeing up the natural drive for adolescent development in terms of separation and individuation. These ideas became more pronounced by the time of the second interviews.

Much has been written in psychoanalytic literature about the painful reality of endings throughout life, and the way in which these experiences can be felt, unconsciously repeated or perhaps understood and re-worked within the therapeutic relationship, particularly when in touch with ideas and feelings regarding the termination of therapy (Holmes, 1997; Murdin, 1994; Szecsödy, 1999; Salzberger-Wittenberg, 2013). In STPP, where *'the ending's there from the start'* (Participant C, Time 1, Line 856), feelings about the ending and concern about the lack of time were unsurprisingly in the forefront of participants minds as they started to implement STPP within their services.

The '*hard reality'* (Participant D, Time 1, Line 392) of time, was in the experience of the Time 1 interviews, felt as harsh or cruel. There was an idea of not having time to let something *'float'*, instead having to go at *'double speed'* (Participant B, Time 1, Lines 501 and 498). Another participant similarly commented that STPP was unlike long-term open-ended work, where '*sometimes it feels like you just float through, though sessions.'* (Participant C, Time 1, Line 886). This evoked a sense of 'mother time' - something that might be seen in fantasy as never ending, a womb-like embrace, different in essence to ideas about 'father time', bringing in the reality principle of an ending, a boundary in time, as discussed in Mann (1982). There was a sense in which participants, during the process of implementing STPP, had to wrestle with the impact of facing the finite nature of time on their patients and themselves within the therapy.

There was a concern raised by two participants in the Time 1 interviews, that the time-limitation of STPP would likely lead to them being more firmly in the position of a depriving, withholding or bad object in the therapeutic relationship, and an idea in one participant that this had previously prevented them taking up STPP work. A year on, one participant reflected on the need to *'understand what we're being in touch with there, what is that deprivation? Why do we feel that we've got to fill it…with endless sessions, when it…might be able to be worked through in a…time-limited way*.' (Participant C, Time 2, Lines 272-274).

Winnicott (1965[1960]) wrote about what the infant needs in order to develop, prominent amongst his ideas was the concept of the 'good enough mother'. This is someone who could give enough, but not too much, for there to be a gradual disillusionment in the baby regarding their parents, and thus provide a sufficiently 'facilitating environment'. By definition, CAPTs are seeing young people who are in difficulty, who are accessing mental health services. Many of these patients will not

have had this experience that Winnicott said was essential for development but might instead have experienced too much intrusion and therefore struggled to individuate, or (perhaps more likely in the participants descriptions of the referrals to CAP) far too little, leaving them in a position of deprivation.

CAPT participants would be in receipt of projections from their patients. These are 'the process by which specific impulses, wishes, aspects of the self or internal objects are imagined to be located in some object external to oneself' (Rycroft, 1968, p.125-6), and transferences, 'the process by which a patient displaces on to his analyst feelings, ideas etc which derive from previous figures in his life' (Rycroft 1968, p.168). It is likely that participants might receive the transference of not being a 'good enough' object, and have an experience of this position in their counter-transference. Clinicians know how powerful these counter-transference experiences can be (for example Canham, 2004).

The psychoanalytic lens could therefore illuminate some of the feelings underlying this theme; that CAPTs are already under great internal pressure from the adolescent's feelings that they are deprived of a good enough experience or that they themselves are not good enough. The participants could have experienced the time-limited nature of STPP as making it a difficult intervention to start using because it intensified the feelings of not being good enough, or giving enough, to their patients. Hopkins (1996) also emphasises the importance of avoiding being 'too-good' within the therapeutic process, highlighting this could result in a state of a merged therapist-patient (like mother-baby) and make endings particularly difficult.

Integral to this finding, is what the ending of therapy might mean for the CAPT participants, within themselves, which could increase the power with which they

received projections from their patients. Research highlighted in the Literature Review spoke to the influence of individual characteristics in the process of change (Vakola et al., 2004). Participants repeatedly used the term *'personally'* (e.g. Participant D, Time 1, Line 250) when talking about aspects of STPP they were struggling with. Voirst (1982) alerts us to the loss inherent in the ending of therapy, and the role of holding on to realistic hopes of therapy in managing this. The way in which an ending of therapy resonates with past experiences of loss and the extent to which the clinician feels they have realised the aims of the work have also been highlighted as important. It is understood that it is more difficult to end when one feels the therapeutic aims have not been achieved, which can result in feelings of guilt, anger or self-criticism (Kantrowitz et al., 2017).

The interlinked subordinate theme regarding the psychological work participants seemed to undertake to avoid thinking about the ending of STPP as final is understandable in the context of the powerful emotional impact of endings and the limitation of time described. That this subordinate theme decreased a year into the implementation of STPP was likely linked to the reduction of the participant's anxieties and need for this psychological defence. Perhaps these ways of thinking had provided participants with a way in which they could mentally manage to start STPP work, without feeling too much at the mercy of the powerful feelings described above.

Participants remained reflective about how they were grappling with which patients to offer STPP to, at both interview time points. They consistently spoke about their consideration that severe, entrenched difficulties from early in life, or where there had been extensive trauma, might be contraindicative of STPP and these patients might usually require longer or more intensive forms of treatment. This consideration

is in tune with the literature regarding issues that play in to the decision making of psychotherapists considering whether to offer short or longer-term work (e.g. Hallett, 2012; Lanyado, 2009). However, as outlined in the literature review, there is a growing body of research that indicates even highly disturbed children may make use of and progress with time-limited psychotherapeutic interventions (e.g. Trowell and Kolvin, 1999). The STPP Treatment Manual highlights that STPP's strength is that it can be used where there are more complex presentations and higher risk. One participant touched upon this idea that it might be a '*myth…that case is too complicated'* (Participant B, Time 2, Lines 14-151) for STPP and that revisiting the STPP Manual might be helpful in thinking about future referrals.

Although generally cautious about whether STPP would benefit patients with more severely entrenched difficulties, participants were open to the idea this would need to be considered on a case-by-case basis. Indeed, in the STPP Treatment Manual it is highlighted that the research into which child or adolescent can best make use of psychotherapy is 'patchy at best' (p50), which would mirror participants' experiences of feeling uncertain.

Participant's ideas that STPP was unlikely to generally suit patients where there was greater complexity or risk may have been another barrier to them feeling able to offer STPP, as they highlighted that they did not see the more *'straightforward cases'* (Participant C, Time 1, Line 36). This is reflective of the pattern of CAP referrals where CAP is often used after other shorter interventions have been tried as a 'last resort' (Cregeen et al., 2017, p. 51), or for the most complex cases. Further work could be helpful within the CAPT team to consider this in relation to future STPP referrals.

At the time of the second interviews there was more evidence in the data of an idea that STPP might offer *'enough'* (Participant C, Time 2, Line 314) to some adolescent patients. Perhaps following the experience of using this model participants were more in touch with the beginnings inherent in endings (Salzberger-Wittenberg, 2013), and the possibility of change within the STPP timeframe. As Obholzer (1986) and Cooper and Wren (2012) highlighted, clinicians need to fundamentally believe in a change they are trying to implement for this to be successful. The evidence pointing to an increased sense that participants, over time and through their experiences of using STPP, began to have an increased sense of its value to some patients suggests that they might be increasingly more open to using the model in the future, follow up research would be required to investigate how this process progressed.

The aim of psychotherapy, and the change or progress hoped for, seemed implicitly central in whether participants might view STPP as offering *'enough'*. There is a wealth of psychoanalytic literature about the general aims of psychotherapy, which is beyond the scope of this project to expand upon in detail (see Genga et al., 2019; Leuzinger-Bohleber & Target, 2002; Sandler and Dreher, 1996). In STPP, the aim is focused more specifically on alleviating the symptoms of depression by understanding the individual processes underlying these symptoms in a particular patient, within the context of their adolescent development, to 'create increased resilience and foster a capacity in the young person to manage difficult feelings and experiences' (Cregeen et al., 2017, p. 56). In short-term work or consultations, Lanyado (2009) considers the aim of the therapist to be a 'catalyst for change' (p.198). Lanyado (1999) also highlights the difficulty of ending with patients where there is a recognition they may later benefit from further work, if it is unclear if this

would realistically be available to them due to service pressures, which might have been an additional factor in participants minds (explored further in Superordinate Theme 3). Participants had such considerations regarding the aim of STPP in mind, with one participant specifically citing Lanyado's work where '*the question of having done enough'* (Participant D, Time 1, Line 252) is so prominent. From the data, there was a sense that in such time-limited work participants might have to let go of broader or emerging further therapeutic aims, or a fantasised ideal ending, to take a more focused approach as was also described by Briggs (2015) in the literature review.

In my reflexivity and countertransference, I picked up some of these feelings described by participants, of being a depriving or withholding object, who did not give enough time, who cut something off just as it got going. For example, in one interview, as we came to the end and I was switching off the recording equipment, the participant added *'I'm very cautiously…'* (Participant D, Time 1, Line 539) just as audio stopped, in my notes I added that they had said *'I'm very cautiously optimistic'*. Additionally I noticed that, like the participants, I had internalised an idea of STPP being for older adolescents - in my own writings I had put it as being for those 13 years old and above, rather than 11 years old and above, as detailed in the STPP Treatment Manual.

Centrally, I think my experiences in writing up this thesis also illuminates some of the processes at work in the participants. Firstly, I found it very difficult to write clearly, even though this is something I find I can usually do, and have had feedback that I am accurate in this assessment. Secondly, I had far too much data, and all of it felt important; there was nothing trivial in it. I had to undergo the painful process of deciding what to prioritise, what to include and what has had to be left out. I

understand that this is a normal experience when writing up research; as noted by Larkin (2021) it is 'much easier to "edit up" than "edit down'". However, I think my difficulty also reflected the participants' difficulties in implementing STPP. Any time-limited therapy involves the clinician and patient in an explicit selection process of what can be tackled and what has to be left, and what has to be left is not usually unimportant. This clinical struggle I suggest was reflected in me, communicated through the transference and projective processes previously described.

4.3 Superordinate Theme 3: '*People are very depleted'*[18] -the need for organisational holding and containment.

This superordinate theme focused on the organisational cultural context within which STPP was being implemented and consisted of two interconnected subordinate themes, as illustrated in Table 2.

A: The wider context of pressurised services where *'people are very depleted'*[19]

Findings from Time 1 Interviews

When asked generally about the services they worked in, all participants presented an evocative picture of pressurised services and a stressed workforce. They repeatedly talked at length about the difficulties of ongoing structural change, teams experienced as divided, and under huge pressure from staff leaving, high sickness levels, and a waiting list of patients needing to be seen and treated. There was a repetition of the word *'depleted'* when talking about colleagues, for example:

[18] Participant C, Time 1, Line 314
[19] Participant C, Time 1, Line 314

‘people are very depleted internally’ -Participant C, Time 1, Line 314

Whilst talking about their colleagues in this example, it does not feel a stretch to imagine in such service contexts participants might also have felt themselves *‘depleted’*. This is perhaps a familiar picture to those working in NHS mental health services, and vital to understand when considering how it felt for participants to be interested in, or take on the demands of anything new, as described in the following extract:

‘the workload makes people less interested in anything, you know, because they just try to survive, and everything new is too much, isn’t it? I mean, when I open my emails and I see someone wants a, to, for me to fill, a table to be filled in, I want to scream, you know, and I guess similar, you know, if you come with a new idea, it’s just, it’s, I don’t have really the feeling that anybody is against you, or, you know. It’s much more that the workload makes them so deflated, and less interested, and, and, and the same with psychodynamic thinking, you know?’ –Participant A, Time 1, Lines 316-322

This extract vividly highlights how anything *‘new’* might be felt by colleagues within the service, when thinking about introducing them to psychanalytic thinking generally. Whilst colleagues are not consciously experienced by the participant as being *‘against’* new ideas, they are described as *‘deflated’*, *‘less interested’* due to their high workload; they are in survival mode. These feelings were not explicitly linked by the participant to their own feelings about implementing STPP, however they describe that they *‘want to scream’* when faced with another pressure to do something more. This felt implicitly linked to how it might feel to face what more might be needed from them to implement STPP within such a service context - where *‘everything new is too much’*.

Further to these descriptions, the following extract highlights the psychological demands of the nature of the work participants were undertaking and the impact this has within such organisational contexts:

'Doesn't always feel like we've got enough, external resources. People, interventions, whatever. But, I think people's internal resources are quite, quite limited, as well, given, you know, we've got pressures to see so many people every week…And erm, the cases are more complex and - and there's that idea, you know, we're dealing with trauma but how, are we, as a workforce, also traumatised by dealing with the trauma every day.' - Participant C, Time 1, Lines 124-133

This highlights the idea of the impact of secondary trauma in the workforce and adds another important factor to the difficult context within which STPP was implemented.

Findings from Time 2 Interviews

The findings relating to this theme of pressurised services where *'people are very depleted'* (Participant C, Time 1, Line 314), remained prominent in the Time 2 interviews.

Participants again repeatedly described services in which there were ongoing changes and transitions. Whist one participant said the past year had been comparatively stable in terms of management structures, they viewed this as unusual and unlikely to last. The impact of this context on staff and their internal resources was explicitly talked about again, for example:

'I think inevitably when organisations are going through change it affects peoples, erm, energy levels, doesn't it, and what's available to, erm, think and be, and general morale.' -Participant B, Time 2, Lines 536-538

The context of ongoing change and instability was linked by one participant to their own emotional and psychological resources in being able to think about implementing STPP and part of the resistance to this:

'If you were to review what we'd talked about last time, I'd have been talking about change and things being unsettled, and people not feeling safe, because, actually that change has been going on for years. We haven't had a period of stability in donkeys...that's obviously going to have an impact on everybody, and, and I'm talking about the team, but I'm also talking about myself in that. You know, thinking about maybe th-that is there some of the resistance in thinking about implementing STPP because it was just one thing too many, in uncertainty, in managing change.' - Participant C, Time 2, Lines 493-500

B: The need for organisational holding and containment.

Findings from Time 1 Interviews

Alongside feelings of being *'new to STPP an-and very excited about it'* (Participant B, Time 1, Line 84), the previous superordinate themes have highlighted that the prospect of starting STPP raised many other more challenging feelings within participants. Participants also raised that they felt *'daunted by it'* (Participant D, Time 1, Line 206), *'And I worry about getting it wrong, I suppose'* (Participant C, Time 1, Line 799). In the context of such complex emotional responses, a space to feel held and contained and thus able to think about how implementing STPP felt in order to be able to start to undertake this work seemed of vital import.

Within the context of pressurised services (as described in Subordinate Theme A) there was an acknowledgement from participants of what impact this had in services on the space to think generally, for example:

'I think the "lean" kind of "work more efficiently" doesn't leave any space for thinking, and I think that's the big thing we miss out on.' Participant C, Time 1, Lines 277-278.

Speaking about the benefits of the case discussions they set up in the multidisciplinary team for colleagues to think and talk about patients generally, this participant went on to say:

'initially there was a bit of a panic about, "I can't, I can't do anything extra." But, I think, as time has gone on and there's been a core group that have gone to every case discussion, that, that helps, hold something…Maybe people are finding, I don't know, that actually, it's not, it doesn't deplete you to bring it, it gives you something, you know, it's a good feed rather than a giving more of yourself away.' - Participant C, Time 1, Lines 299 -317

Whilst this feeling was put out into colleagues, rather than talking about their own feelings or need for space to think and talk about their work, or STPP, it felt related. The idea of initially there being *'a panic'* about the idea of doing *'extra'* moving to a sense of this helping to *'hold something'* seemed to also describe a process within the CAPT peer supervision group.

The peer supervision group met on a monthly basis to think about and discuss STPP, to support participants to start to work with this model over the year of implementation. As one participant said:

'I'm pleased that we've got our, erm, peer supervision group, to, to think together' – Participant B, Time 1, Line 513

However, there was already a concern raised in one interview as to whether this would be enough:

'I struggle to imagine it'll be enough, because I, I , you know, I don't, I'm just, I suppose I'm trying to work out where would you take this? I would have to take it to my clinical supervision. Erm, you know, I think the, I think the struggle is, is being able to talk about what it's bringing up for you, as a person, and as a therapist.' - Participant D, Time 1, Lines 384-387

This extract highlights that some of what implementing STPP might evoke in CAPTs could be personal, exposing, difficult to talk about and a question of whether the peer supervision group was the right place to bring these feelings and thoughts. The difficulty this participant had to put what the *'struggle'* was in to words, I think showed

the way in which some of these emotional difficulties were pre-conscious, painful and needed the kind of containment and holding which seemed, from participants descriptions, mostly lacking at the organisational level. It seemed participants hoped to find this in peer supervision to some extent but there was a concern as to whether this would be *'enough'*.

Findings from Time 2 Interviews

By this second time point, participants more strongly identified peer supervision as being valuable in the process of implementing STPP within their services. They described this as a space where participants could think and learn together, highlighting, *'we don't really have to work in isolation'* (Participant D, Time 2, Line 623).

Whilst there were, in two interviews, a mention of there being at times *'tricky'* (Participant C, Time 2, lines 334) group dynamics at play and ordinary tension between group members, there was a repetition from all the participants of also viewing peer supervision as a positively supportive space, for example:

'The peer supervision group has been good, it's been good to hear about other people's cases. I suppose that's where I've learned the most, I think, that group experience despite the difficulties.' – Participant C, Time 2, Lines 442-444

'I really valued the, the monthly peer supervision. I thought that was really, really helpful to kind of be able to bring my own material but also to hear other people's. And, that, was really helpful. I was kind of, thinking about sometimes people's reticence to pick up a case, or bring case material. And wondering was that because we were doing something new, or it can be quite hard to bring something new, erm, when you're kind of, inevitably, you know, in a context that while its safe, its equally, you know, people looking at your practice and thinking about your practice.' – Participant B, Time 2, Lines 450-457

This second extract emphasises the helpful nature of the peer supervision in supporting learning as also described in the first example, and brings our attention to the ways in which this could also feel at times *'quite hard'*, that people might have at times felt looked at, perhaps in a more persecutory sense.

When asked what helped them in implementing STPP in their services, participants also spoke about talking to their clinical supervisors, *'holding on to the core, core child psychotherapy'* (Participant B, Time 2, Line 463), and the STPP Treatment Manual (Cregeen et al., 2017). It seemed that the manual was used to varying degrees by different participants, for example:

'*the manual's really good. Very detailed. Erm..I mean, it's amazing really, I'm very impressed…because it covers so much more than STPP, really, in terms of, you know, it's so applicable in, in other ways in terms of, you know, just in relation to, the adolescent task, but also particularly about practice technique, which you kind of lose or you can forget'* – Participant D, Time 2, Lines 530-535

'it's kind of been in the background, more than actively using it. I've been using supervision much more to think about that beginning, middle and end phase.' – Participant C, Time 2, Lines 380-382

These extracts highlight the differing ways participants related to the STPP Treatment Manual, one had it front-and-centre in their mind and talked about finding it very useful, another focusing more on the role of supervision to support them in thinking about their STPP work. As was highlighted in the discussion of Superordinate Theme 1, there were generally much briefer, less detailed responses regarding the experience of using the STPP manual than I had expected.

Discussion of Superordinate Theme 3 in relation to relevant research, psychoanalytic theory, reflexivity and counter-transference.

In the interviews at both time points, all participants strongly highlighted the difficulty of trying to implement STPP within pressurised services dealing with the impact of ongoing change where *'people are very depleted'* (Participant C, Time 1, Line 314). The need for organisational holding and containment was mainly implicit in the data, but a strong impression. This appears particularly important when considering how CAPTs might identify and overcome barriers or resistance to implementing STPP within services.

This superordinate theme arose unexpectedly from the interview data. The initial opening question in Time 1 Interviews, which I had designed to put the participants at ease and set the scene of the service contexts, elicited more lengthy and complex responses than I had expected. Participants returned to this theme spontaneously throughout the majority of Time 1 interviews and in Time 2 interviews, as well as when specifically asked if there had been substantial changes in their service since the first interview. They painted a vivid picture of the organisational culture, where change was incessant and pressures immense, which is understood from the literature to have a substantive impact on the possibility to think, innovate and implement change (e.g. Rao, 2013).

Participants spoke of how the substantial pressures within services felt to colleagues, and in themselves. One participant highlighted the impact of secondary trauma in the workforce, where people are '*also traumatised by dealing with the trauma every day.***'** (Participant C, Time 1, Lines 124-133). Much has been written about this (for example, Hopper, 2012), and it felt important to keep in mind - that the

general nature of the therapeutic work undertaken by participants is emotionally challenging in itself and has a substantial emotional impact on clinicians.

In findings previously outlined in Superordinate Themes 1 and 2, participants described a variety of complex feelings and thoughts that STPP evoked in them, such as the experience of time, loss, being in the position of a depriving, withholding object, and so on. Added to this, was a sense that '*everything new is too much'*, and extra pressures or demands made them '*want to scream'* (Participant A, Time 1, Lines 317 and 319), alongside feeling *'daunted by it [STPP]'* (Participant D, Time 1, Line 206), and a *'worry about getting it wrong'* (Participant C, Time 1, Line 799). Taken altogether, we can understand that the prospect and experience of implementing STPP was seen as exciting and a chance to learn something new, but also significantly emotionally challenging. Within this context, it is therefore unsurprising that participants explicitly raised that *'there was resistance about implementing STPP'* (Participant C, Time 2, Line 108).

As described in the literature review, resistance is a psychoanalytic concept relating to psychological processes undertaken to avoid or defend against that which would cause anxiety if made conscious (Freud 1910[1909] SE11; Rycroft 1968; Spillius et al., 2011). Mann (1982) highlights that it is vital for the natural resistances involved in starting short-term work to be given space to be made conscious, thought about, verbalised, discussed, if they are not to impede such work from ever being possible to start.

Although participants appeared buffeted by the impact of changes and pressure in their services, they also appeared to be looking at where they might find sources of support, holding and containment, most prominently citing clinical supervision and

their monthly peer supervision. When specifically talking about how they experienced the peer supervision, the aspects of this providing a space that was supportive, where they could learn about STPP and bring case material to think about together were highlighted. There was an acknowledgement of this being at times *'tricky'* (Participant C, Time 2, Lines 334), which felt a realistic group experience, particularly when undertaking something novel.

This relates to psychoanalytic concepts of the importance of containment (Bion, 1962) and holding (Winnicott, 1965 [1960]) in development, as previously outlined in the literature review. In order to innovate and bring in new ways of working it feels relevant to consider that, like the infant written about in these theories, participants needed a space where they felt held and safe to grow and develop, where overwhelming unconscious fears might start to become thinkable through containing, projective and introjective processes.

The prominence of this theme was a surprising finding to me. In my research diary, I recorded during the Time 1 interviews my concern that the time spent answering my opening, contextual question had far exceeded what I had expected, and the focus on service issues had taken up more of the interviews than I expected. I worried at the time whether I had, as a novice interviewer, allowed the interviewees to take us too 'off topic', that I had not steered the interview back to STPP firmly enough.

As I digested the interviews and saw that this theme was common between them all I started to think, through talking with my supervisor, how important and recognisable a picture this might be to other CAPTs working in stretched NHS Trusts. That rather than being 'off topic' this might in fact be 'the topic' when thinking about the reality of implementing STPP in services. These service realities would naturally impact what

change felt possible, and what really could get going, and perhaps help future services consider what kind of support CAPTs would need if they wanted to start to implement STPP too.

The description of service pressures and dynamics was something I was aware of as a trainee but in part protected from, when I consider how I experience services now I am in a qualified post. Nonetheless, I had different pressures to consider, in my own life, and from the training requirements, that meant I was in touch with what the participants talked about. Whilst at times I wondered whether being known professionally to participants interfered too greatly with the findings, on balance it felt like a benefit to the process: they were able to be frank with me about that with which they were struggling and trust that I would handle this data sensitively.

As I came to analyse the data and write up the findings, I found my feelings about what was coming out of the interviews changing. Whilst I had noted throughout the year my own frustrations about what I felt as the slow process of implementing STPP, I came to feel sympathy and understanding for why this might have felt such a stretch, such a big ‘extra’ thing to take on, as considered in more detail in the following section- ‘Further Discussion’.

5. Further Discussion

This section gives a wider perspective and context to the findings as a whole, reflecting on researcher reflexivity and the overall nature of this research project- its strengths, limitations and the implications it has for clinical practice, service innovation, training and research.

Further Discussion of the Findings

In the previous 'Findings and Discussion' section, I separately detailed and explored the three superordinate themes found from the interviews with Child and Adolescent Psychotherapist (CAPT) colleagues about the process of starting Short-Term Psychoanalytic Psychotherapy (STPP) work. These findings showed that the process of starting STPP evoked broader existential questions in the participants, linked to ideas about what Child and Adolescent Psychotherapy (CAP) is; concerns regarding time in short-term work, whether STPP can offer enough to patients; and the difficulties of working and innovating within extremely pressurised services. In this section, I take a wider perspective on these findings as a whole, how they might interact with one another, and be understood within the wider professional and service context as described in the 'Introduction' section.

The interview data at each time point encapsulated a mixture of views and feelings about STPP, but generally concerns about STPP were more prominent in the Time 1 interviews and had dissipated to a large degree a year later, once participants had had a chance to use the model. Participants reflected on their individual and possible group concerns and resistance in starting STPP, including questions as to whether the model held true to core psychoanalytic values and their training (as detailed in Superordinate Theme 1). As the time-limited nature of STPP was integral to its

design as a model, worries about this time limit and the impact on technique as detailed in Superordinate Theme 2, were intrinsically linked to concerns raised about whether such time-limited work is '*what we do*'[20] as CAPTs. All of the concerns detailed in the first two superordinate theme findings were likely to have been exacerbated by the service pressures described in Superordinate Theme 3- as we understand from the literature that resistance is likely to be particularly strong when facing anxiety-provoking change under pressurised contexts (Hurst, 2016).

These findings as whole can only be fully understood within the wider context of the way in which the participants would have been trained and the professional world and associated pressures CAP presently faces as a profession. All the participants trained before STPP was developed and taught on CAP clinical training. Whilst short-term models would have been taught and used by participants, CAP training in the UK has been based largely on psychoanalytic training – where long-term, intensive work is given primacy- and involves personal long-term intensive personal analysis (at least four times a week for four years). As Briggs (2019) describes, whilst there is a long history of psychoanalytic short-term work, this seems to be repeatedly lost from how those within psychoanalytic professions view and understand their own professional history. Participants own experience of analysis and of their training, could understandably have led to an internalised viewpoint that longer and more intensive work is better, or more true to psychoanalytic principles and methods, leading to concerns about STPP and whether it was *'psychotherapy-light'*[21] or *'mess[ing] with the method'*[22].

[20] Participant C, Time 2, Line 136
[21] Participant D, Time 1, Line 425
[22] Participant C, Time 1, Line 793

The findings detailed concerns about a pressure in services to offer more short-term work within the context of services being under stress to increase patient throughput due to limited resources and needing to meet increased demand in children and young people's mental health services. Participants worried that in this context their ability to offer patients choice and long-term psychotherapy might be under threat. Services facing such pressures need to ensure they are offering patients treatments that are effective, and more than ever service transformation is driven by a move to try and align services with NICE guidelines, which are based on evidence from empirical research (NICE, 2019; NHS, 2016).

The findings in this study and how they relate to and are bound up with thoughts and feelings about research are important to consider further. STPP was developed as a model for use in the IMPACT study, a Randomised Control Trial (Cregeen et al., 2017; Goodyer et al., 2017). Whilst STPP was developed by CAPTs who were members of the Association of Child Psychotherapists (ACP) and rooted in core psychoanalytic principles and technique, it was also inevitably in the minds of participants bound up with research, and in a particular way CAP could engage with research as part of providing 'evidence-based' treatments in services. The underlying debate that these findings may have been tapping into is perhaps a question as to whether CAP is staying true to its core psychoanalytic values and methods whilst adapting and evolving to work in and be part of modern pressurised NHS services or losing, or in danger of losing, something in this process.

Overview of researcher reflexivity

Throughout the 'Findings and Discussion' section I examined my researcher reflexivity and counter-transference in relation to each of the three superordinate

themes. I detailed and explored how at times I felt as a researcher I became unhelpfully imbued with participant's feelings and thoughts related to STPP and research and how this came into the data, findings and analysis. That occasionally I felt myself in the withholding and depriving position associated by some participants as a key feature in time-limited work. Furthermore, that in the research process I had to undertake a painful process reflective of, and heightened by, that which the participants were grappling with in the time-limited nature of STPP- having to narrow down my focus and accept what must be lost or not included as part of this. In now taking a broader view in reflecting on my thoughts and feelings throughout the research process and in relation to the topic, STPP, I hope to provide greater context and another lens through which to understand this research project and its findings.

Unlike the participants of this study, STPP was part of my clinical training- the model was studied and this type of work discussed in seminars I took part in, I had started an STPP case a few months before the Time 1 interviews and took up two more cases subsequently in my training. Thus, STPP was very much in my mind as I developed and undertook this research and I had more familiarity with it than most of the participants in the study.

I found STPP well suited to the depressed adolescent patients I was seeing and I felt that this model, with a time-limit central to the work, helped them in this developmental stage with the difficulties they were having. Perhaps particularly in my position as a trainee, the STPP manual (Cregeen et al., 2017) was very helpful to me, it helped me navigate and understand complicated psychoanalytic theory and technique applicable both in STPP and more widely. Clearly, my personal views about STPP were more positive than those found in the interview data with my participants, particularly in the first set of interviews. I noted during the process of the

data collection my surprise and frustration with the strength of the concerns raised by participants, and how much less STPP work was undertaken and the length of time it took to start in comparison with what I had expected.

My views and understanding of STPP and the research findings evolved as I took up a CAPT position post-qualification and came out of the comparatively protected position of being a trainee. I found myself inundated by clinical work, trying to keep afloat in a service that was under incredible pressure and having to manage immense changes in the face of the Covid pandemic. With greater exposure to service dynamics, I saw in this context why participants were concerned that the degree to which services were under pressure could lead to service decisions about length of treatment being unconsciously driven by a need for throughput to an extent that might in the end not be of patient benefit.

I also found myself much more in touch with how difficult it would have been under such service circumstances for the participants to have had the space in their minds and practice to learn about and start using STPP. I found it difficult to find space for my own professional development, to do much more than survive. There were practical difficulties in starting STPP work too which I started to better understand- ensuring referrals into psychotherapy were suitable for such work and finding capacity within colleagues to offer the parent/ carer work required to support it. Whilst I was very keen to start STPP work and my managers and colleagues were supportive of this and wanted me to offer it as a treatment, it took me a year in this post to start any STPP work and I feel there is still a way to go to fully embed STPP into the service.

I used my researcher diary and supervision throughout the process of collecting data and writing up this thesis to interrogate my own feelings and how they interacted with the data I collected and my analysis of it. However, throughout this research process I was more publicly trying to hold my own thoughts and feelings about STPP, to take up instead a more neutral position in peer supervisions, in informal discussion with colleagues who were also participants and in the interviews. I found this difficult at times, but I hoped that in doing so, I would lessen the interference of my own position in the research data and findings, and allow space for participants to talk to me about their feelings and views of STPP. In retrospect, I wonder how far this was successful. Participants knew I was interested in STPP as it was my chosen topic to study, and likely felt through our unconscious communication, if not our conscious verbal one, that I was generally positive about it. I wonder if, as Holmes (2018) suggests the research design would have been strengthened by my more straightforwardly acknowledging and incorporating these aspects of my subjective position, whether this would have helped make some of what was unconsciously communicated between participants and myself, conscious and available for exploration.

Through this research project, my general understanding of research has increased, I feel more research literate and that my practical research skills have developed. Whilst I had some prior experience of conducting research from my previous studies in psychology, I had never undertaken such in-depth research, used qualitative methods in a large scale project or conducted interviews before. In my research diary, I noted how anxious I was about the Time 1 interviews, despite practising the techniques and using clinical skills developed through my psychotherapeutic training, at times I felt clunky and unsure of myself. In comparison, I observed that I felt much

more confident during the Time 2 interviews and I felt that they flowed more easily. Given my status as a novice interviewer, it is hard to unpick whether the difference between how the two sets of interviews felt was due to the development of my interviewing skills or changes in the participants views and ways of relating to me, most likely it was an interaction of both.

As previously detailed, I was in the first cohort of trainees on the new clinical CAP training programme, where the professional doctorate was undertaken within the clinical training timeframe. In the discussion of Superordinate Theme 1, I explored how this might have unhelpfully conflated my position with general feelings about research for participants and influenced the findings. In my position, embodying a significant change in the CAP the training course, I felt trainees in my year were at the epicentre of a split and debate that I was aware was felt more widely across CAP regarding research, its place in the profession and how we should or could engage with it. This debate is explored by Henton and Midgley (2012), who highlight a professional divide, where some feel CAP needs to be engaged with research to develop thinking, evolve practice and to survive in the NHS given the growing emphasis on providing evidence-based treatment; whilst others conversely feel research is an unhelpful distraction from core psychoanalytic work and focus, which undermines the profession as it tries to measure or quantify human experience in a manner that is reductionistic and misses the point of psychoanalytic work. I was in the midst of these debates within the different trainee cohorts in the training school and heard of them taking place across services where my fellow trainees worked. It is likely such considerations also provided the backdrop to the findings of this research project given the relationship between STPP and research.

This debate was not only taking place externally, but internally within me too. I too felt ambivalent about research, alive both to the possibility of it being useful and illuminative and also to its limitations in what it can tell us about rich, complicated, contradictory human experience. However, as I understand more about how research shapes services and how it can help us to interrogate and develop better practice for patients, I think that it is important as a profession that we engage with it in a way that is meaningful.

I have previously described the way in which the process of undertaking this research reflected and was bound up with the process of time-limited work as described by Briggs (2015), requiring me to adapt and focus my study, to leave out things that felt important and confront limits and loss. My research experience also felt a parallel process to that which participants described in their experiences of STPP in terms of its time-limited nature. As participants had found with STPP, the time-limit expectation of my doctoral study provoked in me strong feelings of panic, that I would not have enough time to do all that I needed to, and left me feeling at times persecuted by the task, feeling that I did not have what it required to complete it. Due to personal circumstances I did in the end require and receive more time to complete the write up of this thesis, and it changed the nature of it somewhat as my perspective evolved and shifted. However time-frames continued to feel very tight, and the ending of the process, the deadline, as confronting and worrying as the ending of STPP work was felt by participants.

Strengths and limitations of this research project

This was a naturalistic study, with findings drawn from interviews with CAPT participants working in busy NHS services, treating patients accessing these

services and trying to start to use STPP in their work within this context. As such, this research captures and explores the complexity of real world experiences of starting to use STPP in services, giving insight into the concerns, challenges and barriers of rolling out such a treatment model, as well illuminating what might support this process and be important to consider when undertaking it.

The research design, in following and exploring CAPTs thoughts and feelings about starting STPP work as they started to implement this model into their services, and revisiting how these thoughts and feelings had changed a year into this process, allowed for exploration of how their views changed over time. In particular, this showed that concerns about STPP generally reduced as participants had more experience of using the model within their services. However, the research was limited in capturing potential changes in participant's views due to them generally having a quite limited experience of the model over the course of this year. Participants learnt about STPP and shared clinical experiences of the model in monthly peer supervision over this year, however they took up less STPP work that I had predicted (one or two patients each) and took longer to start to use the model than I had expected, with half the participants only just at the midway stage of STPP by the Time 2 interviews. It would have been interesting to see how their thoughts and feelings about STPP might have developed with more experience of using the model, and particularly in completing a piece of STPP work.

Participants did not form a completely homogenous group in terms of the variety of their prior STPP experience. At the point of the Time 1 interviews one participant had used STPP in their previous role outside of the Trust, they and another participant had also started a piece of STPP work in their current services by the time of the first interviews, whilst the other two participants had not. That there was a range of

previous experience of using STPP within the participant group, was a complicating factor but I think reflects the makeup of most NHS child and young people's mental health services, where some CAPTs may have learnt about STPP as part of their core clinical training or following this, but others would not have. I think this may make the findings more relevant and applicable to other service contexts.

That participants were known to me through my position in the Trust as a trainee was also important to consider in thinking about the data that was co-produced in such circumstances and how it was analysed, using my subjective positon and limited by it, as I have previously explored in the Findings and Discussion section. Participants might have felt that they did not have much choice in the recruitment process, as they knew me professionally they might have felt they needed to be helpful to me in this process and take part. However, that one colleague did not take part in the research, points to there being some room within this process for people to say 'no'.

Whilst participants and I being known to one another professionally will have affected the data, findings and analysis, I think it was also a benefit in the study design. Participants seemed to open up to me in the interviews, being honest about quite difficult and personal thoughts and feelings, trusting me with these in a way that perhaps might have been more difficult if I had not been known to them, and what they shared with me in this context was illuminative about the process of starting STPP.

An additional difficulty in this research was the extent to which I felt the need to be cautious in regards to protecting participant anonymity whilst presenting and analysing the findings. This limited more detailed exploration about individual

differences within this process but felt necessary given how small the CAP profession is and therefore how even limited demographic information about participants might make them identifiable, particularly given the link to me and my training post. That participants were aware and conscious of this, discussing the boundary of what would or would not be shared in and after interviews showed that my caution was justified, and also important to them- perhaps also that having trust in me handling this issue with care was integral to participants feeling able to speak openly with me.

The design of this research project evolved and changed over time. I had at first hoped to include patient related data, demonstrating and evaluating the take up and delivery of STPP from this point of view alongside capturing the thoughts and feelings of CAPTs. As more fully described in the Methodology section, the design had to adapt to the limited nature of the patient data that I could collect, and to the limitations of the scope of this research project. Whilst this reflected a significant challenge in this process, it also showed the benefit of having a wider research design, that it could change and adapt in this way and still produce relevant, robust findings.

Research using IPA is aware by the very nature and design of this methodology, of the limitations that exist in how much we can know and understand of another person and their experiences and the subjective nature of knowledge. In this context one does not usually think of findings of IPA studies as being generalisable. However, I do think that despite the limitations of this research, the findings are transferable to other service contexts. In my own experiences post qualification, and in discussions with colleagues and current trainees the picture these findings paint of service pressures and the issues and concerns relating to how CAP evolves and

changes within modern services and engages in research continue to be recognisable and live. As such, I hope that this research is useful to other CAPTs who want to start using the STPP model, or introduce other innovations in their services and could have implications for clinical practice, service innovation, training and research as outlined in the following section.

5.3 Implications for clinical practice, service innovation, training and research.

I hope that findings from this research could inform and be part of continued thinking about we improve clinical practice, what is required to support service innovation, influence aspects of CAP training and encourage meaningful professional engagement in research.

From the findings, it was clear that working in a way that best helps and supports patients was a key consideration in starting STPP work and very important to participants. From all of my other professional experiences, this feels consistent with core professional CAP values. Therefore, for CAPTs to fully support changes to services and innovations in CAP practice they must be convinced of the benefit to patients and that these changes have patients at their heart.

These findings demonstrate CAPTs are motivated to develop and improve their own clinical practice and that service context is highly important in thinking about how clinicians feel and what they feel able to take on and do in this. The findings from Superordinate Theme 3 were striking in the extent to which they described the difficulties and pressure of the service contexts within which participants were working, and in just how recognisable and ubiquitous a picture of services this currently feels to be. If service innovation and development of clinical skills and practice is to be possible, I believe there needs to be improvements to these working

environments where all clinicians including CAPTs feel better supported, where burn out, high staff turnover and high staff sickness are avoided and development and innovation can flourish. Psychoanalytic thinking has much to offer in this area, in thinking and organisational dynamics, and supporting improvements in services.

To increase the STPP provision for patients, more CAPTs would need to feel confident and see the value in using this model. These findings show the key importance of experiential learning in this process. CAPTs need opportunities to learn about and try out the model for themselves to see the value in it and feel more confident in using it in their practice. Thus additional STPP training and supervision groups, perhaps run by the ACP, may support wider roll out of this model.

In terms of implications for training, this research sits within the context of changes to the CAP core clinical training programme with the specific inclusion of STPP and a greater emphasis in research skills. I think these findings show that training courses could helpfully introduce trainees to the history of time-limited psychoanalytic work and the grounding models such as STPP have in well-established time-limited ways of working. They could also be instrumental in helping trainees think about and engage with the professional debate that exists about optimal duration of treatment, time-limited work and how to work with an ending therapeutically.

The relationship between CAP and research is complex. From my experiences in undertaking this research project, I think that it is helpful to think about the way in which research and psychoanalytic thinking and practice can influence and support one another. Holmes (2018) highlights the benefits psychoanalytic thinking and understanding can bring to eliciting valid, rich, useful research that takes in to account unconscious communication and makes use of this in the design and

analysis to increase understanding. As services, under the NHS long term plan (NHS, 2016), are changing to provide more evidence-based treatments in line with NICE guidelines, which are based on evidence from empirical research (NICE, 2019), engagement in research seems key to CAP continuing to be a key part of the professional make up of services and CAPT being available to patients. Thus CAP can bring something of value to the research field, and as a profession be supported by research.

If CAPT engaged more in research, felt more confident in taking up research and being part of it, I think that they might use it to better understand and support aspects of clinical practice that they feel are particularly important. For example, findings from this study showed that participants were concerned about whether they would continue to be able offer patients long-term psychotherapy in the context of huge pressure to increase patient throughput, and perhaps this would be an area of further research that would feel particularly important to them.

Whilst in the last few years there have been changes to the CAP core training to include the doctorate study within the clinical training, there is ongoing debate in the profession about engagement in and the value of research. In this context, I understand from informal discussions with current trainees research continues to feel a difficult aspect of their training and there continues to be a proportion of trainees who drop off the doctorate component of the course. I think it would be helpful for CAP training schools to actively support trainees to understand, think about and navigate the professional divisions in relation to research that they will encounter during their training in others and perhaps also in themselves. This would require close working between training schools and service supervisors, that the latter may also be actively involved in supporting trainees to develop their research skills and

take up research, just as they would support finding and working up an intensive clinical case. I believe this process would also be supported by trainee's doctorate research projects being supervised and supported by clinicians or CAPTs who are themselves experienced in research and can confidently guide trainees through this process.

6. Conclusion

The endeavour of undertaking this research has been key to my deepening understanding of time-limited work such as Short-Term Psychoanalytic Psychotherapy (STPP), the processes involved in implementing innovations and changes within services and within individuals, myself included. It has solidified my understanding of the necessary, important position of research within the Child and Adolescent Psychotherapy (CAP) profession and the understanding and opportunities this can bring. I hope that the next stages of this research process, of feeding back and reflecting on the findings with participants, will support the further embedding STPP in our Trust services, bringing this treatment option to more patients in frontline NHS services.

STPP is a treatment that has been shown to be effective in reducing the symptoms of depression in adolescents (Goodyer et al., 2017), with psychoanalytic understanding and technique at its core (Cregeen et al., 2017). Whilst there is an impetus in the CAP profession to roll out the use of STPP, the practicalities of introducing STPP into NHS services requires an understanding of the context of implementation. This includes how STPP as a time-limited model is viewed by Child and Adolescent Psychotherapist (CAPTs), the hopes and concerns it might evoke in them, and the realities of the pressures and difficulties of their day-to-day working lives. As Mann (1982) highlighted, it is only through thorough understanding of resistances to innovation that real change in working practise can be possible.

Through focusing on the perspectives of CAPTs working in an NHS Trust, this research illuminated the thoughts and feelings they had about implementing STPP, and how these changed (and did not change) over the space of a year. Whilst the

methodological design of including interviews at two time points was challenging in terms of managing the amount of data collected, it was also a strength as it allowed a deeper understanding of the process of change.

I found that CAPTs starting to implement STPP into services were concerned with existential questions about STPP, whether it fitted with how they viewed CAP, and how they felt they had been trained to work. Concerns that STPP might be considered '*psychotherapy-light*'[23] or '*anti-child psychotherapy*'[24] appeared to shift and reduce over the year as CAPTs learnt more about STPP and used the model in their work. There was a feeling that STPP might helpfully be part of the '*wide repertoire*'[25] of work CAPTs could offer- well suited to adolescents - but there continued to be an emphasis on the core of open-ended, longer-term work and a feeling STPP could only occupy a small place within CAP. The concern of who was driving the implementation of STPP highlighted the importance of CAPTs feeling innovations needed to be grounded in better helping patients, and to really believe in the professional validity for the changes that were being implemented.

Whilst CAPT participants initially appeared preoccupied with the '*hard reality*'[26] of time-limited work and the feelings of loss, concerns about the ending and the position this put them in in relation to their patients as they started to think about or use STPP, these concerns dissipated over the course of the year. There was a growing feeling that STPP could offer '*enough*'[27] to some adolescent patients to elicit beneficial change. It was however interesting that most CAPTs chose to use STPP with older adolescents where there was a service dictated ending, and where there

[23] Participant D, Time 1, Line 425
[24] Participant C, Time 1, Line 793
[25] Participant B, Time 2, Line 634
[26] Participant D, Time 1, Line 392
[27] Participant C, Time 2, Line 314

were less concerns regarding risk and complexity. Perhaps this allowed them to start using STPP without feeling too guilty or anxious, but to further embed the use of STPP, support would be needed to consider the nature of who is referred for CAP in services and whether this could be expanded as well as developing the range of patients CAPTs felt able to use STPP with.

The finding of the extent to which CAPTs felt impacted by the context of extreme service pressures, and how this played into the process of implementing STPP, was surprising to me. However, as I have moved in to a qualified post, I have experienced an increased understanding of the power of organisational dynamics. I am now in the position of talking to managers about how to increase referrals in to CAP that would meet the criteria for STPP, trying to find time and energy to improve my own practise rather than just get through the day and '*survive*'[28].

These findings add to the existing literature and psychoanalytic understanding that highlights how organisational culture influences the capacity for innovation and how holding and containment are of vital importance when considering the process of change. I hope that this would be integral to the planning and implementation of any future changes within the Trust I work in, and other services.

In this project, as the researcher, I was embedded in the process trying to elicit understanding that would be of direct benefit to the Trust. This was well received and encouraged by the Trust Research Department. However, this methodology could be seen as problematic within the Interpretative Phenomenological Analysis (IPA) methodology as I professionally knew participants, which could have affected the findings. I have endeavoured to mitigate this as far as possible through the use of

[28] Participant A, Time 1, Line 317

systematic reflexive processes and close supervision to support the production, interpretation and understanding of the findings within this relational context, and check for bias. An unexpected benefit of having to continue my doctorate work post-qualification has meant the passage of time supported a distance and clarity in looking at the data. However, at its foundation, IPA supports the development of co-constructed meaning and the nature of these relationships is part of this construction. The benefit of this methodology was that I found participants were able to be open in their thinking and frank in verbalising very personal and at times difficult thoughts and feelings that were integral to understanding the dynamics of implementing STPP within the Trust.

Through this research process, the biggest challenge I experienced was the need to revise and adapt the scope of my project to make it feasible. This required leaving out much that felt important- particularly a fourth superordinate theme and patient related data. This was a painful and difficult process, with which I needed support. It also felt in parallel to that which I was researching and understanding about STPP; an initial drive to try to do too much, the need to focus in on what was of most relevance and import, the pain and loss associated with this process, the impact of pressure and feeling of lack of time, and the need to feel contained and held in order to manage it all. That I, due to personal circumstances, in the end required and got more time to complete this project has not gone unnoticed in the light of thinking about this parallel process.

Since I have been writing my doctorate, the Covid pandemic has hit and the impact of this is on general life and mental health services has been huge (Liberati et al., 2021). Pressures within services have only increased, and the findings of this study

are therefore more relevant than ever when thinking about what might be provoked by and required to support change.

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Appendix A: Tavistock Research and Ethics Committee (TREC) Approval Letter

The Tavistock and Portman NHS
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Katy Hole

By Email

20th September 2017

Re: Research Ethics Application

Title: Evaluation of the provision of Short Term Psychoanalytic Psychotherapy in an NHS Trust Children and Young People's Service

Dear Katy,

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,

Lisa Dean
Quality Assurance Administrator
T: 020 938 2659
E: ldean@tavi-Port.nhs.uk

cc. Janet Shaw, Course Lead

Appendix B: DSM-5 Diagnostic Criteria for Major Depressive Disorder

Table from Kirpatrick et al. (2017)

Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. Symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (**Note:** In children and adolescents, depression may present as “irritable” mood.)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (**Note:** In children and adolescents, consider failure to make expected weight gain.)
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

Appendix C: Interview Schedules

INTERVIEW SCHEDULE TIME 1

1- **Could you tell me generally about your service and the work you do here?**

Prompts- Area covered, rural/city? How integrated is Child and Adolescent Psychotherapy in the wider service?

2- **Could you tell me about the experiences you've had to date in learning about or delivering STPP?**

Prompts- Was STPP part of your training? Have you had past experiences of delivering STPP?

3- **I'm wondering what you think about STPP as a way of working with depressed/anxious adolescents?**

Prompts- Do you think it differs from other models of psychotherapy- in what ways? How useful do you view it as a model?

4- **How do you feel about starting to deliver STPP within your service?**

Prompts- What do you think the challenges/benefits might be? How do you feel about the level of support you have in delivering STPP?

5- **I'm also interested in what your perceptions are of how STPP will fit within your service?**

Prompts- How do you anticipate colleagues/managers will respond to this kind of work being delivered in the service? How will referrals work? How will parent/carer work be delivered?

6- **Have you got any more thoughts or feelings about STPP that you could share with me?**

INTERVIEW SCHEDULE TIME 2

1- **Could you tell me about how STPP came to be set up in our Trust and in your service?**

Prompts- Where did the idea come from? What has the process been of starting work?

2- **What is the picture of STPP delivery in your service now?**

Prompts- Referrals-who from, how many, why do you think this is? How do you assess/decide who is offered STPP?

3- **What has your experience of delivering STPP been?**

Prompts- Have you used this model in the past year? What have been the benefits/ what interested you? What have been the challenges/ frustrations?

4- **What are your views about STPP generally now?**

Prompts- Has this changed in the past year- in what way? How does it differ/is similar to your other work?

5- **How have you found the support around delivering STPP?**

Prompts- How did you experience monthly peer supervision focusing on STPP? Was it supported by MDT colleagues/managers?

6- **What are your thoughts about using STPP in the future?**

Prompts-Will you continue/start to use the model- why? Would you recommend STPP as a way of working to colleagues- why/why not?

7- **As you know, it's been a year since we first met to talk about STPP. To get a feel of the wider context have there been any significant changes in the Trust or your service since our last interview?**

Prompts- Any re-structuring/major staffing changes? Has/ how has this impacted your work?

8- **Finally, do you have any reflections on whether or how this research impacted your STPP work?**

Prompts- Did the research impact on your feelings about starting to use STPP? In what ways? How have you found using the outcome measures?

Appendix E: Summary of Methodology and Findings from Patient Data

Methodology

Participants

This data was collected from a small sample of eligible patients within the Trust who met the following criteria:

- Patient under the care of one of the three children's mental health services (CYPS) within the NHS Trust
- Patient referred for and offered STPP during the period of study
- Patient aged between 11-18 years old
- Patient had a recognised difficulty with low mood, depression or anxiety. A formal diagnosis of depression or anxiety was not required
- Child and Adolescent Psychotherapist (CAPT) delivering treatment agreed to offer the patient the opportunity to take part in the study- based on their professional opinion that it would not harm the therapeutic relationship or frame
- Patient and parent/carer (if patient under the age of 16 years old) agreed to give written consent to take part in the study

Following this inclusion criteria five patient participants were identified and included in the study.

Data Collection and Analysis

Data was gathered from accessing participating patient records to give descriptive statistics of age at start of treatment, gender, diagnosis, number of psychotherapy sessions offered and attended, number of parent/ carer sessions offered and attended.

CAPTs were asked to complete Goal Based Outcome Records (GBO) and the Revised Children's Anxiety and Depression Scale (RCADS) with patient participants at beginning and end of treatment.

It became clear through peer supervision and informal discussion with the researcher that there was reluctance to use these outcome measures. To avoid this becoming a barrier to CAPTs using STPP the decision was made that the lack of outcome measures would not prevent CAPT or patient participant's data being included in the research.

All patient participants and their parents/carers were given an Experience of Service Questionnaire (ESQs) at the end of treatment.

GBOs and ESQs were a normal part of general CYPS outcome measuring for all clinicians working with patients, and thus chosen as a usual part of treatment.

Ethics

The original research study involved vulnerable patient participants as they were all under the age of 18 years old at the start of treatment, and were included in the study by virtue of them needing to access a mental health service. Therefore, special consideration of their needs was paramount in the design of this study. CAPTs discussed the opportunity of taking part in the study with potential patient participants and their parents or carers prior to starting STPP treatment. If interested in taking part, they were given a Patient Participant Booklet explaining in plain language what information would be kept about them, that this would be anonymised, what the information would be used for and their right to withdraw from the study. They were given the opportunity to talk to their CAPT further about the research and invited to contact the researcher or the Head of Academic Governance if they wished. Written consent was then obtained by their CAPT with particular emphasis given that they did not need to participate in the research in order to access STPP or any treatment within the service. All parents or carers were asked to give written consent alongside the patient's written consent, and for those under 16 years old this was a requirement for inclusion in the study.

The decision for discussions about the research to be undertaken by the patient's CAPT in the first instance was made to ensure consideration of participation in the research did not intrude in to the therapeutic model and relationship as far as was possible. Any thoughts and feelings stirred up by their records being accessed for inclusion in the research study could be talked about and explored as part of their therapy with their CAPT, and they had weekly sessions in which they could speak about this. All participants had their right to withdraw consent explained to them verbally and in written form and should their CAPT have ascertained that involvement in the research was having an adverse effect on the therapy this would have been encouraged.

Findings

Five patients were offered the opportunity to be part of research study and consented, these were from two of the three CYPS services in the NHS Trust. The CAPT in the third service did work with a patient using STPP but had begun this work prior to the start of the research and so did not want to interrupt the therapeutic process with a discussion about becoming involved in the project at this later point.

Gender

Two patients identified as male (one transgender), three female.

Age

Age when started STPP work	Age when finished STPP work
15	15
16	17
17	18
17	18
17	18

Risk

No patients were under Child Protection or were Cared for Children. All were attending school or college. All were assessed as 'low risk' meaning that the risks relating to their mental health (for example through risk of self-harm or of suicide) were not at the level of requiring a risk management plan. Two patients were prescribed anti depressant medication alongside their STPP treatment.

Referral

Externally into CYPS- Patients had been referred to CYPS via a range of avenues- including GP, paediatrician, and primary MH worker.

Internally for STPP-One patient was seen by a CAPT during their initial CYPS appointment and referred for STPP at this point, Care Coordinating colleagues within CYPS referred the remaining patient participants for STPP. All referrals detailed low mood and therefore met the usual criteria for STPP.

Time between referral for STPP and start of treatment ranged between 1-3 months.

Prior CYPS work: One patient was referred for STPP at their initial CYPS appointment. Four patients had been seen in CYPS for a range of between 7months-2 years prior to starting STPP.

STPP Sessions attended

One STPP therapy was terminated at 16 sessions as the patient disengaged, they had attended 12 sessions.

Three patients were offered 28 sessions, one of whom attended all 28, one attended 27 and the other 24 sessions.

One patient was offered 35 sessions as they missed sessions or cancelled, which meant at the end of treatment they had attended 28 sessions.

Parent work: Parent sessions were taken up in relation to three patients- for one patient 7 parent sessions were attended, another 10 and another 2. Parent work was provided by a qualified CAPT, a trainee CAPT or a family therapist.

Discharge

Following STPP, all patients were discharged from the service. One was referred to Talking Matters, one was considering adult psychotherapy referral via GP following a break from therapy.

Outcome Measurements

GBOs were not consistently used for the period of STPP work. Sometimes goals had been set prior to the STPP work commencing by CYPS colleagues, at times some time before STPP. It was unclear whether goals that were completed in the STPP timeframe had been done in conjunction with patients, or reflected only the CAPT view point and therefore, although the results showed positive improvement in mood, confidence, and independence the results were not included in this study.

One patient completed RCADS prior to starting STPP but did not do a follow up so no comparative score and this data therefore not included.

ESQs:

Parent/carers-

Only one ESQ was returned from a parent and it had been completed in relation to over-all CYPS experience rather than STPP specifically, therefore not useable data in the main. There was one comment relating to STPP work, which was that the CAPTs involved ‘were exceptional and treated me and my child with care and respect’.

Patient participants-

Amalgamated comments from three returned questionnaires:

What was good about your care?

‘I felt I was listened to, not made out to be hysterical or wrong.’

‘consistent’

‘I was made very comfortable, never felt rushed or as though I was doing anuting wrong. Always felt like I was being listened to genuinely’

Was there anything you didn’t like or anything that needs improving?

‘No methods/ strategies and minimal feedback’

‘No’

Is there anything else you want to tell us about the service you received?

‘Let down by lack of provision moving to adult services.’

‘I found the therapy very helpful. I never felt pressured or uncomfortable. I got a lot out of the service.’

Appendix F: Information Sheet and Consent Form for CAPT Participants

The name of NHS Trust has been redacted to maintain confidentiality.

PARTICIPANT INFORMATION SHEET

Interview about the Provision of Short Term Psychoanalytic Psychotherapy

I'd like to invite you to take part in an interview about providing Short Term Psychoanalytic Psychotherapy (STPP) in the Children and Young People's Service, XXXXX Trust. Before you make a decision, please read this information sheet about the project and what it would involve for you.

What is the purpose of the interview and why have I been invited to take part?
The purpose of this interview is to find out about how psychotherapists view the provision of STPP in our Trust. I would like to interview you at two time points: firstly during the start-up period of delivering STPP in our Trust, and again a year into delivery. I have asked at least one psychotherapist from the three service areas in our Trust to consent to being interviewed to give a range of opinions and views from the different services.

What will happen to the information I share?
The interview will be recorded and, once it has been transcribed and anonymised, the original recording will be deleted. Data Protection Policies of XXXXX Trust and Essex University will be followed.

Details from the interviews will be analysed and verbatim extracts will be used to illustrate the analysis. As you know, our Trust has a small team of psychotherapists and this will be carefully considered in deciding how information from the interviews is presented. However, is important that the voices of psychotherapists are properly represented whilst making every effort to ensure anonymity as far as possible you may recognise yourself and others in the data. It will be possible for us to discuss consent again during the interview, particularly in relation to any comment you may make which feels sensitive.

Do I have to take part in the interview?
You do not have to take part in this interview and you can withdraw any unprocessed data.

What will happen to the analysis of these interviews?
The analysis of these interviews will contribute to the wider evaluation of the implementation of STPP in our Trust. This will deepen our understanding about delivering STPP and how to shape this service moving forward. I will present my findings to the Trust as well as other psychotherapists and professionals. It is possible that results from this study may be published in the future.

Further information
This study has been approved by the XXXXX Research and Development Department and the Tavistock and Portman Trust Research Ethics Committee.

If you have any concerns about the conduct of the researcher or any other aspect of this project you can contact:

Simon Carrington **academicquality@tavi-port.nhs.uk**
Head of Academic Governance and Quality Assurance

PARTICIPANT CONSENT FORM

Interview about the Provision of Short Term Psychoanalytic Psychotherapy

After you have read the **Participant Information Sheet** please complete this consent form to show that you are happy to take part in this interview.

If you have any further questions at any stage you can contact Katy Hole, telephone: XXXXX.

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

Please tick and sign the following:	**YES**	**NO**
I have received information about this interview and the evaluation of Short Term Psychoanalytic Psychotherapy (STPP)		
I understand that I have been asked to take part in interviews about STPP which will be audio-recorded.		
I agree to anonymous verbatim extracts from these interviews being used in the STPP evaluation.		
I understand that all the information I provide will be kept securely and anonymised.		
I understand that I can withdraw unprocessed interview data from the evaluation and that it would not then be used in the final report.		
I agree to this evaluation being shared with other professionals and consent to my anonymous information being included if the findings are published in the future.		
I have been able to ask questions and am happy with the responses I've been given.		
I consent to take part in the interview.		

PARTICIPANT

Signed:

Print name: Date:

RESEARCHER

Signed:

Print name: Date:

Appendix G: Superordinate Themes- Verbatim Examples

Superordinate Theme	**Subordinate Themes**	**Illustrative Examples**
TIME 1 **1: Is STPP *'psychotherapy-light'*? Existential questions.**	A: How STPP fits with or is in opposition to what CAP is and how CAPTs are trained to work	'So, I think there were lots and lots of hesitations, you know, and, and seeing a problem in something' – Participant A, Line 197
		'they are also the driving energy within their teams, because if they are not convinced, or if they do not like it, they won't continue it' – Participant A, Lines 302-303
		it will not be something which completely changes our picture or our profession, being here, you know? Perhaps I'm more, it's, it's more of a challenge within our profession, you know? To think, or to allow this thinking, of having a short-term model as well' – Participant A, Lines 283-286
		'I think, and perhaps it's healthy or not, I don't know, but I think that I'm, all in all, you know, I believe that it does something, but I'm not believing that this is it completely, you know? I also believe in the open-ended psychotherapy, you know, but I think for some people it is right, you know, it's just right, what you can offer them. You know, and, and therefore I think, for, for myself, you know, I can't speak for anybody else, but for myself I think to have this little bit, little, little bit of doubt of the whole procedure, I think is good' – Participant A, Lines 458-453
		'I think in the room you are who you are and you do what you do. So, I think, whilst being conscious of, of the framework, you're also staying with the process and thinking about the, er, transference and the countertransference.' Participant B, Lines 172-174
		'business as usual, in, in, in many respects' -Participant B, Line 177.
		'I think when we, we've had a training in traditionally long-term psychotherapy, it does bring a new dimension, er, to think about the, the 28 sessions. Obviously, we, we've, you know, all got experience of, of brief work as well. But to kind of specify the 28 sessions and the, the number of sessions for parent work as well. Er, is, er, is kind of a learning curve. ' -Participant B, Lines 98-103
		'An-and your question makes me think about, erm, thoughts that we've had about, erm, CPD events, to think about psychotherapy and introducing people to psychotherapy and understanding psychotherapy. So, I think probably if we asked people, erm, randomly, "What do you think about STPP?" People wouldn't know what, what we were asking them about' – Participant B, Lines 338-342
		'I guess what, what it also highlights in what I'm saying is, is the need for a particular kind of supervision…To kind of help with that process, because this isn't…It, it's not what we've been traditionally trained to offer..' -Participant B, Lines 506-509

TIME 1

1: Is STPP *'psychotherapy-light'*? Existential questions.

A: How STPP fits with or is in opposition to what CAP is and how CAPTs are trained to work	'it's not a prescription, although it's, it's a manual' Participant B, Line 179
	'we had a, a chunk of ti- a, a kind of reasonable amount of time before the summer break. And then, we had had the summer break. And I think, ordinarily, that would have been fine, we would have picked up an-and we would have carried on. I think what we've had to negotiate is, erm, education and changes in timetable. And, er, and I think that's kind of, erm, brought in another dynamic, that we've had to attend to' – Participant B, Lines 416-421
	'we can have a wide repertoire, not, not "psychotherapy does this, full stop."'-Participant B, Line 634
	'Well, it reminded me in a way about, er, under-five work and, er, the five-session model, erm, introduced by the Tavistock. And my service supervisor initially helping me to think, think about that, and , and that you kind of have to, to work at a, a faster pace, in a way' -Participant B, Lines 151-153
	'I think probably traditionally in people's mind, they think that that's going to be for as long as it takes.' -Participant B, Lines 130-131.
	'as somebody who's traditionally done longer-term work'- Participant B, Line 197
	'I think sort of ethically that often children are referred to mental health services is if they, erm… The pathology, for want of a word, is, is kind of integral to the young person, as opposed to being about relationships and interrelationships and family system.' -Participant B, Lines 371-375
	'maybe traditionally a, a psychotherapist might not have wanted to be perhaps as pliable as I was.' -Participant B, line 429-430
	'I don't know if it would in, in the patient's mind, but it feels different in my mind'.- Participant B, Line 495
	'So, ones that I've thought might potentially be STPP have just, actually, after assessment or… Or whatever, I'm just, kind of, thinking, "Actually, no, this is…This is, this, this, this needs to be a little bit more," not open-ended, but to have a little bit more, kind of, freedom to it"' – Participant C, Lines 738-742
	You know, is it, is it enough and is it the right thing to do?- Participant C, Line 797
	'I suppose there is something about li-limiting sessions- that is a, it's not against everything that we do but it does feel, kind of, anti-child psychotherapy, when, when your training is very much about long-term intensive, erm, cases, really. -Participant C, Lines 790-795
	'I suppose it feels problematic in the, is it the right thing and is it enough? I think it, part of me's quite interested in that though' – Participant C, Lines 854-856
	'I don't know. Maybe I'm, maybe I'm, maybe I'm just too cynical about it, maybe I need to give it a go.' – Participant C, Lines 904-905

TIME 1

1: Is STPP *'psychotherapy-light'*? Existential Questions.

A: How STPP fits with or is in opposition to what CAP is and how CAPTs are trained to work	'something time limited wouldn't feel enough for a lot of those issues. Erm, and that although they will have to come- A- a- and come to fruition-Between us quite quickly, I feel, that it still needed a little bit more space to grow. And she'd been offered a couple of shorter term interventions before psychotherapy as well- Which was the other thing that I kind of felt like, "Do I…?" God, I just sound like I want to be the good object. "Do I become like those other clinicians who offer her a short…?" Yeah. I, I just, she was quite clear that she didn't want something that was, that kind of short-term, being measured every session.' – Participant C, Lines 921-930
	'What does STPP mean? You know, what, why would you use it? What's the-? I mean, that was a very, because of the time limited, and would we call it STPP or would we just call it time-limited psychotherapy?' – Participant C, Lines 1069-1073
	'ethically, I think you kind of, just your, your clinical decision making has to- your patient has to be at the centre of it.' -Participant D, Lines 499-500
	'I think some people might think it's psychotherapy- light. Erm, and sometimes the sugar free versions, or the caffeine free versions aren't, you know, there's, they're not considered the real thing. So, I don't know if, erm, I think for some there may be a feeling that what they're getting, or if they're offered this- I don't, I mean they might feel it's that, you know, they're not getting the whole the, the full deal.' Participant D, Lines 425-430
	'we tend to be seen as the people who see patients the longest, or we see them more intensively. Or when everything else has been tried.' Participant D, Lines 109-111
	'its such a different way of working. Specifically having to be so focussed upon the end-point and the mid-point…the sort of emphasis upon recognising some of the primary, erm, I think work, achieving a working formulation from a very early point' Participant D, Lines 207-209
B: What, or who, is driving the decision to implement STPP	'I can't remember how I heard about it, er, you know, it was just that I, of course I was interested, because it was research' – Participant A, Lines 166-167
	'I think everybody likes that it's time limited' -Participant A, Line 263.
	'so much driven nowadays, by cost savings and things like that, of course you think then, you know, are we losing our thinking about, you know, you introduce a patient, and it, its really up to the patient and you, in the therapy, when an ending will happen, you know, and are you just going along that you are accepted for longer in the NHS, you know, or in general, you know. But still from my experience I would say, you know, there are benefits, you know, and I can see some advantages.' -Participant A, Lines 238-244
	'it's clearly, for the climate, it's better that we have something like that, because of course everybody wants shorter and shorter therapies. So, we are not then only the ones who had, have open ended and can only see a, a limited, erm, amount of patients for years, you know? So, we can offer something which is more precise in numbers, and I think that is a big

TIME 1

1: Is STPP *'psychotherapy-light'*? Existential Questions.

B: What, or who, is driving the decision to implement STPP	advantage, and I think, especially for adolescents, I think it, it is a good model, because you often don't get them for much longer, you know? They develop, and they want to go off, and so I think that fits them, somehow.'. -Participant A, Lines 219-226
	'We are meant to have quite a structured approach to the young people, the, and the families that we work with round having a plan-When they come into the service, of what we're going to offer, what we're achi- er, aiming to achieve, how we're going to achieve it, how we measure that and then how we discharge families.' – Participant C, Lines 58-63
	'I think there, there is this kind of idea that, that we can make a difference in a short-term-Limited, er, depth intervention' - Participant C, Lines 83-86
	'Because, actually, a, a, quite a large percentage of those families could probably do with the, the kind of thinking that, that child psychotherapy offers, but we can't, we can't offer it to everybody.' –Participant C, Lines 91-93
	And I think the other part is trying not to stir up too much envy, I think, in people, about what we offer and how we can offer…It's not a luxury, but I think it feels like a luxury that we can go, "Well, we're going to see this person long-term."- Participant C, Lines 99-103
	Here, we are not questioned about how long we see people for. Again, that, that's not, I don't take that for granted and I don't feel that, that could always be there, but at the minute, and as, the whole time I've been here that's never been, "Why have you seen this person for two years or two-and-a-half years?" or whatever? So there, there is that, kind of… How, how do I make sure that those families get enough where they need it, but then also know there's, there's a list of people that also need' – Participant C, Lines 105-113
	It's a tension, yeah. Kind of, between what people need and what we can offer. Yeah. And again that, I think that's everybody, you know, we want to do the best that we can for these families, and that's not always, erm… Doesn't always feel like we've got enough. – Participant C, Lines 119-125
	'People keep referring to us, our referrals have gone up.'- Participant C, Line 219
	'So, it's that, kind of, working… There's an idea that it should be working smarter, and I think the things that are, have been implemented around that are, it's a business model that takes out of the equation actually these are people. With emotional needs. Not commodities. And I think that's where it falls on its arse a bit, really.' – Participant C, Lines 223-228
	'Like a unit of, of work that needs to be done.' – Participant C, Line 233
	'[other change in service] Yeah, and, and… It, it's imposed on us, you know…It's not something we have chosen, as a team, to take on. You know, I don't think any of us wanted it, but somebody has decided, "This is what's going to happen, so you will do this."- Participant C, Lines 390-395

TIME 1

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B: What, or who, is driving the decision to implement STPP	'all of the time and effort that went into it, I really feel like, you know, the ACP, I think, can become a bit super-egoey in its, erm, everybody's super-ego-y in my life, erm, in its kind of, erm, you know, "You should be at the conferences and you should be doing that and you should be doing that." That, erm, that there is a, is there something about we should, we should be, you know, all these clinicians have done all of this really, really thorough work into STPP, let's give it a go' –Participant C, Lines 1008-1014
	'Even though the research is kind of saying there is no difference, isn't it? Erm, everybody think's CBT's great though, and there's no bloody research into that, so… Erm, erm, and you can quote me on that, go on. (Laughter) Erm, yeah, and, and, and an idea that, you know, we are not a profession with a gold standard research background-And, and should we be, kind of, pursuing this' – Participant C, Lines 1018-1024
	'To, kind of, say, "We have done some research into it and there is something there to make us a bit more credible." I don't, not credible, but established. I don't know what the word is. Yeah, so there is a, there's, there's kind of pressure internally and externally, I think.' – Participant C, Lines 1026-1030
	'I'd say the average is about five or six months people wait, from discussion to being seen for an assessment. Erm, so, yeah, like the people that we picked up this month are from, about, March/April time, so that's actually not so long this time. Erm, but there is a, I know there's a, a lot of people were referred in June, so I think that's where our list will get longer again. Erm… And we're both, I think, at full capacity now'- Participant C, Lines 1283-1289
	'sometimes that can cause massive delays because a family could have got referred and waited on the waiting list for the emotional wellbeing team, and then are seen, and then re-referred to us, and then end up, again, waiting to be seen' – Participant D, Lines 27-30
	'I think the service has gradually developed more treatment interventions to meet more specific presenting difficulties, seen in child and adolescent patients. And in some ways it's, you know, it's offering to- it's striving to offer a lot, but sometimes, perhaps, overstretching itself.' – Participant D, Lines 95-99
	'we were amongst therapies that were, as, you know, we've recently had this whole process about looking at what- our capacity, and the demand, and how we meet it' – Participant D, Lines 128-130
	'the service is very interested in it as a model, partly because it seems to offer a far shorter intervention timescale than psychotherapy is historically known for. That's attractive to the service. Erm, er, so I think the service are going to be, erm, pressing more, really ,for us to be working, providing more short-term intervention, or short-term treatment, if and where possible.' -Participant D, Lines 182-186

TIME 1

1: Is STPP *'psychotherapy-light'?* Existential Questions.

B: What, or who, is driving the decision to implement STPP	'I think most services will struggle with depression in adolescents… they're going to need access to, erm, you know, high quality talking therapy'- Participant D, Lines 190-193
	'I can see within this service, that's recognised, and I could therefore see that there's a scope for this'- Participant D, Lines 203-204
	'but then if we're able to, you know, see- if we're, if it enabled us to have more capacity, or to see more patients than we otherwise would have been able to see, then th-that's, you know, that, that might be appealing to some people. You know, if it meant, meant that they could ask us to see more people, and thus be more receptive and able to say yes more often. They might feel good about that' – Participant D, Lines 431-435
	'I just know there's such an emphasis upon us, on, on throughput. So, you know, you only create capacity by discharging people as- and you've got to discharge them at the same rate you pick them up, otherwise, you know, erm, I don't know' – Participant D, Lines 529-531
C: STPP as a part CAP work, concern that it does not take over	'I'm not sure if I'll see a handful in the future, you know, ongoing. So, it will be a very small amount of my caseload, and therefore I think, you know, it will not be something which completely changes our picture or our profession, being here, you know? Perhaps I'm more, it's, its more of a challenge within our profession, you know? To think, or to allow this thinking, of having a short- term model as well. –Participant A, Lines 282-286.
	'And it's not all our work, it's only a little part of our work. So, most colleagues may not even recognise that we are doing something different here' – Participant A, Lines 409-410
	'I believe that it does something but I'm not believing that this is it completely, you know? I also believe in the open- ended psychotherapy, you know, but I think for some people it is right, you know, it's just right, what you can offer them. Therefore I think, for, for myself, you know, I can't speak for anybody else, but for myself I think to have this little bit, little, little bit of doubt of the whole procedure, I think it good.' -Participant A, Lines 449-455
	'I am new to STPP an-and very excited about it.' –Participant B, Line 84
	'so very excited that we can begin to think about its introduction into child psychotherapy in the trust, and, and how that, erm, develops. Erm, an-and also a great learning opportunity for us, as child psychotherapists, think about new… Erm, development a new approach'- Participant B, Lines 90-93
	I've looked for STPP cases but never quite found the right one. – Participant C, Line 735
	part of me kind of thinks, "Well what am I looking for for an STPP case?"- Participant C, Line 749
	'I've struggled with, with, with STPP, about the right case. And, and what it offers and why can't we offer just what we ordinarily offer, rather than offering something more structured and, and shorter term.'- Participant C, Lines 753-757

	'I would hope there would continue to be scope for the different models, you know, well those patients that we know we're going to need to see longer term' -Participant D, Lines 519-521
	'I'd be concerned if this became the only model for working with adolescents.' -Participant D, Line 523
	'I suppose I sometimes wonder whether this, this might get extended to younger, to latency age children. I just know there's such an emphasis upon us, on, on throughput.' -Participant D, Lines 527-530.

Superordinate Theme	**Subordinate Themes**	**Illustrative Examples**
TIME 2 **1: Is STPP *'psychotherapy-light'?* Existential Questions.**	A: How STPP fits with or is in opposition to what CAP is and how CAPTs are trained to work	'in general, it differs not much, you know, because I'm still the same object. But what is really different is to have the timetable in mind- the beginning, middle bit and ending. And especially the ending, which is not focused on in open ended therapy as much.'- Interviewee A, Lines 252-255
		'I think it's got appeal to the service. Erm, I think for, for me, although I, I kind of, enjoyed learning and thinking about it, erm, my- one of my, er, intensive case supervisors always sits on my shoulder and, er, and she always used to say, "Don't mess with the method.". Erm, and, erm, we're already reducing what we do, you know. People already just coming once a week as opposed to twice or three times a week. And, erm, I suppose sort of something about holding on to what we do and holding on to something that we've been trained to do and that we're good at.' – Participant B, Lines 389-395
		'So I think maybe there's something about this is what we do, this is how we do it, This is why we do it. Erm, don't mess with the method, erm, as much as I'm kind of interested in the experience and what it meant and, and maybe what I should do is, erm, see somebody else and have a different experience and then I've got something to compare it with.' – Participant B, Lines 400-404
		So I think it depends on what the function of the, the parent work is. Erm, but interesting in terms of ethics… that ethically we weren't sure whether she wanted to do that and whether she had the capacity to do that or what the consequences of that would be.' – Participant B, Lines 307-312
		'I think it's got appeal to the service. Erm, I think for, for me, although I, I kind of, enjoyed learning and thinking about it, erm, my- one of my, er, intensive case supervisors always sits on

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	'Maybe like me, they've got a supervisor on their shoulder of "don't mess with the method".' – Participant B, Lines 507-508.
	'so why not trust that you know, this could be equally valuable' – Participant B, Line 413
	'I think, technically, I think I just did what I do. Erm, I think the calendar and, and time was, kind of, being on the table as it were, kind of, erm shaped something.'- Participant B, Lines 254-255
	'Maybe STPP could have lots of different functions as well. It could be standalone or shape what comes next. So, I've got an open mind I think, but yeah, I think, kind of your, your training, kind of, it stays in your veins, doesn't it.' – Participant B, Lines 416-419
	'I still kind of wonder, "Is this what it should be?" I'm not overly anxious about it, but the thoughts are still, I still question it I suppose' – Participant C, Lines 97-98
	'it does give it a, it's a, a different focus. I wanna say more focus, but I don't think it is more focus, I think it's different. It's a different lens we're looking through, slightly different lens we're looking through to these cases. I think that's the difference with the STPP case. ' – Participant C, Lines 167-170
	'before this piece of work that you've done it was talked and heard and thought but not practically, kind of, implemented. And I guess there's been a bit of resistance to it, I think, a little bit, I think it's felt a bit out of what we know, which is silly in lots of ways. That fear of, "We can't do it differently". ' – Participant C, Lines 16-21
	'You know, the absolute core of what we do is, is long-term, open-ended psychotherapy, and that's not gonna change, that's, that's what we do.' – Participant C, Lines 136-137
	, I think it's that change. Yeah, I, I suppose the practical concerns of that change, and who we get referred to as, erm, because we're getting, you know, the, the more entrenched difficulties that wouldn't necessarily be STPP cases.'- Participant C, Lines 450-452
B: What, or who, is driving the decision to implement STPP	'I think for us child psychotherapists, it's just really also another tool which we have and can use in- especially in NHS- which help us to survive. Interviewer: '"as a tool in the NHS, which might help us survive"-could you say more about that? 'Erm, just really the rollercoaster of NHS and the constant change and even less and even less money. And, that means of course long-term therapies are under threat. And so it's just really that we have something that convinces us, ourselves, you know. Or at least, that was my experience, because I had many other, you know, doubts that this is something good- but it, it

TIME 2

1: Is STPP *'psychotherapy-light'*? Existential Questions.

B: What, or who, is driving the decision to implement STPP	does work, and so I hope that this is something, you know that will be widespread- that many psychotherapists take it on board.' – Participant A, Lines 444-456
	'it was very, very welcomed on the more manager side' Participant A, Line 5
	'when we say we do short term, short term always, I think, sounds good to them (laughter)' – Participant A, Line 16
	'it is welcomed [by MDT and mangers] –but with the limitation that there is no understanding and no curiosity, really about it' -Participant A, Lines 20-21
	Then the idea that you might erm, evaluate it, or do some research on it, which I think also helped, you know, that we take it seriously' – Participant A, Line 51
	' I received a call from my former supervisor when I was in , the, the STPP research project- and asking me whether I could facilitate this in PLACE NAME' 'they were looking for people...to then spread it out in the country.' – Participant A, Lines 30-39
	'I think it's about quality and quantity' -Participant B, Line 111
	'and clinically wanting to pilot that within child psychotherapy and see if that was going to be valuable, helpful, compliment to more traditional, erm, approaches.' – Participant B, Lines 3-7
	'so it was a kind of, that balance and ensuring people were, kind of, in agreement and up for it, given the fact that there might be a loss as well as a, a learning gain. – Participant B, Lines 25-27
	'[Gaining patient participant consent] Yeah, it just didn't feel- it wasn't ethically indicated' – Participant B, Line 572
	'It's interesting I'm thinking about a strategic benefit, and not necessarily a, a benefit for the patient. Interviewer: Why do you think that might be? I suppose the obvious answer is that, do I see any benefit for the patient? And I don't know. I suppose I haven't had enough experience.' – Participant C, Lines 415-419
	'I can feel the belt tightening all the time in the service, and I think to have- we, we're reasonably lucky here that psychotherapy has been embedded in this team for an awful long time, more than any other therapy here, really. Erm, but I still- you know, you can imagine those conversations if things start- if there's another sea change, and, "So how long do you see patients for?" and to be able to say, "We see them long-term, open-ended," as one option, but to also say, "We see patients for STPP as well."'- Participant C, Lines 407-413
	'didn't you ask me that question last time?' – Participant C, Line 8
	'I think there was resistance about implementing STPP, I'm sure it's not gone unnoticed, kind of, the, "Why are we doing this?" like, almost like people being forced into, into it, and that's – there's been some quite strong opinions on that within the psychotherapy group, and I think that's caused some resistance.' – Participant C, Lines 108-113

TIME 2

1: Is STPP '*psychotherapy-light*'? Existential Questions.

B: What, or who, is driving the decision to implement STPP	'I wonder if that caused some of the resistance as well, though, that, you know, we're doing this just 'cause of the research, rather than thinking we're doing this because it's a, it's of value to us. But, also I think that, once I got over myself a bit, and, you know, thought "This is better", it, it is actually helpful. I also think it was because of the research we got all the support, you know, the peer supervision, and everything.'- Participant C, Time 2, Lines 507-511
	'The service were very attracted to the option'- Participant D, Line 23
	'In terms of how it started is that, as a small group of psychotherapists, we've discussed it and we've agreed amongst ourselves that we will go to begin to implement it as one of the range of treatments that we provide.' - Participant D, Lines 12-15.
C: STPP as a part CAP work, concern that it does not take over	'I think I am quite confident that people will use it, perhaps in the same way I am, you know, it's just something on the periphery really. But erm, at least it's something in our, or what we can offer, you know- and, and say- and I think in-nowadays, it's quite good if you could say, "You can do something short-term.". – Participant A, Lines 298-301
	'one at a time is, at the moment, exactly what fits in my caseload' – Participant A, Line 286
	an idea of through-put' as 'there's probably an idea in some people's minds that we primarily do long term work as opposed to a range of interventions.' -Participant B, Lines 102-105
	'I think it's, er, it's something that I'd return to if a referral came through, but I think it's, it's not just about saying if referrals came through. I think it's about sort of going back to managers and saying, "We don't seem to be getting many, erm, referrals of adolescents, and, erm, maybe just to remind people that we can offer this and please hold us in mind when you're allocating cases." Erm, but, but that's not straightforward' – Participant B, Lines 467-472
	'I think I would encourage people to, erm, to explore it, why not try really and see for yourself. I suppose in terms of learning from experience we all have to learn from our own experience of it, don't we, and whether it suits you, suits the kinds of referrals that you're receiving.' – Participant B, Lines 521-524
	'I think it has a place. I wondered if some of the anxiety about implementing it would be that, that we would be expected to do all of this, you know? It would take over, kind of, what we do, but it's not. You know, it's very clear that it's not at all, and it's helpful to have, erm, an alternative, really. Because sometimes we have young people who don't want to, that won't manage that open-endedness' -Participant C, Lines 205-210
	'we're always under pressure "What are you doing? What are your skills?", I think it's another skill, to, kind of, say, "We can offer a shorter-term intervention."' – Participant C, Lines 133-134
	'Well, I think it'll be something that will be- it, it's there as an option.- Participant C, Line 389
	'we're up and running' -Participant D, Lines 117-118

Superordinate Theme	Subordinate themes	Illustrative Examples
TIME 1 **2: The *'hard reality'* of time- is there *'enough'?***	A: Limitations of time, loss and being in the position of a bad, withholding, depriving object.	'I brought the dates and the numbers…I think there's been a, probably a, a hard swallow. To kind of think, "Golly, we've, we've already done X number of appointments, and I've got this many left.". I think it does bring, erm themes around loss, and that, that process very, very much to the core.' -Participant B, Lines 145-148
		'I'd been a bit worried that they might feel that, erm, that…Well, well, that they might be full of questions about, "What happens if at the end of the 28 sessions, erm, I don't feel any better?" We, but, but equally kind of thinking that this was a substantial piece of work in their mind, and, and had possibility.' -Participant B, Lines 119-123
		'There's something about having the calendar there..I think I felt that sometimes knowing that I'm going to sort of stir something by its concrete representation, as opposed to it being in their mind and my mind.' -Participant B, Lines 463-465
		I hoped that it [STPP] might provide a framework to do a piece of work that, erm, could kind of be…Erm, although time-limited, to be, erm, meaty enough or substantial enough, to, to really help. Erm, and I think especially, er, thinking about loss, er, as a, a, core theme, erm, in, in their life, that, er, i-it was inevitably going to be on, on the emotional agenda in, in our relationships from, from the beginning. So, I think I thought we, we would really be able to, to grapple with something perhaps in a more acute way than we might have done if, if it was a longer, slower, er, process.' -Participant B, Lines 403-413
		'So I think there was something about loss already in the, in the process, an-and in people's minds' -Participant B, Lines 133-134
		I think it does bring, erm themes around loss, and that, that process very, very much to the core.' --Participant B, line 147-148
		'That you're, you're kind of… You've got time, but you're also conscious that you haven't got time.' – Participant B, Lines 158-159
		'Oh, and one of my supervisors, the one I talked about, about a case, was kind of really thinking, you know, "What a lot of work," really to do in a, a short amount of time' – Participant B, Lines 167-168
		Louise Emanuel I think wrote a nice paper on, er, moving slowly, but at double pace. And it feels a little bit like, like that. That you're, you're kind of…You've got time, but you're also conscious that you haven't got time. A-and maybe it does concentrate everybody's minds and brings something in a different way into the room which is valuable as well as anxiety provoking. - Participant B, Lines 155-162
		'I think I've also kind of wondered, a-and this is probably me as opposed to thinking about the, the model. So, you're kind of always having to kind of keep reflecting on, on yourself and your own process and what you're bringing to it. Erm, I think there's something about the calendar an-and having the calendar there every time, or sometimes, or at reviews. Er, and I think I felt that sometimes knowing that I'm going to sort of stir something by its concrete representation, as opposed to it being in their mind and my mind.' – Participant B, Lines 460-465

TIME 1

2: The *'hard reality'* of time- is there *'enough'*?

A: Limitations of time, loss and being in the position of a bad, withholding, depriving object.	'if it were a longer piece, I think we've got longer to, to work through it or go back to it and, erm…But, but maybe it is rather like wh-when I mentioned the under-five work, you've ki-you, you do have to go at double speed…. You can't sort of, erm allow something to kind of, erm, settle or…That's the wrong word, or float and feel it in perhaps the way that you might if it were open-ended.' - Participant B, Lines 495-502
	'limited time might bring something in in a more acute way than we might have done if, if it was a longer, slower, er, process.' -Participant B, Lines 410-413
	'I wonder how rich it makes the sessions? Because, you've got, you have to bring stuff, almost, you have to work through it, it, it's there. You know, if you've got that longer and open ended, sometimes it feels like you just float through, though sessions.' -Participant C, Lines 883-886
	'I suppose it feels problematic in the, is it the right thing and is it enough? I think it, part of me's quite interested in that though, as well. Cause the ending's there from the start.' Participant C, Lines 854-856
	'there is this kind of idea that, that we can make a difference in a short-term, limited, er, depth intervention' - Participant C, Lines 83-85
	'The ending's there, the, the, the loss and the worry about the loss, and it not being enough, is there.' Participant C, Lines 873-874
	'There's an idea around that it should be working smarter, and I think the things that are, have been implemented around that are, it's a business model that takes out of the equation actually these are people. With emotional needs, Not commodities. And I think that's where it falls on its arse a bit, really. It, it, doesn't take account any of the complexity, but just that this is a…Almost like a, a, I don't know what you call it, unit, that's it. Like a unit of, of work that needs to be done. Like that unit of work needs six sessions or needs 12 session, or whatever it is. But that doesn't, it, it yeah, it doesn't, there, there's no nuance, no subtlety.' Participant C, Lines 225-237
	'from a very personal point of view, about not wanting to put myself into that bad objects kind of place, And, you know, hearing other people talk about it, that's not always the case, but, I suppose that's a, maybe fear of mine - That stops me, kind of, you know, three years now and I still haven't done one [an STPP case].' Participant C, Lines 813-818
	'the end was very in the room from the beginning.' – Participant D, Line 311
	'the sense of loss, or imminent loss, was around from the onset' –Participant D, Line 315
	'I've had quite a lot of experience of seeing adolescents for about a year, which seems to be about the, the usual length of time, which seems to feel about right for lots of the adolescents I've seen.' Participant D, Lines 228-229
	'this wouldn't offer that same possibility, 'cause your-the timescale's shorter.' –Participant D, Line 244
	'You can lose, you could lose time or, before you know it, you're at mid-point and…(silence).' Participant D, Line 219
	'the emphasis upon, the availability of time.. I think I was more focused on things being good enough…the end was very in the room from the beginning… the sense of loss, or imminent loss, was around from the onset.

TIME 1

2: The *'hard reality'* of time- is there *'enough'?*

A: Limitations of time, loss and being in the position of a bad, withholding, depriving object.	One of the personal difficulties for me, as the therapist, was that… just at the point of receiving it, she was, she was going to lose it really quickly, and so that was uncomfortable… 'It put me in mind of STPP because I thought, "Well, that situation is going to be a regular aspect…definitely it was the right decision to see her, even though it was time limit-very time limited and she certainly, erm, seemed very helped.' -Participant D, Lines 306-347
	'I think for me, personally, it's going to be a, it will be a struggle, because I think, erm, I think endings are difficult. I suppose it comes down to this stuff Monica Lanyado draws upon, where the question of having done enough, you know. It's, it's about reaching a point of having, having, having done enough to enable a young person to, erm, progress, or recover. And perhaps that's an inner struggle for me, is about, erm, feeling okay with having done enough' -Participant D, Lines 250-256
	From a personal perspective, is about managing feelings it provokes in me as being wearing the shoes, the shoes of the withholding object…I, I find it hard to occupy that space of, of being withholding, or not giving enough. Erm, of being in the position of seemingly depriving, and so, for me, this raises major anxieties.' -Participant D, Lines 382-389
	'Perhaps in some instances I've worked longer with patients than I might have worked, but I felt they need more, and I think this will force me to wrestle with those things, in myself, a bit more.' -Participant D, Lines 260-262
	'so it's how to manage that pressure to want to , perhaps, pressure to want to offer more perhaps, or whilst meeting the requirements of this as a working, a, a, you know, working model.' -Participant D, Lines 377-379
	speaking about what the time limit brings in to the work, 'to have to face that as a hard reality' -Participant D, Line 392
B: Psychological avoidance of the ending, having longer in mind	Interviewee: 'I can see an advantage for young people, to know that it has an ending, but I also, I guess I'm someone who, if it turns out that it's not really good to end it after the 28 sessions, I'm not hesitant to do so, you know, so… Interviewer: 'So you would keep it going if it felt that actually ending it now, wasn't...' Interviewee: Yeah. Yeah, and I think that was also always said in the, in the study, you know, that if there is a clinical need, it overrides whatever the research says' -Participant A, Lines 229-236
	I think you have to be a bit open about this, you know, and see, see more your patient, you know, but also don't go overboard with that, you know and think "Okay, then, when it's the 20th session I'll tell the person we can just go on" you now? To make this decision, you really need a lot of discussion, a lot of thinking, reflecting, what's going on, why do we want?' Interviewer: So that there's a space for the questioning the model, as a frame, but also there's another space for questioning why you're questioning it? 'Yeah, yeah. Yeah, yeah. They're just, I think, very typical of what we do in our work. You don't introduce a new toy every week, and if you introduce a new toy, you would think about, "Why now? What is the toy

TIME 1 **2: The *'hard reality'* of time- is there *'enough'?***	B: Psychological avoidance of the ending, having longer in mind	about? How would it be received by the patient, and what does it make with my relationship" and so on, and it's the same with the session.' -Participant A, Lines 458-470
		'Erm, I mean, I guess that's something like bringing the adolescents in, going, or, or, or, stirring up adolescent, an adolescent process. Which is separation process, so, helping the parents and the young person to move on and be not stuck in this, kind of, "I don't want to move between childhood and adulthood", you know? I think that is something, I guess, which STPP fits very well.' –Participant A, Lines 474-478
		working with a, an adolescent girl. And it seemed appropriate, both in terms of her presentation, erm, and her age, that there's a kind of a, er, a time at which she won't be eligible to receive a service from the Children and Young People's Service.' – Participant B, Lines 108-110
		'It was, erm, er, selected, a selected intervention, that it, it might address her particular clinical need. And also, the, the timeframe around it would fit in terms of either discharge from this service or a transfer onto, to adult services.' -Participant B, Lines 113-115
		'I guess it's a number isn't it? I suppose it's a bit like, you know, we, we see people in psychotherapy for 50 minutes, but where did that come from? I-it's a number, isn't it? What would 30 look like? 35 look like? Would it, it make a difference?' - Participant B, Lines 685-688
		Hmm, a good first case I think, yeah. It's a good way of putting my toe in the water and seeing what it feels like.' -Participant B, Line 223
		'I wonder if I might feel differently about it if the young person wasn't the age that they are. So, I know that we're going to have to stop. So, it feels like, er, a very appropriate intervention. Perhaps if they were 14 or they were 15 and, erm, it was a finite number. I wonder if, as somebody who's traditionally done longer-term work, I might have other questions or other thoughts or other feelings in my mind about, "Is this actually going to, erm, be enough?". –Participant B, Line 190-199
		Yeah, I didn't count the assessment.' Participant B, Line 683
		although she's aware of, of the stipulated number [of parent sessions], she's, erm, taken responsibility for the case and seeing the, the parents when they need to be seen. As opposed to, "You're going to have to wait a month to be seen again." So, she's following the clinical, erm, formulation really.' -Participant B, Lines 301-308
		I might think about transfer to adult psychotherapy….it's an opportunity we, we can do a piece of work, the young person can see how they are if, erm, they still feel that there's work to be done, if I still feel that there's work to be done then I could support a re-referral to say, "This is what we've done, actually a longer term or more intensive therapy might be indicated."' Participant B, Line 209-221
		'And even if I start, I suppose, there's a worry we're going, am I going to stick to the, to the structure or I, is it going to be, erm, yeah, am I just going to end up doing a couple of years, you know, and… going, "Well, he started in STPP but, obviously it just want right."' Participant C, Lines 821-824
		'I haven't done much [time] limited work. It is, it's usually been around age. Erm, or people are going away…You know something that, that, kind of, limits it really.' Participant C, Lines 1139-1141

TIME 1

2: The *'hard reality'* of time- is there *'enough'?*

	'Those are the sort of get outs that I , th-those are the caveats that would enable me to be able to do it, because I'd say, well, you know. They wouldn't get completely boxed in if I thought something was really not working out.' Participant D, Lines 507-509
	'I should be thinking about younger adolescents, really. Erm..' Participant D, Line 289
C: Could STPP focus the work and be 'enough' for some adolescents?	'I think, especially for adolescents, I think it, it is a good model, because you often don't get them for much longer, you know? They develop, and they want to go off, and so I think that fits them, somehow.'. – Participant A, Lines 223-226
	it can not work sometimes, you know? Anxieties, for whatever reason, are too big, or so, and it also works differently, you know. You sometimes make a big step, and some of them make a small step, but in the right direction, but I think that is really kind of, making both parents and the young person aware of anxieties, of being able to talk about these anxieties… and I think therefore STPP is very good.' –Participant A, Lines 483-489
	'it can push something, you know, and so you don't need an open-ended thing, to go through this kind of developmental push thing.' -Participant A, Lines 480-481
	'I guess that's something like bringing the adolescents in, going, or, or, or, stirring up adolescent, an adolescent process. Which is separation process, so, helping the parents and the young person to move on and be not stuck in this, kind of, "I don't want to move between childhood and adulthood", you know? I think that is something, I guess, which STPP fits very well.' –Participant A, Lines 474-478
	'I mean, we've had a lot of complex cases which fitted STPP, and you had complex cases which didn't. I, I guess with looked after children it's more difficult, but in the literature I know it's not proven that it is like that, but my experience definitely is that it's more difficult, because it's so, I mean, separation, everything is so difficult for them.' –Participant A, Lines 490-494
	there might be a looked after child who benefits from it, you know, but in general I would say, you know, it's more difficult with them, in only 28 sessions' -Participant A, Lines 505-506
	'I mean, I can, I can see a repetition of being hesitant with the short- term, you know, and then also, I mean, there is no clear cut that this person is for STPP and this one is not, you know? I mean, with some you see more clearly, but with others you might be in the wrong, with the wrong decision, you know? So. And you have to live with that, you know? I mean, the same with psychotherapy, if you assess someone. You cannot really, 100% sure, that this is the best option for this child, or for this young person. So, with STPP, I think it's similar, you know, and I guess the more you do the more you get a feeling what is right and what is wrong, or what is, perhaps, beneficial.' -Participant A, Lines 202-207
	'Not always to kind of think that we're there to erm…If you think about, er, families, or, or young people where, erm, diffiuclites are entrenched or perhaps immovable or, you know, so, so, so complicated that, that it is also about people who, who have a capacity to make use of a particular intervention, isn't there, an-and can interject as well as project' -Participant B, Lines 626-630

TIME 1

2: The *'hard reality'* of time- is there *'enough'?*

C: Could STPP focus the work and be 'enough' for some adolescents?	'We'll all learn, wont we, through this process of who's able to use it? Who, who can really use it?' – Participant B, Line 651
	'We are meant to have a quite structured approach to the young people, the, and the families that we work with round having a plan- when they come into the service, of what we're going to offer, what we're achi-er, aiming to achieve, how we're going to achieve it how we measure that and then how we discharge families. But, I think, as is, kind of, present across the board for lots of different services, where there is less resource out there, actually, that's not very straight forward. And, we're working with very complex families with intergenerational, multi-layered trauma. And, and actually, erm, six sessions and out doesn't, doesn't cut the mustard. And, erm…We're often battling trying to, kind of, find a, a way to help these, these families.' Participant C, Lines 58-70
	'and then it felt like she couldn't go on, almost like she couldn't, it was too much for her, she couldn't do it and I wondered then actually whether STPP would be too short?' Participant C, lines 964-967
	'One of the things that I've struggled with, with, with STPP is about [finding] the right case. And, and what it offers and why can't we offer just what we ordinarily offer, rather than offering something more structured and, and shorter term. And I know there's lots of benefits to, to that, we, to offering something shorter term. Erm, but yeah, I do struggle with, with that.' Participant C, Lines 764-759
	'I have this idea in my head of, of it being something more around the adjustment of adolescence rather than something, kind of, entrenched. But then I kind of think we don't see those kind of kinds, you know, we, we, and if we do they don't come to psychotherapy.' Participant C, Lines 1182-1186
	And it might be that, you know, I get an adolescent that's very clear that they don't want long-term work. And that would be, I suppose the other way, they don't want to come forever and ever, and they actually but want an intervention. And that might be a way to offer STPP. They don't want that over-dependence. Because, you know, in lots of ways that's very appropriate, because it's, they're adolescents.' Participant C, Lines 1211-1215
	'it requires quite a bit of ego strength' -Participant D, Line 414
	'STPP does offer something for a specific group of patients' Participant D, Line 199
	'I've got some positive feelings though…this idea, adolescents, they hate commitment, they can't stand it…adolescents balk at the idea [of longer treatment]…For some reason I don't think I see lots of adolescents balk at that, that idea, and I've seen quite a lot that, erm, er, have responded very positively at the idea of, of something substantial'. -Participant D, Lines 399-405.
	'I suppose it comes down to this stuff Monica Lanyado draws upon, where the question of having done enough, you know. It's, it's about reaching a point of having, having, having done enough to enable a young person to, erm, progress, or recover. And perhaps that's an inner struggle for me, is about, erm, feeling okay with having done enough' - Participant D, Lines 252-256

Superordinate Themes	Subordinate Themes	Illustrative Examples
TIME 2 **2: The *'hard reality'* of time- is there *'enough'?***	A: Limitations of time, loss and being in the position of a bad, withholding, depriving object	But I think these anxieties came-eventually, you know, but, erm- and, and they, I think, are normal, you know, for everybody who does STPP for the first-time- Participant A, Lines 206-211
		'afterwards I thought, "Hmm I wonder if a longer period would have been helpful to have more slowly worked through it" But then my other thought was I wonder if actually this was just what it required for us all to learn that actually there's something that's really stuck and I'm not sure really whether people want it to unstick.' – Participant B, Lines 165-168
		'It's taken six years for her to, build to be in a position like this…it's not going to be resolved in, you know, ten weeks, or something like that.' – Participant B, Lines 270-272
		'I might have felt a little bit of a push of, "Are you going to offer me more, will you offer me more? I'm already saying it's not enough." Erm, so I think those dynamics were a little more acute than there might have been for a usual practise.' – Participant B, Lines 238-242
		'you are having to, sort of, pick things up more quickly, aren't you, and think about it more quickly.' – Participant B, Lines 176-177
		'I think, technically, I think I just did what I do. Erm, I think the calendar and, and time was, kind of, being on the table as it were, kind of, erm shaped something.'- Participant B, Lines 254-255
		'I think from the beginning in the young person's mind perhaps similarly [to the parent], kind of, what if it's not enough.' – Participant B, Lines 196-197
		'The end is there. It's just there. It's in, it's such an interesting- because the end should be there all the time anyway, but it's not, where here it is, and, and actually, all of her material is about death and endings anyway.' – Participant C, Lines 159-161
		Speaking about the time limit- 'it does give it a, it's a, a different focus. I wanna say more focus, but I don't think it is more focus, I think it's different. It's a different lens we're looking through, slightly different lens we're looking through to these cases. I think that's the difference with the STPP case. ' – Participant C, Lines 167-170
		'it's more manageable now…it's almost like holding your nerve, not giving in to my own anxieties about not giving enough. And, and, kind of, being able to, "This is enough," you know, "There's enough here". – Participant C, Lines 310-314
		'I suppose it's trying to understand what we're being in touch with there, what is that deprivation? Why do we feel that we've got to fill it with, with endless sessions, when it, it might be able to be worked through in a timely way, really, a time-limited way. And, I suppose, within our patients, what does it feel like to have an

TIME 2

2: The *'hard reality'* of time- is there *'enough'?*

A: Limitations of time, loss and being in the position of a bad, withholding, depriving object	end point put on something? You're only worth this much. Does that- what does that stir up within them? Do they feel like there limited with it?' – Participant C, Lines 271-276.
	'and the control over the end as well, 'cause obviously, when it's open-ended, we really control the end, but if we come in and say straight away, "This is however many sessions", th-then they know from the start that that's what's there' – Participant C, Lines 212-215
	'they gain from the sense that there's the opportunity and space for them to bring their own concerns and preoccupations. And there's enough space for those things to be able to be thought about. – Participant D, Lines 472-474
	'at the onset I had to think about my anxieties and doubts and fears associated with the task. I think, you know, it's very given to worrying about the limited time available, what happens if pro- things prove too complicated or…You know, the patient doesn't seem to be gaining any benefit. I think, erm… I think it was quite useful to do that thinking because I was just aware of things that would be provoking resistance within myself.'- Participant D, Lines 619-623
	'Well, my immediate impression is, is limited time, is thinking immediately about the end from the beginning because no sooner have you started that you're already aware of, erm, the ever-reducing time that's- you just don't- you know, your sessions are ticking down. So I've been struck at there not really being any time to waste-in terms of getting to grips with things. I'd be much more quicker to get going and-recognise and acknowledge evidence of, you know, transference and commenting on it. And, and I think partly because the feeling is there's no time to waste. There's no- it's, it's now or it may be never. -Participant D, Lines 253-261
	"If I was important enough you wouldn't be offering me something that was a short-term."- Participant D, Time 2, Line 656
	I don't know if this is right or wrong, but in some ways it feels like there's a clearer task…. a sense of purpose to what we're doing – Participant D, Lines 482-483
	whether to offer another, but that could end up meaning it isn't really STPP and lasts longer. ___ to try and fit the extra session in that might've missed or do you just accept that it's gone? Erm, I mean that's not ___ a problem, it's just, you know, it's, there's, there's just less means to pick up or to deal with those situations.- Participant D, Lines 438-440
B: Psychological avoidance of the ending, having longer in mind	'would be a normal assessment… and then, within the assessment within the assessment, to re-co-confirm that this is really an STPP case- or whether there are things which need longer-term work' –Participant A, Lines 80-81.
	'fitted in terms of what the service was going to be able to offer anyway.'- Participant B, Line 63
	'We did the assessment. Was kind of thinking, "Hmm, shall we, shan't we?"' – Participant B, line 366
	'we organise to see them initially, organise an assessment, do a feedback, we're in an STPP frame really then at that point' Participant C, Lines 46-48
	'from my point of view, it's been quite rich in terms of being able to get into that, sort of, material quite quickly. Erm, I think I've had quite a lot of anxiety about running out of time and- I don't mean like major

TIME 2

2: The *'hard reality'* of time- is there *'enough'?*

B: Psychological avoidance of the ending, having longer in mind	anxiety, but I, I'm just aware that- I think the two cases I've got, the other thing that, kind of, is bearing down on me - I, I wonder whether it would be different if this were not so - but they, they both turn 18.' - Participant D, Lines 282-288
	But, I think if they were younger and they weren't turning 18, I think it would be, I think if there's… You know… I think, you know, facing the dilemma of ending… It will be difficult. Ending, where the therapy is the, you know, would end, I think, because there'll always be that sense of, erm… The possibility to be able to continue on and do other things, or, or new problems that might manifest, that might feel to need to be dealt with or worked with. So, I think it's just working with that internal dilemma of-being able to end and manage the feelings associated with that. Withdrawing something where you think, well, maybe they could gain from continuing. –Participant D, Lines 449-458
	it might be 'a gateway experience' –Participant D, Line 294
C: Could STPP focus the work and be 'enough'?	'with adolescents, there are benefits, you know, because they are usually not inclined to have open-ended psychotherapy. You know, they're usually scared by this idea, and especially for those who, their main problem focuses around adolescence and they're stuck somewhere. This model kind of gives them, really, this kind of, push or the opportunity to go into it or go out of it. (Laughter).' – Participant A, Lines 131-135
	Adolescent topics- like separation, sexuality, relationships and so on. If this is the main – or if this becomes more obvious that this is the main focus, I think I'm more inclined to say, "This is STPP.". If it is more long-term problems from very early childhood and- I mean, they might link to childhood, you know, but, erm, if this is more severe, I think then I would more hesitate.'- Participant A, Lines 86-90
	I think for adolescents, this is more helpful than harmful, I would say, because it is just their way of life. They don't want to stick forever with something. They want to try out things, and they want to be- to go through it and go and, and then, of course, it's also the aim of the therapy that they move on. So, of course, if this takes too long-you would, you would paralyze them again in a way. I guess that- that is, for me, you know, the confirmation of this model, you know –that it is really working.' – Participant A, Lines 258-265
	''Cause I think maybe there's a myth or an idea, of, "Oh, oh that case it too complicated. Er, or, "My cases are too complicated." When actually it might be that, erm, this would kind of be helpful recognising it may or may not meet all of the needs , but it can, kind of, erm, address something of value within that time frame.' – Participant B, Lines 148-151
	I suppose I was just wondering whether in our peer supervision it might have been helpful for us to, kind of, gone back to the manual when people might say, "Well, I've got this case but I don't think it's suitable or I've got that case but I think that's, erm, not really an STPP case to think well, what do they mean by that?" And, and you know, was that an opportunity to say, "Well, let's, let's go back to the book, let's go back to the kinds of cases and, and is- are we kind of needing to be better informed or learn something more or is it a defence or, you know, what is it that's kind of in our own mind shaping a decision about yay, no."- Participant B , Lines 492-499
	'there isn't so much of the early, kind of, trauma stuff' -Participant C, Line 424

TIME 2

2: The *'hard reality'* of time- is there *'enough'?*

C: Could STPP focus the work and be 'enough'?	'it's helpful to have an alternative really. Because sometimes we have young people who don't want to, that wont manage that open-endedness either, you know. ' –Participant C, lines 209-210
	'The end is there. It's just there. It's in, it's such an interesting - because the end should be there all the time anyway, but it's not, where here it is, and, and actually, all of her material is about death and endings anyway.' – Participant C, Lines 159-161
	I think it's still a, er, a battle, really. Not a battle, but, er, a kind of a consideration that I don't, I don't have, like, a tick list of criteria that I think, "Oh, this really sounds like STPP." I think that it's probably a conversation that CLIN X and I have together as psychotherapists, about whether somebody- y-you, kind of, get a sense if, if there's a chance of a lot of early trauma, and, erm, they're in their adolescence and th-th-there's just a lot of turbulence still, and, and relational problems. That, that feels more open-ended than somebody who, maybe it's a shorter-term difficulty, it's more in the here and now, rather than related to, kind of, earlier experiences. Participant C, Lines 86-95
	I think if somebody's just 17 and they come to us, we're looking, we're looking at STPP really. I think it's, you know, in a world of anxiety and system pressures, it's something tangible to get hold of as well, I think, for lots of- for care coordinators for the service, for us as professionals, for families. Sometimes that's quite, quite nice for them, I guess-Participant C, Lines 50-54
	there are ones that come through that we think, "Oh, these could be STPP cases," and there are some of those that are limited by age, which I don't know if it's necessarily to, to, to see people on, but it- that also is quite helpful to then have that, kind of, structure, and, "We can offer you this." Erm, all those cases where it might not need that long-term, open-ended work. We don't get very many of them as- I think it's across the board for child psychotherapy and CYPS in general is that the more straightforward cases just don't come to us-Participant C, Lines 29-36
	'such complexity… would contraindicate using the STPP model' -Participant D, Line 34
	'And so something that's a bit more able to stay in contact with more difficult feelings, doesn't seek to evade of side step or negate them through solution focused type intervention. And so, you know, I think it seems to, it seems to fit that really well. The other aspect I think, is the obvious one, is that with adolescents, commitment is a major issue-erm, for some adolescents. And I, I think that, erm, anything that signs them up for anything that feels too long or beyond a few months can feel slightly claustrophobic for some.' – Participant D, Lines 369-380
	'they gain from the sense that there's the opportunity and space for them to bring their own concerns and preoccupations. And there's enough space for those things to be able to be thought about.' – Participant D, Lines 472-474
	STPP seemed to be useful for helping those patients where that was probably a large part of their stuckness, that they were- you know, they, they were facing things that felt beyond them and they didn't feel to have, within themselves, the emotional resources, the , the available or, erm- you know, internal objects that would

C: Could STPP focus the work and be 'enough'?	render them able to manage the, sort of, stress and anxiety that they would be facing, that, that, erm- But it, it set- you know, it sets a tall order for STPP, really. –Participant D, Lines 338-343
	if there's a sense that their difficulties are very complex, whether it's a, you know, a developmental crises or whether there's some level of trauma and- or where there's very, you know, reg- rigid, constructive defences, I think in those situations, I think you think carefully about whether a 28-session model would be adequate to necessarily providing any sort of relief or affecting any sort of structural change. And of course, with STPP, you're probably looking like- you're probably hoping for less, in a way, structural change, maybe more insight, awareness.- Participant D, Lines 128-135
	I there's a benefit in terms of as a form of treatment in contrast to other treatments available within this service, where are, largely, more cognitively based' – Participant D, Lines 358-359

Superordinate Theme	**Subordinate Themes**	**Illustrative Examples**
TIME 1 **3: *'People are very depleted'* -the need for organisational holding and containment.**	A: The wider context of pressurised services	'the workload makes people less interested in anything, you know, because they just try to survive, and everything new is too much, isn't it? I mean, when I open my emails and I see someone wants a, to, for me to fill, a table to be filled in, I want to scream, you know, and I guess similar, you know, if you come with a new idea, it's just, it's, I don't have really the feeling that anybody is against you, or, you know. It's much more that the workload makes them so deflated, and less interested, and, and, and the same with psychodynamic thinking, you know?' –Participant A, Lines 316-322
		'It's just gone, somehow, because there is no energy left, and all the ticking boxes have to come first, and then there's no space anymore.' – Participant A, Lines 324-325
		'the team was completely headless, in a way.' -Participant A, Line 39
		'nobody really connected' Participant A, Lines 38
		'everybody was not interested, really, in me… You feel very excluded from everything, you know. Excluded from the exclusion.' -Participant A, Lines 54- 57
		'it doesn't feel that I'm attacked, or that people are against it, you know, that makes me hopeful, you know, that there will be moments where you can establish something.' Participant A, Lines 353-355
		'I think also that has consequences of how you feel within a team.' -Participant A, line 10
		'I have a feeling everybody is just really managing their day to day life, and their caseload' -Participant A, Lines 273

TIME 1

3: *'People are very depleted'* -the need for organisational holding and containment.

A: The wider context of pressurised services	'But that doesn't mean that I have given up completely, you know, but I think you need to be, you need to be at the right time and the right place, you know? Where you're just suggesting something, and there are people interested, and you get something going.' -Participant A, Lines 331-332
	'You have to knock the door 1,000 times before you get a reaction -and I also can't knock all the time, because I also have a workload to do' –Participant A, Lines 345-346
	'the splitting of different sub-teams, and then reorganising it again' -Participant A, Lines 26-27
	'This kind of instability the team has when it's so scattered, and then introducing a new profession, or relatively new ideas to them. Plus all the changes we had already in these three years I'm here, is, is of course then difficult to ground, or to find, or grounding this kind of profession.' -Participant A, Lines 21-24
	'staff are divided between, er, those areas..and the, er, service that's delivered is within different, erm, streams.' - Participant B, Lines 10-14
	Interviewer: And how does psychotherapy fit within the team? Participant: Erm, it was firmly embedded. Erm, so although small numbers, erm, it's got a history within the, within the department. And, er, a-and people, er.. Some people who've worked here for a long time have a good understanding of child psychotherapy. New members of staff might not if they haven't worked with child psychotherapy before.' -Participant B, Lines 52-60
	'It becomes quite super-egoey. That commissioners or even, like, not managers who are based here but the next ones up, they become, kind of, these quite persecutory figures, really…people have this image of them standing over us, like they're this monster, sort of, wagging their finger going, "You will do this". And, actually, we're like little children who are powerless to, to, to challenge that.' Participant C, Lines 408-416
	'it's gone through lots and lots of changes' Participant C, Line 160
	psychotherapy's been here for ages…established in the team the longest…they're embedded', 'even though managers have changed in that time, there's still a belief in psychotherapy' - Participant C, Lines 453-459
	'Doesn't always feel like we've got enough, external resources. People, interventions, whatever. But, I think people's internal resources are quite, quite limited, as well, given, you know, we've got pressures to see so many people every week…And erm, the cases are more complex and- and there's that idea, you know, we're dealing with trauma but how, are we, as a workforce, also traumatised by dealing with the trauma every day.' -Participant C, Lines 124-133)
	'You know, it wasn't perfect by any stretch of the imagination, and there was still a very long waiting list when I first started. But things…It felt more like a team and people felt more,

TIME 1

3: *'People are very depleted'* -the need for organisational holding and containment.

A: The wider context of pressurised services	internally more resourced. Erm, there wasn't that, kind of, "You're not doing enough" pressure that, kind of, feels like it's a, a, a blanket over everybody at the minute.' Participant C, Lines 193-197
	I think, its driven, partly, from the cuts and a, a bit of a panic of, actually "We haven't got money.". -Participant C, Line 211
	'sickness is high, people leaving is high. People aren't replaced. Use of agency staff.' Participant C, Lines 257-258
	'It's just made people more stressed.' Participant C, Line 250
	'our referrals have gone up. Cases are more complex.' Participant C, Line 219
	'I think people really value psychotherapy and the team, I think that's not an issue, but I think it's the, "Who do we give psychotherapy to?" Because, actually…we can't, we can't offer it to everybody. We're very limited resource.' -Participant C, Lines 88-91
	'our service is split into, kind of, specialist areas' Participant C, Line 31
	'we have had so many changes over the last, well, sin-since I started doing the training…it feels like there's been a change every six months. So, it's ebbed and flowed about whether people can think about psychotherapy. At the minute it feels quite well established.' Participant C, Lines 326-328
	'I feel quite hopeful about psychotherapy at the minute. Erm, but, again, we're going through, through more, more changes.' Participant C, Lines 361-362
	'And it's a them and us, and dynamics are all, they're very complicated.' Participant C, Lines 274-275
	'there's been lots of restructures' Participant D, Line 74
	'we're working very much as, erm, separate teams' Participant D, Line 82
	'we've become divided up into teams' Participant D, Line 149
	'Doesn't always feel like we've got enough, external resources. People, interventions, whatever. But, I think people's internal resources are quite, quite limited, as well, given, you know, we've got pressures to see so many people every week…And erm, the cases are more complex and - and there's that idea, you know, we're dealing with trauma but how, are we, as a workforce, also traumatised by dealing with the trauma every day.' - Participant C, Lines 124-133
	'people are very depleted internally' -Participant C, Line 314
	I think probably the biggest thing for me is doing it. You know, I need to find a way to, to , to do it, 'cause I think that's the thing that will make it much more real, you know?' Participant C, Lines 1238-1239.
	'the family of psychology, feels, at the moment, rather, erm, depleted…it feels a little bit, erm, depleted…So, it's feeling very depleted' –Participant D, Lines 60- 71

TIME 1

3: *'People are very depleted'* -the need for organisational holding and containment.

	'joint working, erm, I think that's becoming harder over time, because it's just the allocation of resources' Participant D, Lines 156-157
B: The need for organisational holding and containment.	'we can only meet monthly' -Participant A, Line 396
	'in our peer group we had much less time to prepare it in comparison to what we had in the study. I mean, even that we established the reading together, you know, and first nobody read it, and then the second time we talked a bit about it but it was also, I think, divided with talking about other things, and, and, erm, so I guess that we can be surprised to know whether this has an effect. But I think it, it is just part of kind of getting over the first hurdle and get the first patient going.' -Participant A, Lines 377-383
	'they are the driving energy within their teams, because if they are not convinced, or if they do not like it, they won't continue it. Or, also, to motivate people to do the parent work. If you are not motivated, you can't motivate anybody else.' -Participant A, Lines 302-304
	'we've had an opportunity to do some reading together and thinking together, erm, as well as people being able to bring their cases.' -Participant B, Lines 234-235
	'new to STPP an-and very excited about it' -Participant B, Line 84
	'I don't know. I know we had an idea that maybe two people could bring something each time so that there isn't such a long wait. Hmm Erm, and I know that for one of my sessions, a-and it had been a complex session, and I thought, "I'm going to have to wait until then." And I thought, "That's too long for me to wait." And I did consider it in my usual participantical supervision… I needed some additional help with it. An-and I guess, we can all do that as well.' -Participant B, Lines 519-528
	'I'm pleased that we've got our, erm, peer supervision group, to, to think together' –Participant B, Line 513
	'initially there was a bit of a panic about, "I can't, I can't do anything extra." But, I think, as time has gone on and there's been a core group that have gone to every case discussion, that, that helps, hold something…Maybe people are finding, I don't know, that actually, it's not, it doesn't deplete you to bring it, it gives you something, you know, it's a good feed rather than a giving more of yourself away.' - Participant C, Lines 299 -317
	'I think the "lean" kind of "work more efficiently" doesn't leave any space for thinking, and I think that's the big thing we miss out on.' Participant C, Lines 277-278.
	'And I worry about getting it wrong, I suppose' -Participant C, Line 799
	'Maybe I feel a bit ambivalent about it. Because I kind of feel like I'm flittering between, there could be something really interesting about this to, oh my God, it's really scary, as well so.' Participant C, Lines 890-892
	'daunted by it' -Participant D, Line 206

	B: The need for organisational holding and containment.	'The primary anxieties, you know, I have is not having, no, not being able to produce good results. Well, being rubbish at it, to be honest with you.' Participant D, Lines 445-447
		'I struggle to imagine it'll be enough, because I, I , you know, I don't, I'm just, I suppose I'm trying to work out where would you take this? I would have to take it to my clinical supervision. Erm, you know, I think the, I think the struggle is, is being able to talk about what it's bringing up for you, as a person, and as a therapist.' -Participant D, Lines 384-387
		'so you can see I alternate between these different positions, Sometimes trying to see, you know, find the positive in it, but based on my current experience, I'm, you know, it generates quite a lot of anxiety.' -Participant D, Lines 417-420

Superordinate Theme	**Subordinate Themes**	**Illustrative Examples**
TIME 2 **3: *'People are very depleted'* -the need for organisational holding and containment**	A: The wider context of pressurised services	'I haven't got enough time to think, "Oh, now I will- I want to have an STPP case- Participant A, Line 70
		it has to do with capacities. You know, we wouldn't have the capacity to constantly having a referral line for psychotherapy- Participant A, Lines 113-114
		I guess that is something which is difficult in the time where we are at the moment and within NHS.- Participant A, Lines 157-158
		' I think we have a really good period where we had a relatively new, stable arrangement of teams. If it had been the year before I don't think it would have been as good because then we just were in the middle to change teams again.' Participant A, Lines 326-328
		'I think, erm, it was quite positive, you know, for that, that if was something new- for the Trust, you know.' Participant A, line 3
		'I think inevitably when organisations are going through change it affects peoples, erm, energy levels, doesn't it, and what's available to, erm, think and be, and general morale.' -Participant B, Lines 536-538
		'If you were to review what we'd talked about last time, I'd have been talking about change and things being unsettled, and people not feeling safe, because, actually that change has been going on for years. We haven't had a period of stability in donkeys...that's obviously going to have an impact on everybody, and, and I'm talking about the team, but I'm also talking about myself in that. You know, thinking about maybe th-that is there some of the resistance in thinking about implementing STPP because it was just one thing too many, in uncertainty, in managing change.' -Participant C, Lines 493-500

TIME 2

3: *'People are very depleted'* -the need for organisational holding and containment

A: The wider context of pressurised services	'there's an ambivalence, really, isn't there, of us doing it, and that was, like, nearly a year ago, kind of, September, October last year when we were having those conversations. I think in the, like, the participantical team, people are interested in it, but I don't think th-that, again, it's not really filtered through, what it is and what we do, and, and how we might be able to- you know, sometimes I say, in case discussions, "Oh, this could be an STPP case." Everyone's, like, "What? What's this?"- Participant C, Lines 372-377
	'people are independent practitioners and can absolutely do what, what they want to do, but I think just- I can feel the belt tightening all the time in the service- Participant C, Lines 402-406
	'things are changing now where all initial appointments are discussed in the team meeting, so that would've been a perfect place to hear, because we could've gone, "Okay, well there's a- that's an STPP case," b-but when we were picking cases up, initial appointments weren't discussed. We weren't part of those discussions- Participant C, Lines 462-465
	'We've had change of manager. Erm, and the, th-there's been a big change of staffing in the team. So a lot of people left, and a lot of new people have come in, and that changes the dynamics of the team anyway, so a lot- we had loads and loads of new participants come in, and a lot who have never worked with child psychotherapy. So we're doing a lot of work with them to try and help them understand what we do. Erm, and that, you know, that in itself creates that lack of security and safety, and people feeling unsettled and participantging to something r-rigidly, because that's what they, they know. So then introducing something new, like STPP, is, is, it's really not the greatest environment to, kind of, introduce, introduce that into' -Participant C, Lines 483-491
	but I think everybody's just so busy, they couldn't hold everything in mind, and, you know, when they were looking for, for cases that we thought would fit STPP. It's, you know, we can only do so much, we only get some much exposure to, to cases, so we had to rely on other people, and they couldn't then hold that for us because they've got so much going on.' Participant C, Lines 456-459
	there's been such a lot of transition and change within the service and changes of managers, to be honest, since the point in which STPP was discussed, we've got a completely different management structure and management team' – Participant D, Lines 61-65
	'In terms of the service, this isn't a criticism of the service, but it's just an acknowledgement of characteristics of the service, the service tends to let participants get on with what they need to get on with' – Participant D, Lines 505-507
	'In terms of management, will support, the delivery of STPP. But, it's very much left well alone.' – Participant D, Line 520

TIME 2

3: *'People are very depleted'* -the need for organisational holding and containment

	the service seems to, to, to go through phases where suddenly it becomes fixated about outcome measures, and then it kind of forgets all about them. So, you know. – Participant D, Lines 678-680
B: The need for organisational holding and containment.	'I guess it's, again, something which has to be gradually, patiently developed.'-Participant A, Line 312
	'My biggest frustration was…trying to establish within our psychotherapy group, the model, which I thought was-had a lot of obstacles, you know. And sometimes I didn't really know what they were, but – I- it only really took off at the very end, when everybody was more eager to have a patient. Interviewer: Do you have any ideas about why? I mean, clearly, one is because I was a member of the group, and, you know, I, I was not seen as an authoritative person, who, erm, -Laughter) who,… so I guess that was one problem. It was never, really discussed or mentioned, but I have a strong feeling about that. And, I guess why it came, at the end, more to life was because it ended. But at least everybody now has the experience, and from what I hear they also like the idea, or they, they got over this first anxiety. From what I hear people will try again, perhaps that was, was the only aim. Perhaps I should be satisfied with that.' -Laughter) – Participant A, Lines 165-188
	'I always thought it was helpful, you know- having different people, different views and,.. You know I always find peer supervisions, you know, erm, helpful.' Participant A, Lines 291-292
	'the biggest benefit of, erm, of the manual was to have this in mind that I have a beginning, a middle bit and an end bit, and that I have to , really work along that.' – Participant A, Lines 427-428
	'I think the, the, the, the difficulty was that everything what was offered, really, was not taken up to the full amount, you know… I think we could have come much further, you know, if- everybody would have had- been behind it-earlier. – Participant A, Lines 194-198
	'You know, when patients can't do something for quite a while-and they have resistance…you know. And, er, why- I mean, I guess there is not only one reason for that-you know. One is what, what I said before, you know, to do with me, I guess. Erm, and perhaps also there are other problems between other people in the group, you know- Participant A, Lines 218-222
	'the rollercoaster of NHS and the constant change and even less and even less money. And that means, of course, long-term therapies are under threat. And so it's just really that we have something which even convinces us, ourselves, you know- Participant A, Lines 448-450
	'holding on to the core, core child psychotherapy' -Participant B, Line 463
	'I would just think about the book, and, and, you know, the chapters that we read and the core principles of, or psychotherapy, and how helpful that is. That's in the book and there they are and we can all, kind of think about that and erm, return to it.' – Participant B, Lines 437-441

TIME 2

3: *'People are very depleted'* -the need for organisational holding and containment

B: The need for organisational holding and containment.	we've been lucky, erm not lucky, we've been strategic in being able to, er, still meet as a professional group' - Participant B, Line 541
	'I think over time, people have been able to, sort of say, "Oh I miss bringing other cases as well." ..It's such precious time to kind of come together and think.' – Participant B, Lines 30-33
	'I think it's been really helpful to develop my thinking about it. I think sometimes until you've put it into words you, kind of, haven't got space to reflect, So, I think it's been a helpful part of the process and provided some containment I think for, for the group, to do that.' – Participant B, Lines 557-561
	'I really valued the, the monthly peer supervision. I thought that was really, really helpful to kind of be able to bring my own material but also to hear other peoples. And, that, was really helpful. I was kind of, thinking about sometimes people's reticence to pick up a case, or bring case material. And wondering was that because we were doing something new, or it can be quite hard to bring something new, erm, when you're kind of, inevitably, you know, in a context that while its safe, its equally, you know, people looking at your practice and thinking about your practice.' – Participant B, Lines 450-457
	'The peer supervision group has been good, it's been good to hear about other peoples cases. I suppose that's where I've learned the most, I think, that group experience despite the difficulties.' – Participant C, Lines 442-444
	'it's kind of been in the background, more than actively using it. I've been using supervision much more to think about that beginning, middle and end phase.' – Participant C, Lines 380-382
	I, I suppose I'm being hesitant because I'm thinking about the amount of support we've had around this, and what would it be like to- I mean, obviously I've got a supervisor and we still have peer supervision, but there's been a focus on it that's been really helpful, I think, over this, kind of, embedding it, kind of, time, and what would it be like to try and take it forward when that's not- that focus isn't there so much.- Participant C, Lines 391-396
	'I think that, that, that having that support of the group behind me as well I think has been helpful to, to feel like it is the right case to go forward with this, this model with. And whether this is the place to mention it or not, the, the group dynamics have been tricky around STPP and peer supervision. Erm, and that's, there's been quite a lot of tension between- we, we agreed to do this as a group, and then, a, a feeling, a feeling of being pushed into doing it, and it's continued really. I don't know, that's a wider dynamic issue than STPP I think, that's a group dynamic, I suppose, that hasn't really been addressed as a group of psychotherapists, interestingly. So, personally I found it supportive, and, and I found in the supervision when I'm presenting, I found myself thinking differently about a case….feeling empowered … which is what supervision should do really. -Participant C, Lines 332-352

TIME 2

3: *'People are very depleted'* -the need for organisational holding and containment.

B: The need for organisational holding and containment.	'The peer supervision group has been good, it's been good to hear about other peoples cases. I suppose that's where I've learned the most, I think, that group experience despite the difficulties.' – Participant C, Lines 442-444
	I wouldn't say it was smooth' – Participant D, Line 30
	I think the peer group supervision has created the momentum and that's kept going.- Participant D, Line 117
	'we don't really have to work in isolation' -Participant D, Line 623
	'the manual's really good. Very detailed. Erm..I mean, it's amazing really, I'm very impressed…because it covers so much more than STPP, really, in terms of, you know, it's so applicable in, in other ways in terms of, you know, just in relation to, the adolescent task, but also particularly about practice technique, which you kind of lose or you can forget' – Participant D, Lines 530-535
	'I suppose there's been support amongst the peer supervision group within the service. But it's, we don't, meet, I mean, we meet once a month so. Well, it's been, you know, a sense that, that "Let's just do this, and let's see how we go." And nobody's out to get anyone and, you know, it's not…this area of, in terms of the way we work as a group, which is good. – Participant D, Lines 499-504
	I think there's been momentum within the small peer group. Partly there's been some sense of we're all taking some ownership of providing this rather that it being, you know, erm, one or two individuals. And we've also agreed that we would, erm, use the peer group supervision as a space where we would take some of our material gain from STPP cases. So I think, you know, those agreements, I think, set in motion the, er- or gave the momentum, really, for us to get going with it.- Participant D, Lines 17-22

Superordinate Theme	Subordinate Themes	Illustrative Examples
TIME 1 **4:*'Parent work I think is still a big issue'*- The importance and challenges of delivering parent work'**	A: Importance of parent work	'I mean these parents looking a bit further, you know, where it will be in a few years' time, and not just seeing this tunnel vision at the moment' -Participant A, line 488-489
		'often clinicians are working independently, but actually, it's core that parents are supported, er, as part of it'-Participant B, Lines 243-245
		'We're well used to working together, so I think we've got great trust in each other.' Participant B, Line 311
		cause we've talked about parent work in our peer supervision-More recently, about, actually, how important it is.- Participant C, Lines 650-653
	B: Challenges of establishing parent work	Or, also, to motivate people to do the parent work. If you are not motivated, you can't motivate anybody else.' -Participant A, Lines 302-304
		'I also had to find parent workers. Who were absolutely not trained to do this, you know, just they're interested, or told to do it'- Participant A, Lines 160-161
		'Establishing some parent work, you know, I think they will also feel then more familiar with it, or that it's doable'- Participant A, Line 212
		'parent worker and who is interested, and with TEAM MANAGER NAME in supervision talking about it, you know, and she seems to be open that people who have some interest, she would support it, you know?'- Participant A, Lines 302-308
		'Of course we have to establish parent work, but here parent work is not new, and, I mean, at least it is heard about in our team, you know? It's they know that this is happening… so it's not completely out of the blue.' -Participant A, Lines 413-416
		'the parent work will be, I guess, the most difficult thing. You know, that everybody can establish that.' -Participant A, Lines 426-427
		'for your colleague and I to meet with team managers, to explain, erm, to them and think with them about STPP as, as a new form of intervention for young people with depression, erm, so that they can be aware of it and understand it an-and also recognise, within that, the importance of, of parent work'-Participant B, Lines 237-240
		'cases were allocated, and they were allocated to two people and the psychotherapist usually saw the child and a co-worker usually saw the parent, and that might be in parallel once a week or it might have been once a fortnight, erm, to support the psychotherapy and to help the parents think about their child an also think about, er, what they bring to that particular relationship. Erm, so I think that always been sort of our foundation… I think that it's, it's; not so prevalent now.' Participant B, Lines 260-276
		'and I think people are open to and interested in it. Erm, and I think it-it's not that parent work hasn't been part of, of our service, as it has.'-Participant B, Lines 246-248

TIME 1

4*:'Parent work I think is still a big issue'*- The importance and challenges of delivering parent work

B: Challenges of establishing parent work	This is the manual, this is how it happens. There's an expectation, er, that the parent work takes place, as opposed to, er, a consultation about it.' -Participant B, Lines 281- 287
	'thinking about whether or not we might roll out some, erm, CPD event to help people think about parenting, for those people who haven't traditionally been involved in parent work. Maybe this is an opportunity to help them think about it from a different, erm, angle- Participant B, Lines 353-357
	Hmm, aha Maybe reignite something that, erm, you know, has traditionally been grounded, yeah.' -Participant B, Line 364
	'Developments can be made more quickly if there is that, that containment of, of the , the parent or the family. That, that we can't always do it just with, with a child. An-and also, I think sort of ethically, that often children are referred to mental health services is if they, erm… The pathology, for want of a word is, is kind of integral to the young person, as opposed to being about relationships and interrelationships and family system.' Participant B, Lines 371-374
	Maybe it'll evolve an-and we'll all be parallel working again' -Participant B, Line 703
	'It's a contentious issue' -Participant C, Line 556
	'it's very difficult at the moment' Participant C, Line 630
	'Parent work is a whole other ballgame. 'Cause having the clinicians who might have enough of an idea about what might be needed alongside psychotherapy- Is, is tricky. There really doesn't feel like there's a, a massive resource available for that. And there's also an idea that that's not our role, as a service, to offer-Participant C, Lines 603-607
	Just trying to build people…'Cause, 'cause some people are very clear of, "Oh my God, I couldn't do that, that's not in my skills set."'. -Participant C, Lines 621-622
	'I think we're almost starting to scaffold people up' Participant C, Line 626.
	'you get a bit tunnel-visioned into things, and somethings I think, "I just need to get on and, and see people for psychotherapy", and then you start thinking about parent work and thinking, "Oh actually, that's such an important part of, of the role."' Participant C, Lines 655-657
	'like a lot of things, it's seen as a bit of a luxury' -Participant C, Line 668
	'we have to, I think when we're, if we're asking for it in quite a structured way we have to be, kind of , saying, "It's to support therapy.", "The therapy will not work unless we have this." Erm, but we don't use that card very often, I don't think. -Participant C, Lines 670-674
	'I suppose, we try to seek out the people who we think have the skills and would have the capacity and understanding of what-Of the importance of parent work. Erm… Yeah, there, there is, there is, and there is a, as we establish ourselves, continue to establish ourselves as a team, there is a, still that, "What, what is our business?"'- Participant C, Lines 676-680

TIME 1 **4:*'Parent work I think is still a big issue'*- The importance and challenges of delivering parent work**	B: Challenges of establishing parent work	It kind of feels like parent work needs to be established more generally'- Participant C, Lines 1097-1098
		'I think it is about those where it's most vit-absolutely vital have it'. Participant C, Line 1112
		'actually I'm surprised about how many adolescents I see who don't want their parents to have anything. They don't want them involved.' Participant C, Lines 1120-1121
		in terms of joint working, erm, I think that's becoming harder over time, because it's just the allocation of resources. And that means, if you've got two clinicians working on a single case, it's usually got to be deemed that it's really good- there's good reasons for, for that, but you can do it. It's just, erm, it has to be argued that, that, that, that basically it's, it's necessary, and I think as psychotherapists we're good at arguing it. We, we can. We can say, we can say that, "This clinical work with this child is not going to be valid," or, "It's not, we're not likely to make any significant inroads, if there isn't some direct, you know, some parallel work taking place with the parent." And I think, I think we perhaps might need to be a bit stronger sometimes in arguing that, but, but we do. – Participant D, Lines 156-164

Superordinate Theme	**Subordinate Themes**	**Illustrative Examples**
TIME 2 **4:*'Parent work I think is still a big issue'*- The importance and challenges of delivering parent work.**	A: Importance of parent work	'I still think STPP has to be with parent work because you lose, I mean with normal psychotherapy, I would say you lose 50%, with STPP, you lose even more I think. You know, it's a really strong thing, I think, if you can establish parent work with STPP.' – Participant A, Lines 96-100
		Service wise, it is a bit frustrating that we could not establish more, you know, broader the parent work.'- Participant A, Lines 153-155
		'it was the young person, erm, who lived with their mother. Parents had separated when she was young. There was strong ___erm, dynamics within that'- Participant B, Lines 153-154
		'So there was a lot of process countering that, that shift and I think it would have required the parent and the young person to have worked on something to kind of unstick some of that.' – Participant B, Lines 190-192
		are we kind of setting people up by not saying "actually, this is a family affair and everybody needs to be signed up and committed" rather than keeping the focus on only the young person and not having in mind the family dynamics. – Participant B, Lines 280-283
		'there does need to be, er, a narrative at referral of this young person has parents who are functioning in this, these states of mind or aren't very well; or we will do what we can and

TIME 2

4:‘*Parent work I think is still a big issue’*- The importance and challenges of delivering parent work

A: Importance of parent work	might not be enough, but actually you need to go and get some help or we need to see you as a family; or there needs to be an acknowledgement that this is everybody’s business.’ – Participant B, Lines 285-290
	‘it’s not the parent supporting the therapy. It’s the parents doing some work in their own right which they may or may not sign up to.’ – Participant B, Lines 298-299
	‘he’s saying that he doesn’t want the parents involved in the case, so I haven’t had that opportunity. CLINICAN X is doing parent work for my case though, and that’s- it, it’s actually quite nice to have a, an- you know, somebody who can do, I mean, I, I’m the care coordinator, which is, which is fine, but actually it just keeps Mum a bit more separate, actually.’ – Participant C, Lines 183-187
	‘I think it’s helpful for my patient, because she knows that Mum’s getting her own, her own support as well, and it’s not me, and that’s really nice for- because, some adolescents, you get so drawn into parents, and it’s hard to then pull yourself away without then rejecting- you know, the parent is rejected.’- Participant C, Lines 195-198
	‘Yes, the young person might be seen for psychotherapy, but there may need to be some parallel parent work taking place simultaneously. There maybe needs to be some more exploration of whose, whose stuff is whose stuff, really, in terms of confusion and- 'cause, erm- so it's questions about where things get located and who is- and, and, you know, the young person, yes, may be where there's the concern, but there- it may be the symptoms are manifest there, but it's-borne out from something that's rather more, erm, active within the relationships between the young person-and the parents or carers’- Participant D, Lines 166-172
	‘And I've conceded in that incidence that I'm not gonna get to see the parent, erm, which is regrettable because I think that a lot could be gained for that particular case. And I think, erm, the parent could gain some beneficial- well, could, could be helped, I actually think, to think about some of the- where things get located, things get projected’ – Participant D, Lines 204-208
	I've enjoyed that part of the work. I mean, it's, it's, you know, it's quite nice to have a- to feeling like I've, kinda, got some license to do some parent work. I mean, I do bits- I do parent work, but in this incidence it feels- felt like, erm, I've been able to organise it in a way that's- feels like it's legitimate and accepted, whereas sometimes it feels like parent work's got to go slightly under the radar. Erm, I mean that, you know, you don't make a big song and dance about doing parallel parent work in the service because when it's, you know, it's already stretched, capacity wise, the question would get raised, "Why are we seeing parents when we're already offering their child, erm, you know, their adolescent child, appointments?" – Participant D, Lines 241-249.

TIME 2

4:‘*Parent work I think is still a big issue’*- The importance and challenges of delivering parent work

B: Challenges of establishing parent work	Service wise, it is a bit frustrating that we could not establish more, you know, broader the parent work.’- Participant A, Lines 153-155
	‘Parent work I think is still a big issue’ - Participant A, Line 92
	‘Yeah, but it's, erm, not really developed. I mean, parent work at all and in, in general is not really developed in our service, and mainly to do with that they don't want us to be two clinicians on one case. Yeah’ – Participant A, Lines 102-104
	I think, clearly, if you could establish more parent work a more, more reliant parent work, that would really be good, for STPP, but also for other therapies-or other psychotherapies. Otherwise, it's very tricky, you know, because we are so limited with you here and I'm here and this big area.’ – Participant A, Lines 310-314
	‘because of the structure of STPP, they need a parent worker, so they’ve got one, and it’s another psychotherapist. You know, it’s perfect world situation. I know it won’t always happen. Participant C, Lines 200-201
	‘the discussion around parent work was much more difficult, it’s that almost like that’s not gonna count as a contact. Y-you, that if that’s what that means, then you, you know, that’s done on top of what you're already doing’- Participant C, Lines 368-370
	‘Erm, it is being delivered, but it's not being delivered prolifically, partly because of the nature of some of the cases that we've been seeing for STPP. Erm, so, for example, the two cases I've got, one, one young person, who's 17, the parent seems- well, his parents appear to be very absent and he seems to- well, I, I suppose the parents seem quite intent on being absent or making themselves absent to the problem. And it's been hard to find any means to engage them, and the young person them self seems- I wouldn't say ambivalent. Probably, probably resistant to a suggestion that, erm, his parents participate in any, sort of, parallel process’ – Participant D, Lines 194-201
	‘the starting point, was very anxious about what and why she was being seen at the parent session. She's really worried that it was part of a conspiracy to locate blame and responsibility… in her, erm, for her daughter's problems. But she's- she now declares she finds the sessions really helpful and she's- feels that she would really struggle if she did not have them. – Participant D, Lines 235-240