What can be learned from an understanding of the lived experience of treatment journeys into psychotherapy through interviews with adolescents and their carers?

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

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March 2020

Contents

Abstract

Exploring young people and families' lived experiences prior to encountering a child psychotherapist in Child and Adolescent Mental Health Services (CAMHS) is a scarce area of research. Previous studies have sought to explore specific characteristics in lived experiences rather than a naturalistic phenomenological view. Alongside this, the challenges faced by NHS CAMHS services in the current socio-economic climate include underfunding and a scarcity of resources, which then result in effects such as long waiting times and increased entry criteria for services. The public are likely to view CAMHS negatively and is exacerbated by the media depicting CAMHS as a 'failing service', unable to effectively meet the needs of the population they serve; young people struggling with their mental health.

This study explored the lived experiences of three young people and three parental figures prior to their contact with a child psychotherapist within CAMHS. Each participant took part in a single semi-structured interview which was then analysed using interpretative phenomenological analysis (IPA) to gather pertinent themes. The themes were grouped into two data sets; parental figures and young people. The IPA highlighted predominantly negative experiences in all participants regardless of data set. The experiences conveyed were characterised by some hopeful connections, but mainly involved persistent struggle and psychological deterioration which resulted in the participants using fractious and compartmentalised ways of relating in order to survive. All participants found themselves inevitably reaching a crisis point in their functioning.

The discussion utilised various psychoanalytic theories in order to further highlight the negative and fractious ways of relating the participants employed. Further to this, it could be understood that the participants entered a 'crisis state of mind', where

disturbances are not recognised as such until they reach crisis point. This is heavily influenced by current socio-economic factors and the impact that this has on NHS provision. Broader research is required to more conclusively identify the individual characteristics that may influence young people’s lived experience and help-seeking.

Introduction

The work of psychoanalytic child and adolescent psychotherapists (child psychotherapist) involves gathering a detailed and intricate understanding of the internal emotional lives of the young people and families that they encounter. This involves developing an intimate and trusting relationship between the child psychotherapist, young person and family in order to embrace the painful and concerning aspects of their emotional lives. Both therapist and young person have faced turbulence in their journeys into finding and sustaining the opportunity to work together in recent years.

The lead researcher was a psychoanalytic child and adolescent psychotherapist in specialist doctoral training working in a community CAMHS team at the time of this study. Whilst working in CAMHS, the lead researcher became interested in the differing journeys in getting help and treatment that young people experienced prior to engaging in psychotherapy. The differences included significant disparities between onset of psychological difficulties and gaining access to help. Many families experienced a multitude of challenges in gaining access to help and treatment. These challenges appeared to be both internal; in the form of resistance to seeking help, and external; through barriers such as waiting lists and limited service provision. The lead researcher's interest prompted an exploration of available literature on the topic of young people's experiences of seeking help and treatment.

Background Literature

Initial literature searches yielded limited and irrelevant results, therefore the search criteria was broadened out. This wider searching process aimed to gather information from lived experiences of treatment journeys into psychotherapy by using the following search terms; ‘lived experience’ OR ‘experience’, ‘getting help’ OR treatment’ OR ‘seeking help’, ‘psychotherapy’. These terms were combined using the AND function whilst input into the following databases via EBSCO Host: APA PsychINFO, APA PsychBOOKS, Psychology and Behavioural Sciences Collection, PEP Archive, Education Source, ERIC, SocINDEX with Full Text, MEDLINE, eBOOK Collection, Library, Information Science and Technology Abstracts and CINAHL. The search was limited to academic journal articles only. This yielded an abundance of studies, so the results were further limited by age range; applying limiters for adolescents (twelve to eighteen years old) and young adults (eighteen to twenty-five years old). The results were individually screened for studies that explored pre-treatment lived experiences, which produced twenty-three papers on a broad range of topics. Five papers were excluded due to inaccessibility on academic electronic databases used by the researcher’s educational establishment, and also inaccessible via inter-library loan from the British Library. This left eighteen papers to consider as part of this literature review. The search process is also detailed in Appendix 1.

A significant number of the papers were conducted with young adults in universities and higher education establishments across several different countries. The rest of the papers were conducted with adolescents in schools and mental health clinics. The articles have been grouped together by area of exploration; ‘experiences accessing services’, ‘influence of culture’, ‘stigma’, ‘level of depression’, ‘masculinity’, ‘suicidality and help-seeking’ and ‘parents experiences’.

Experiences accessing services

The first paper is a descriptive qualitative study conducted in Ireland which explored the experiences of young people and their parents in accessing CAMHS (Coyne et al., 2015). The research involved interviews and focus groups with fifteen adolescents and thirty-two parents. The thematic analysis highlighted challenges for young people engaging with CAMHS due to poor access to services and limited information available about mental health problems in adolescence. Young people gave mixed feedback around shared care planning, and discussed their parents forcing engagement. Stigma around mental health problems was felt to be a significant factor in young people not wishing to engage in services, as were frequent changes of staff, and having unwanted sessions with parents. In conclusion, gathering feedback from families and the importance of a collaborative partnership was emphasised.

The next study was also conducted in Ireland, with young people with an eating disorder and their families (McNicholas et al., 2018). This mixed methodology study used one of the three study arms to gather the lived experiences of the young people, their parents and their healthcare professionals through one-off interviews. The grounded theory analysis for the adolescents is limited in its exploration of the material. The themes included ambivalence towards treatment, feeling 'done to' rather than included in decision making and a desire for more peer group support. The parents' themes included criticisms of availability and access to services, feeling alone and unsupported by services. The overall findings asserted that young people with eating disorders tend to conceal their difficulties and have limited awareness of how to access services. High levels of stigma were also reported. As a result professional help-seeking for this group was found to be poor; they predominantly sought support from personal contacts who felt poorly equipped.

The following research (Prior, 2012) specifically looks into young people's engagement with a UK based school counselling service. Prior discusses the difficulties for adolescents seeking help and the gaps in young people's mental health services, asserting that school counselling is well placed to address these gaps. The study used a new school counselling service which recruited participants on initial engagement with a school counsellor. Each participant (six girls, two boys) took part in a single interview, the content of which was analysed using thematic analysis. The main themes were; ‘agency’, ‘control’, ‘evaluation’, ‘social interaction’. A process for engagement in school counselling was discussed; beginning with acknowledgement of a problem, interacting with a supportive and facilitative adult, contemplating starting counselling, deciding to meet with a counsellor, evaluating the reliability and trustworthiness of the counsellor and disclosing problems to the counsellor. Engagement was strengthened by assessing trustworthiness in the counsellor, who was viewed as separate to the school. Access to a counsellor was catalysed by helpful facilitating adults, such as teachers. It is important to note that males only accounted for one quarter of the participants.

This study looked at help-seeking in bisexual individuals in North America (MacKay et al., 2017). Despite this research involving predominantly adults (with some adolescents and young adults), the findings were of interest. Grounded theory was used to analyse interviews with forty-one participants which highlighted non-linear stages of experiences. These moved from ‘consideration of services ’where often help was suggested by others after exhausting personal support. The ‘process of finding services ’was hindered by poor access and several ‘barriers and facilitators to accessing services’, including significant stigma around sexuality and mental health, and experiencing sexuality-related micro-aggressions in previous therapy. The last theme of ‘experiences within services ’were mainly negative due to poor experiences and aforementioned barriers. However, some positive experiences were had via specific LGBTQ+ services. The discussion points focused on better access to social support networks and fairer access to services as participants were mainly of low socio-economic status.

The final study in this area investigated the barriers UK homeless young people experienced when accessing counselling services (Chaturvedi, 2016). This study used a small purposive sample of homeless young people who previously engaged in counselling from the researcher's workplace; a charity for homeless young people in a large city. Recruitment was limited due to difficulties in contacting previous attendees, resulting in a small sample size which was predominantly female. The participants 'demographics were unknown. The themes elicited (using thematic analysis) from semi-structured interviews were grouped into barriers and facilitators, finding that there were more barriers than facilitators. Barriers included stigma, poor mental health support and feeling help was not needed, which was helpfully considered in the context of adolescent development. The study highlighted the specific vulnerabilities of homeless people; they can be harder to engage and less trusting of others.

Culture

Considering the influence of culture and its impact on help-seeking, the following studies were conducted in the United States of America and South Africa. They predominantly occurred within white higher education institutions where ethnic minority populations were recruited on their own, or alongside white counterparts where the two groups were compared.

The first is a mixed methods study which explored South African students' attitudes and experiences of counselling (Fande and Naude, 2019). This project recruited a small group from a culturally mixed higher education college (limiting generalisability) in order to compare the counselling experiences of white, westernised individuals with black African individuals. Various questionnaires were used to measure aspects such as help-seeking attitudes, which were then analysed using multiple analyses of variance. In addition, group discussions were used to gather what the participants felt to be their most important help-seeking thoughts. Both qualitative and quantitative arms achieved similar results; finding that females had more positive attitudes to counselling with males seeming more resistant and negative (possibly due to stereotypical attitudes of masculine strength and avoiding vulnerability). It was also discussed that white westernised participants had greater negativity towards counselling. The discussion points were felt to correlate with previous literature discussing negativity towards seeking help as well as those discussing the gender and cultural variances.

What follows is a small scale quantitative study conducted in an American higher education facility which explored the influence of culture on help-seeking (Kim, 2007). Participants completed questionnaires exploring adherence to Asian cultural norms, European-American or Western cultural norms, and attitudes to help-seeking. The results were analysed using multiple analysis of variance. The findings suggest that higher levels of adherence to Asian cultural norms was consistent with negative help-seeking attitudes. The study also suggests that Asian students with predominantly Americanised or Westernised attitudes were more likely to seek help. These points are in contrast to findings of the South African study, as it is suggested that Asian culture imbues negativity around seeking help, whereas African culture was felt to encourage help-seeking.

Stigma

Moving onto articles that attempt to explore how stigma influences help-seeking, the first is a quantitative Canadian study which explored the moderating factors in adolescent help-seeking behaviour (Beatie et al., 2016). Areas of enquiry included levels of mental health, self-stigma and psychological resilience. Nearly five-hundred young adult, (three quarters were female) higher education students complete multiple questionnaires. The results were subject to multiple quantitative analysis of variance, which concluded that stigma was the biggest influencer of help-seeking with all other variables having a negligible effect.

The second paper sought to explore adolescents' experience of stigma when accessing counselling for post-traumatic stress disorder (PTSD). This article summarises the qualitative arm of a Randomised Control Trial exploring the efficacy of PTSD treatment for black adolescents in South Africa (van der Water et al., 2018). The participants were recruited from schools in deprived areas of a large city and took part in interviews and focus groups. The sampling methods are unclear and due to exclusion criteria, only recruited a small number of adolescents. The findings suggest black adolescents in South Africa have to overcome significant stigma in order to access help (contradicting the findings of the Fande and Naude, 2019, study), including cultural beliefs that therapy is for white people, and a significant number of participants hadn't experienced a helpful adult. However, adherence to therapy was reported as good. The study recommended increased psycho-education to reduce stigma and provide better access to treatment. Both of these articles assert that the presence of various forms of stigma have a significant negative impact on adolescents' ability to seeking help.

Experience of Depression

The next category broadly looks into adolescent experiences of depression. The first two studies consider this alongside the influence of stigma, both conducted in schools in the Middle East. The first is a quantitative study looking into Jordanian adolescents' attitudes to seeking help in relation to levels of stigma and depression (Dardas et al., 2018). Data was gathered through questionnaires given to adolescents in public schools within Jordan's two largest cities. This yielded a small sample size of 88 (this was a pilot study, the main study is referred to below). Only limited conclusions can be drawn due to the use of non-randomised sampling. Discussion points include; an assertion that female Arabian adolescents' experience depression more often than males, the general presence of significant resistance to help-seeking due to multiple factors, including poor service provision and poor access to help.

The next study looked into psychosocial correlates of depressed Jordanian adolescents help-seeking intentions (Dardas et al., 2019). This quantitative, nationally representative survey obtained data through sending questionnaires to schools across Jordan which explored adolescents' views on depression and help-seeking. It is asserted that the provision of community mental health services in Jordan is poor, and negative stigma about mental health and help-seeking is a significant feature in Middle Eastern culture. The majority of participants would not seek professional help, although those experiencing higher levels of stigma were more likely to seek school-based help. Conversely, lower levels of stigma were associated with higher levels of professional help-seeking. This study recommended greater school-based interventions and psycho-education programmes to aid help-seeking.

The last paper on this topic is a qualitative exploratory study conducted in Germany which recruited participants who were beginning therapy with local therapists (Weitkamp et al., 2016). The study recruited six participants from a total of thirteen identified suitable by therapists in one city. The researchers stressed the importance of understanding the unique aspects of adolescent depression, such as irritability, which has been added to the DSM5 diagnostic criteria for adolescent depression. They gathered information from previous studies highlighting anger, interpersonal difficulties and fatigue as other important factors in adolescent depression. The themes from the interpretative phenomenological analysis (IPA) were; 'suffering is overwhelming', 'loneliness and isolation', 'struggling to understand suffering', 'therapy is last resort'. Some irritability was evident in the interviews, there was also a strong presence of PTSD in the participants alongside their depression. Other common strands included isolation, a lack of confiding in others due to stigma and a fear of being judged. Delays in treatment were related to two factors; waiting lists and young people waiting until they significantly deteriorated to seek help. Recommendations included improved psycho-education programmes in schools alongside an increasing need to fight stigma around mental health difficulties.

These studies looked into young people's depression in differing ways; the Jordanian studies looked into influencing attributes to depression such as stigma and culture which were found to impair help-seeking. The Weitkamp et al (2016) study also highlighted stigma alongside other contributing factors which impacted on depressed young people's ability to seek help. The main recommendations were around greater psycho-education and the need to reduce stigma.

Help-Seeking and Suicidality

This article (Deane et al., 2001) looked into possible links between suicidal ideation and help-negation (the opposite of help-seeking). This quantitative study was conducted in the psychology department of an Australian university which explored the relationship between suicidality, help-seeking and help-negation in a non-clinical population. Three hundred young people completed a series of questionnaires and the results were analysed using multivariate analysis of covariance to consider the relationships between emotional problems, suicidality and help-seeking. Concluding points included females being more likely to seek help, and if it was felt to be a personal problem, help would mainly be sought from friends. When considering suicidal feelings, the participants felt they were more likely to seek help from professionals, although when actually suicidal the young people were less likely to seek help, which consequently increased their levels of suicidality. This negative relationship was considered using the nature of suicidal thoughts, where suicidal individuals were less likely to seek help and experienced greater pessimism and negativity. This was used to suggest that help-negation could be a characteristic of suicidal thoughts with further research recommended. This study's insights had limited applicability, although gave important thoughts around help-seeking behaviours being markedly less in males and in suicidal individuals.

Masculinity

That final point leads onto the topic of masculinity and help seeking. The first paper looks into the concept of 'Male Gender Role Conflict' (MGRC) and it's influence on help seeking in depressed males (Good and Wood, 1995). The concept of MGRC is structured around traditional masculine viewpoints, such as displaying strength not vulnerability. This quantitative study recruited four hundred participants from an American higher education college. The findings from various questionnaires discussed two different types of MGRC; restriction related and ambition related. The study concluded that there was no significant relationship with the two types of MGRC and help-seeking behaviour directly, but stated that when depressed the ambition related type were more likely to seek help.

The second article looked into barriers and facilitators to help-seeking for anxious adolescent boys (Clark et al., 2018). This Australian qualitative study recruited twenty-nine young men with and without anxiety from local CAMHS who took part in focus groups and semi-structured interviews. Themes from the grounded theory analysis pertaining to barriers included 'self reliance rather than help seeking', 'lack of knowledge about anxiety', 'stigma' (especially around masculinity) and 'wishing to avoid the problem'. Facilitators were; 'clear available information', 'easy access to services', 'more anonymous and discreet help' and 'more school-based resources'. The study discussed complicating factors such as a social construct that anxiety is not viewed as a real problem, men feeling 'confronted' by a private emotional state, as well as the inaccessibility of services. The study made a pertinent point about individual readiness to embrace help in order to make use of psychological therapy. The discussion points were similar to the previous studies; masculinity compounds seeking help.

The last study attempted to assess resistance to psychological treatment in young adults (Butcher et al., 1998). Nearly four hundred students from an American higher education institution completed a questionnaire developed by the author, the Butcher Treatment Planning Inventory (BTPI). Another aim for the study was to validate the BTPI; used to assess resistance to psychological treatment. The data from the questionnaires was quantitatively analysed, albeit in a limited way. The discussion commented on the marked difference between male and female therapy-seeking tendencies; males were less likely to seek therapy. The study asserted those who had previously accessed therapy had higher expectations for future therapy. Recommendations included making therapy more appealing to students (particularly males) and the importance of setting realistic goals for therapy in order to provide realistic treatment expectations.

All three of these studies provide some evidence that males find it more difficult to seek help due to stigma around masculinity and mental health problems, compounding their already limited ability to reach out in times of vulnerability.

Gender and Sexuality

The next topic is related to masculinity; gender and sexuality. The following mixed methods study explored transgender individual's experiences of counselling (Hunt, 2014). This UK-based research recruited participants that completed questionnaires via online transgender forums. A small number of participants were then purposively selected to take part in semi-structured interviews. The discussion was based on both parts of the study, but was limited in scope. The concluding points discussed mixed experiences of therapy and being able to trust therapists, highlighting the importance of experienced therapists in working with the transgender community. The study had small numbers of younger participants so applicability to this literature review is limited, however it does provide helpful information about a minority group and their therapeutic experiences.

Parental Experiences

As a final look into background literature, one study looked solely into parental experiences of supporting their children whilst they were accessing treatment from CAMHS (Stapley et al., 2017). Eighty-five interviews were conducted with one or both parents of twenty-eight adolescents, which were analysed using ideal-type analysis. The analysis illuminated three areas of parental experience: ‘the learning curve parents’ who wished for professional help for themselves and their child, ‘the finding my own solutions parents’ recognised their child required professional help but did not see the need for help for themselves as parents, and ‘the stuck parents’ who felt services did not help them or their child. There were greater numbers of parents in the ‘learning curve’ and ‘stuck’ parent groups, generally those in the former were more resilient and of higher socio-economic status and those in the latter were of lower socio-economic status and more likely to experience poor mental health themselves. This study added to the scarce evidence base in parental experiences of caring for young people with mental health problems.

Summary of Literature Review

The gathering of background literature into adolescents’ lived experiences, their help-seeking attitudes and behaviours has highlighted some rich information relevant to this area of exploration. The studies identified in the review appeared clinically robust and reliable unless stated in the individual study’s description, for example the exploration in one study's data analysis seemed limited. The sample sizes appeared appropriate to the study design, i.e. smaller sizes for qualitative research and much larger samples for quantitative studies. None of these studies attempted to purely capture young people's lived experiences of help-seeking in a phenomenological sense without attempting to look at it through a particular viewpoint. However, several qualitative studies gathered lived experiences through a particular viewpoint, such as participants' depression, sexuality and gender, which provided valuable information.

The information from these qualitative studies provides some insight into the lived experiences of young people accessing help for their psychological difficulties, including both facilitators and barriers. The external factors include aspects such as stigma around mental health and poor access to services, for example, limited information about services, long waiting times and high staff turnover. This poor access can also include limited provisions, but also limited awareness of the difference between the presentations of adolescent and adult depression (for example, irritability in adolescents). It can also include limited awareness of specific cultural, gender-based and sexuality-based aspects to hold in mind when engaging with young people. Internal barriers specific to the adolescent developmental process were highlighted as well, such as ambivalence to seeking help and avoidance of disturbance. The limited information related to the experiences of those who care for adolescents showed further complications in accessing help for themselves as parents, and the young people in their care.

The qualitative studies highlighted more generalised factors to consider rather than specific phenomenological data. These studies considered stigma to be a major negative influence in seeking help, as well as males and suicidal individuals being significantly less likely to seek help. Cultural aspects were also captured in various quantitative studies, where it was discussed that Asian, African and Middle Eastern cultural norms (for differing reasons) all further complicate the process of looking for help.

This review of background literature has given insight into some of the various factors that encourage and obstruct adolescents' lived experiences and help-seeking behaviours, both internal and external. Although none of these studies have attempted to capture the phenomenology of adolescents and their families' experiences, relevant and useful information has been gathered to inform this research.

In order to think about other aspects to young people and families' experiences of getting help, further contextual information around service provision will now be considered. The information that follows has been summarised from broad internet searches for relevant articles from different media sources, including news articles, government strategies and policies.

Contextual Factors

Considering mental health services across the spectrum, creating consistency in services is not a new challenge. The policy report 'No Health Without Mental Health' (Department of Health, 2011) from almost ten years ago highlighted the lack of parity for mental health services and set an objective to achieve service equity for both mental health and physical health. This policy aimed to reform services by improving availability and effectiveness (Department of Health and Social Care, 2015). Part of this reform was to implement a specific task force to improve child and adolescent mental health services (CAMHS). Their findings are detailed within the report 'Future in Mind' (Department of Health, 2015) which comprised of a strategy aimed at improving the culture, quality and access of services. Some positive service developments have emerged as a result of these policy drivers, such as local service transformation plans, the development of the iThrive service model (Wolpert et al., 2014) and the implementation of a plan to improve access to psychological therapies for children and young people (NHS England, 2014).

Following on from this, the 'Five Year Forward View for Mental Health' was implemented in 2016 (NHS England, 2016) for a wide array of services, including CAMHS. The plan set out to exponentially increase young people's access to specialist help by increasing funding which would enable a larger, highly skilled workforce. The NHS Long Term Plan, published in 2019 (NHS England, 2019a), aimed to nationally improve a multitude of NHS services, including CAMHS. For mental health services, the Long Term Plan used the Mental Health Implementation Plan (NHS England, 2019b) to achieve its goals. The long term plan aims to build upon the actions of the 'Five Year Forward View…' by further improving access to CAMHS, including aims such as a commitment to reduce the need to travel for essential care and enabling access to twenty-four hour support.

Despite the aforementioned drivers for development, access to services for children remain complicated and difficult such as when accessing their local CAMHS. CAMHS has been under the spotlight in recent years due to concerning social, political and economical factors that influence service provision.

It has been widely acknowledged that demands on CAMHS across the country have increased, with higher numbers of children requiring access to specialist mental health services (Campbell and Marsh, 2016). To meet this increased demand, services needed to grow in parallel. This service growth has not happened despite reports of funding increases (Campbell, 2019) as these increases were insufficient in mitigating the ongoing shortfalls in service functioning, such as scant funding and staff shortages (British Broadcasting Corporation 2019b, Syal 2018). CAMHS' inability to meet demand from their local population has resulted in two main reported experiences. The first is many young people struggling with their mental health are turned away from services until their well-being deteriorates enough to enable access to therapeutic help (Adams 2018, British Broadcasting Corporation 2018). The second is young people within CAMHS report long waiting lists of up to a year or more before they have access to specialist treatment (British Broadcasting Corporation 2019a, Moore and Gammie 2018). The resultant impact of this phenomena is a widely renowned reputation that CAMHS is failing and unfit for purpose (Campbell 2016a, Campbell 2016b, Gallagher 2020, Russell 2018) because of chronic underfunding and governmental neglect (Rahim, 2019). The subsequent experiences for those requiring support from CAMHS are hopelessness and despair (Dorrell, 2020). The Association of Child Psychotherapists, the governing body for psychoanalytic child psychotherapists, has described the current state of CAMHS as a ‘silent catastrophe’ (Davies 2018, Pick et al. 2018) due to the chronic underfunding which has seen staffing numbers and expertise cut. This further limits the amount of specialist therapeutic help available, exacerbating service demand and waiting times.

The implications of this concerning picture can be thought about in a multi-layered way. The initial feelings from young people and families may be that of dissatisfaction and discontent at services’ shortcomings. The longer the situation continues, it could leave young people and families lacking in confidence in services’ ability to support them when required. This could also lead to an avoidance of services until absolutely necessary, or to engage with a sense of negativity and hostility influenced by the media before even starting treatment. These feelings and experiences could be exacerbated whilst receiving treatment by other concerning aspects such as high staff turnover and internal waiting lists. Longer term effects of this worrying picture could be attitudes such as chronic cynicism about the state of services and a lack of hope about whether this can improve. In short, the future picture could be of increased service shortcomings, increased dissatisfaction of services, higher rates of psychiatric hospital admissions and lower rates of successful community based treatment programmes. Considering potential long term implications, if the aforementioned service inadequacies continue there is a greater chance that young people's mental health difficulties will continue into adulthood. If this were to occur, it could negatively impact their future life outcomes and necessitate the need for ongoing input from services during the remainder of their lifespan.

Psychoanalytic Understanding as an Aid

Psychoanalytic theory can be used to understand the psychological processes at play in difficult circumstances as discussed above; the turbulent, fractious situation surrounding young people and families seeking help from services such as CAMHS.

The initial, overarching theory is Bion's idea of containment (1962). Bion draws upon the notion that an infant can feel psychologically held from nurturing and loving parental actions. Conversely, fractiousness and negativity can mean that an infant experiences the antithesis of containment; overwhelming, neglectful chaos. The same principle can be applied to the situation discussed here. When services are able to provide responsive care and support, it allows young people and families to feel contained, however when help is felt to be inaccessible and full of shortcomings the opposite is evident.

Other areas of psychoanalytic thinking applicable to this topic are Klein's concepts of splitting, projection, introjection (Klein, 1946) and projective identification (Klein, 1955). These ideas relate to difficult psychological situations (both internal and external) an infant can find itself in, such as feeling fearful or persecuted by others, particularly by caregivers. It is a huge challenge for an infant to understand the shortcomings of caregivers, which can be difficult to take in (or introject). This can lead to a psychological split between good and bad experiences which can be attributed (projected into) to specific individuals being wholly good or bad, which can then create further difficulty in accepting the confusing reality that a caregiver can provide both containing and hurtful experiences. These processes have relevance in understanding the painful and fractious ways that young people and families view services due to feeling neglected and hurt by services' capacity to provide effective help.

These ideas have broad application due to their fundamental place in psychological development. Some other, more specific theories, could be of use in understanding the nuances of individual experiences within a research study. These will be applied to appropriate content when this emerges within the study material. These ideas, both broad and specific, could be of use in understanding the phenomena that manifests within this study and will be referred to in the discussion.

Formulating the Research Question

The literature review and background context have provided insight into the difficult circumstances that surround young people and those who care for them in their journeys to find psychological support. The literature illuminated some challenging factors that have an influence on young people seeking help, and the services that provide this. These include external influences such as poor service provision, negative stigma, cultural influences and a lack of understanding of gender and sexuality factors. Specific factors for adolescents include irritability, ambivalence towards seeking help, and not wanting to involve families in their treatment. The background information provided some understanding of the difficult current state of CAMHS services and the overarching context around them, as well as the discontent of the end users; young people and their families.

It is important to highlight that the information discussing these problematic experiences has not generally aimed to provide a naturalistic, phenomenological picture of young people and families' help-seeking. This is because the information detailing the service context is provided as second and third hand information via media coverage, reports from health care providers and government documentation. Also most of the studies in the background literature have been conducted by looking at the data through a particular viewpoint, such as influence of culture or experience of depression. The reporting of this information through non-direct means and with specific factors in mind could mean that the individual emotional experience of the young people and families who access services could be inaccurately conveyed. The articles, studies and reports do sometimes contain quotes from young people and families, however these quotes are used to support a narrative the authors wish to convey, rather than aiming to provide impartial, naturalistic data. It is this gap in information from the previous studies that this research will aim to provide some insight into.

The previous literature also showed that the quantitative studies which aim to capture aspects of young people and families' experiences help-seeking do so in a generalised, non-specific way due to quantitative methods of data capture such as questionnaires. It was the qualitative studies which gathered individualistic phenomena from the participants that were more appropriate to gathering individual lived experiences. The studies that attempted to do so, albeit through a specific lens, predominantly used IPA, grounded theory analysis, or thematic analysis to analyse the collected data. The most appropriate choice to gather naturalistic phenomenological data is IPA, the rationale for this can be found in the nature of IPA itself.

IPA is a qualitative analytic process which is concerned with understanding the individual experience using a specific catalysing factor; neutrality. In order to ascertain the highest level of IPA, the subject data needs to be looked at as individual phenomena; free from any other influences or connections that may cause the data to be viewed differently. There have been many phenomenologists involved in the inception and evolution of IPA as a research methodology; Husserl, Heidegger, Merleau-Ponty, Satre, Schliermacher and Gadamer (Smith et al., 2009). Each had their own influence on the formation of IPA through other ideologies such as hermeneutics and phenomenological philosophy. Neutrality appeared to be a factor that informed the merging together of these ideas. The gathering of data, the viewing of it and the subsequent analysis highlights as much of the subjective experience as possible through each stage being conducted as neutrally as possible.

In order to gather individual phenomena, the data gathering method needs to collect rich, detailed accounts of everyday experiences (Smith et al., 2009). The most widely used methods of doing this are interviews and diaries. Utilising interviews would allow the researcher to not only gather experiences through spoken words, but also through how they are conveyed such as through nature of speech, body language and gesture.

All of the above aspects have been utilised to formulate the following research question:

What can be learned from an understanding of the lived experience of treatment journeys into psychotherapy through interviews with adolescents and their carers?

The aims for this study are;

- To gather phenomenological data pertaining to young people and families' lived experiences of help-seeking.
- To add to the evidence base of young people and families' lived experiences of seeking help.
- To gain further understanding of the influencing factors on lived experiences, both internal and external.
- To understand the implications these experiences may have for helping services who work with young people and their families.

Methodology

Research planning

The research was conducted within the county-wide CAMHS in Cornwall Partnership NHS Foundation Trust (CFT), the lead researcher's employing NHS trust. The research idea is an exploration of young people's journeys of getting help for their psychological difficulties prior to contact with a child psychotherapist, and at the time of conducting the research the only way to access a child psychotherapist in the region was through CFT CAMHS - therefore determining the locality and organisation. The lead researcher wrote a research proposal (Appendix 2), the public facing documentation (Appendix 3) and the interview questions (Appendix 4) which all formed part of the ethical application. Prior to applying for ethical consideration, the lead researcher devised the following inclusion criteria.

Inclusion Criteria

Any potential candidates were open to CFT CAMHS and would have been internally referred to a child psychotherapist for an assessment. Due to the research being around the adolescent age range, any potential participants had to be between twelve and eighteen years of age. The young people required a parental figure who also took part in an interview themselves, which facilitated the gathering of two complementary data sets. Each participant in the study needed to be able to accurately recount their past journeys of getting help, therefore anyone with any cognitive impairment was excluded. Similarly, each participant needed to confidently speak about their experiences in an interview, so they were required to feel confident in their use of the English language and finally, each young person and parental figure who participated in the study needed to feel settled in their current caring arrangements.

Potential participants were identified by any of the child psychotherapists that work within CFT CAMHS. The lead researcher was a child psychotherapist working in CFT CAMHS at the time of conducting the research, so any child they had current or historic contact with were excluded.

Ethics

Ethical approval for the study was sought both locally within CFT, as well as through national NHS ethics via their integrated research application system (IRAS). The IRAS application (IRAS Project Number: 244947) required review by a research ethics committee (REC) and approval by the health research authority (HRA). The study was presented to the London - Hampstead Research Ethics Committee on 13th June 2018 (REC Reference: 18/LO/1040) and following some amendments the study was granted ethical approval by both Hampstead REC and the HRA. Local ethical approval within CFT was granted due to National REC and HRA approval. Appendix 5 contains all documents related to ethical approval.

Data Collection

Prior to commencing data collection, the lead researcher met with all child psychotherapists working in CFT CAMHS to brief them on the project, the process for data collection and to provide participant information and consent sheets.

Potential participants were identified by any child psychotherapists (excluding the lead researcher) whilst in the process of undertaking an assessment. The child psychotherapist judged whether participants were appropriate for involvement in the study using the inclusion criteria.

During an assessment, the child psychotherapist discussed participation in the study with potential participants (both adolescents and parents/carers) and provided them with the appropriate information sheets. Upon agreement to participate in the study, the child psychotherapist then provided the lead researcher with the participants' contact details via secure email (NHS Net). The lead researcher then contacted the potential participants and discussed the study in more detail with them, confirming their eligibility for involvement in the study as well as obtaining initial verbal consent whilst finding a mutually convenient appointment for the interviews. Originally this process was planned to be an initial meeting, however in practice the participants preferred to do this over the phone and only meet once to officially confirm consent (see Appendix 3) and conduct the interview immediately afterwards.

The interview itself was conducted in the participant's local clinic's therapy rooms. The interview involved the participant responding to the semi-structured interview questions (see Appendix 4) asked by the lead researcher with the aim of opening up a dialogue about the interviewee's experiences. The questions were formulated from guidance found in IPA literature (Smith et al., 2009), which were further discussed in research supervision. The questions are as follows:

1. When do you think your psychological difficulties began?
2. How do your difficulties feel now compared to how they did back then?
3. From when your difficulties first began to now, do you think anyone, or anything has helped you with them?
4. Prior to meeting your psychotherapist, what types of treatment have you had, and what do you think about those now?
5. What are your thoughts around your psychotherapy, or about any other future treatment or helpful intervention you may receive?

NB: These are the young people's questions, the same questions were asked to the parental figures albeit phrased differently.

The interviews were audio recorded. Once the interview was completed the participant had two weeks from the date of the interview to withdraw their involvement in the study. The lead researcher then transcribed the audio recordings into word document on a secure NHS computer system; the audio recordings were then stored securely within the lead researcher's CFT CAMHS clinic. In order to commence data analysis, each interview's audio recording was transcribed. To allow the researcher to become immersed in the data, the researcher transcribed all the interviews. Once the data was transcribed, all personal identifiable data was removed in order to begin data analysis using IPA.

Data Analysis

The lead researcher conducted the IPA in accordance with the method detailed by Smith et al. (2009) as their method was clearly detailed and explained, making it accessible to a novice IPA researcher. The method employed by Smith et al. (2009) highlights the main action required is an analytic focus on the participants attempts to make sense of their own experiences. Their method uses the following aspects:

- Close line-by-line analysis of the participant's individual phenomena.
- Identifying the emergent patterns within the material, emphasising the convergence and divergence, firstly for single cases then across multiple cases.
- Development of a dialogue between the data, the researcher(s) and their specific knowledge in order to gather understanding of the data, to then attain an interpretative account.
- Development of a structure or frame that illustrates the relationships between themes.
- Organisation of the material into a format which allows for analysed data to be traced through the process; from initial comments on the transcript, through initial clustering and thematic development into final thematic structure.

- The use of supervision, collaboration or audit to test and develop the coherence of the interpretation.
- Development of a full narrative, evidenced by detailed commentary on data extracts which explains the interpretation, discussed theme-by-theme.
- Reflection on one's own perceptions, conceptions and processes.

The data analysis was also guided by the research question. The question asks what can be learned from the lived experiences of treatment journeys into psychotherapy. What the data analysis hopes to illustrate is the young people and families' stories of the young person's difficulties, and at what points these stories were punctuated with attempted help or support.

Each transcript was subject to a preliminary analysis which involved the researcher interpreting line by line data. Once this had been completed, the preliminary interpretations were analysed in order to find the super-ordinate themes for that individual transcript. Following this, the analysed transcripts were grouped into two distinct sets; young people and parental figures. Once in groups, the individual super-ordinate themes were analysed to ascertain overall super-ordinate themes for each grouping (an example of the analytic process is detailed in Appendix 6). These overall group themes were further thought about in the discussion, where relevant psychoanalytic theories were applied to further explore the states of mind of the participants in order to inform conclusions and recommendations.

Reflexive Statement

IPA research is conducted by human researchers, not analytic programmes or mechanical processes. The human researchers themselves cannot completely free themselves of all of their impulses, thoughts and influences which would be required in order to make the data analysis purely neutral. In order to aid the process of achieving some degree of neutrality the researcher needs to attempt to be aware of his influences.

The researcher conducting this data analysis was mindful of several complicating factors, both professional and personal. The researcher was a child psychotherapist in training working in the same NHS organisation where the participants were recruited from. The researcher was also a colleague of the clinicians that the participants came into contact with and discussed in their interviews. The researcher was a resident in the same county as all the participants. The research itself was also part of the researcher’s programme of doctoral study. These are a few of the factors that the researcher had to be aware of throughout the process of the project itself, which vary from connections through environment and relationships, to the influences of the psychoanalytic theories the researcher uses in clinical work. Each of these factors impacted on the search for neutral, phenomenological data and an awareness of them assisted in gaining some level of neutrality throughout the study.

Data Collection

The data collection began on 10th September 2018 after attaining ethical approval. This phase was characterised by several unforeseen problems that emerged throughout data collection. Gathering the data was conducted over a period of twelve months, the last interview taking place on 12th August 2019. A total of eight child psychotherapists worked across CFT during the time of the study, all of whom agreed to assisting this study. Within this time frame, a total of three interviews with young people were successfully undertaken as well as three successful interviews with parental figures. This is lower than what was originally planned for, with an aim of between four and six interviews in both data sets. The lower interview numbers can be thought about in relation to the issues that occurred.

The first issue was the high number of suitable potential participants that declined to take part in the study when initially discussing this with their child psychotherapist. In the twelve month period of data collection, a total of nineteen young people and their parental figures were identified as eligible for the study. Of these nineteen pairs, fourteen declined to take part at initial discussion. Some of the young people who declined at this stage were unable to say why they didn't wish to take part, those that were able to say described not wishing to talk about their journeys in an interview. Some young people said they had to wait a long time to have the opportunity to receive psychotherapy, so wished to proceed with treatment and not take part in anything unnecessary.

The unexpectedly high numbers of refusals could have some relation to the functioning of the CFT CAMHS at the time of the study. The service was unable to keep up with demand which resulted in long waiting times for an assessment, and in some cases treatment. In order to manage the increased demand, the entry criteria for the service became more stringent, meaning that young people were more mentally unwell before they were seen within CAMHS; impacting on how able they felt to engage in this study.

Following initial recruitment, five young people and their parental figures agreed to partake in interviews. Out of these five pairs, two parent-child pairs completed their interviews, one individual young person interview was completed and one individual parental figure interview completed. One parent-child pair and one young person declined to take part on the day of the interviews, and one parental figure did not feel able to take part. The parent-child pair who declined was because of some ongoing legal proceedings and did not wish to jeopardise them, declining to discuss their concerns with the lead researcher. The young person who declined had waited several weeks for their interview due to logistical reasons, within which time the young person's mental health had deteriorated and they declined to take part. This young person's parental figures continued with their interview. Finally, one young person's parental figures felt unable to participate in the study as they had recently begun caring for the young person and felt they did not know enough about the young person's journey to enable participation in the study. They consented to the young person in their care taking part.

The young people who took part in an interview were between fourteen and seventeen years old; two of them were male and one was female. The young people's interviews were between twenty-nine minutes and sixty-five minutes in length, with an average length of forty-nine minutes. A brief anonymised description of each young person follows:

- Albie was a white, working class, late-adolescent young man living with his white middle class adopted parents, who he had lived with since he was a toddler. He was attending a local sixth form college at the time of interview. Albie was diagnosed with neurodevelopmental difficulties in middle childhood and in more recent years had struggled with regulating his mood and levels of aggression as well as managing his friendships.

- Callum was a white, working class, mid-adolescent young man living with his single-parent mother and younger siblings. Callum was on roll at a local secondary school, although struggled with regular attendance due to difficulties with anxiety and mood. He also displayed aggressive behaviour towards his family and property. Callum had a part time job at a local club.
- Dee was an early-adolescent, white, working class, young woman living with a temporary foster carer. Dee was adopted at a young age, however this broke down in recent years. Dee was on roll at a local secondary school however attended sporadically due to difficulties with mood and anxiety. Dee self-harmed regularly and had attended local A&E on several occasions due to self-harm.

The parental figures consisted of one parental couple, an adoptive parent and a single birth parent. The parental figures' interviews were between forty-nine minutes and fifty-five minutes in length, with an average length of fifty-two minutes. A brief anonymised description of each parental figure follows:

- Anne is Albie's white, middle class, adoptive mother. She was an older lady with some health issues in a long term marriage to Albie's adoptive father.
- Brian and Bea were the white, middle class parents of Beth (who initially agreed to participate and then withdrew on the day of interview). Brian and Bea lived separately although were not clear if they were still in a relationship.
- Connie was the white, working-class, birth mother of Callum. She was a younger mother who had a stable partner, who was described as supportive.

Data Analysis

The analysed interview data is described in two separate data sets; young people and parental figures. This involved a systematic exploration of the distinct themes that emerged for each data set, including interview quotes which enhanced the investigation of the emergent phenomena. All participants in the study were given pseudonyms to protect their confidentiality. Any other personal or identifiable aspects have been removed.

Before discussing the analysis itself, it is important to illustrate some aspects to the analytic process. As previously discussed in the data collection, only six participants were recruited (three in each group) in one year of recruitment. When considering the analysis, the small number of participants meant that the analysis itself moved between an overall IPA and something more akin to comparing individual case studies. This could be attributed to one central aspect to an IPA; conveying individual naturalistic experience. In conducting the IPA there was a tension between the need to convey the participant's experiences and providing interpretations of more overarching phenomena. The small number of participants inevitably meant that at times the data analysis moved into more of a single case study feel than it would have had if there were more participants.

It is also important to comment on the personal aspect of conducting the analysis as a follow on from the earlier reflexive statement. The fact that the lead researcher worked in the same CAMHS service as where the research was conducted produced some complications. There were some moments where the participants directed their dissatisfaction about the service they received from CAMHS at the lead researcher, moving from a discussion about their experiences to something more of aggressive complaint which required a reminder that the research interview was separate from

CAMHS treatment. There were also other occasions where the participants seemed to perceive the interview as more of a therapy session for their ongoing treatment. It is unclear whether this can be solely attributed to some confusion about what is research and what is CAMHS, or whether it could be associated with having access to an available psychological space. The emotional impact of conducting the interviews was a challenge; the researcher had to hold in mind any thoughts or interpretations relating to his training as a child psychotherapist in order to try and attain some neutrality by becoming more facilitative with his comments. This meant the researcher had a regular internal dialogue about what to say before he could say it. This was particularly difficult to do when highly emotive material emerged in the interviews. The analysed interview material follows.

Young People

The content of the young people's interviews were gathered into five overarching themes; 'culmination', 'precarious', 'embroilment', 'segregate' and 'mutuality'. Each of these themes have been explored thoroughly in order to convey the experiences and communications from the young people. This has been laid out in a systematic way to portray the experiences as a spectrum ranging from the most difficult points in their journey, towards times of positivity and hopefulness; this appeared to represent the range of the young people's communications.

Culmination

This was the most climactic thread that emerged within the interviews. Before continuing, it is important to note the vocal nuances used were equally as important as the word use. Two young people spoke in definitive and potent ways about their difficulties coming to a crisis point which was not effectively helped before. The other young person spoke in an equally powerful but more despondent way of coming to a hopeless climax.

This gave a sense that each young person portrayed their difficulties coming to a crisis point. Culmination is a term to show each were facing negative spirals in their psychological wellbeing, which was a continual process until a climactic point was reached. In order for this to happen, there was a common experience of difficulties not being noticed, or that any offered help felt mismatched and ineffective.

In his interview, Albie emphasised a moment in a school day that portrayed his culmination, which occurred despite the offering of seemingly poorly-matched help.

> *“Researcher - If we could think back to, erm, at 16 when it was GCSE time, and that’s when you think things were really difficult. What did that, what was that like for you?*
>
> *Albie - I spent most of my time locked in a cubicle (laughs briefly)*
>
> *Researcher - Locked in a cubicle?*
>
> *Albie - Yeah. There’s something about bathrooms that calms me.*
>
> *Researcher - Oh I see, so you locked yourself in the cubicle?*
>
> *Albie - Yeah, yeah and .. got to the point where my science teacher, bless him .. would pop up and would just pop some work sheets under the cubicle door and I’d have a crack at them. I wasn’t on the toilet, it was a confined space, something about that that relaxed me. I think it was something from my past but I don’t really remember it, my body does but I don’t consciously remember it .. just felt comfortable. I spent a lot of time in the isolation unit.”*

Albie talked further about how he isolated himself at school, appearing unable to face being in a room with others. Albie found it difficult to talk about particular events in his interview, instead portraying his difficulties indirectly. For example he spoke about ‘taking things out on Mum and Dad at home’ and having difficulty in relationships with his peers. He did not describe anything specific about his culminating experiences, but spoke about the function of them. What follows is Albie describing a critical point in his journey.

> *“Researcher - What do you think helped that change?*
>
> *Albie - Erm, getting to the crisis point I think. And sort of show people, it wasn’t good that we had to get there for people to see, but I think showed out, stood out more then. That it got worse, people did realise, alright crap he does really need help.”*

When portraying her culmination, Dee gave a clear idea of her hiding her difficulties, which remained unnoticed by others until she began isolating and self-harming. The following extract gives a sense of firstly, her struggle being noticed, then having to wait for help where getting to the top of the waiting list seemed aligned with who was the biggest emergency.

> *“Dee - Yeah I mean, I kept my self harm hidden for quite a while and when I started it was only like just them tiny scratches, I just told erm my adoptive Mum that erm, I just caught it in a bramble bush like you know, and yeah I started getting down and that’s when sort of like CAMHS got involved … because obviously the CAMHS waiting list was really long, like really really long, and we were like we’re not going to get seen for like .. ages, then things did get worse because people started noticing it more, and like the cutting got worse and all of that, so then .. I think it’s called like an emergency thingy, so I got put to like the top of the list and I was seen within like 2 weeks”*

The experience Dee portrayed is a culmination which produced the spilling out of distress. This seemed to extend beyond this scenario for Dee; there are other areas of her life where difficulties only became apparent when a climax was reached. The following are two occurrences which highlighted Dee's experiences of unexpected, shocking contact with a traumatic climax. The first of these is related to a parental separation.

> *"Dee - So, sort of as soon as I started secondary school it sort of became bad, but it wasn't sort of like bullying or anything like that, it was just sort of things got bad as like, my adoptive parents split up. I had a lovely day and then they just sat me down and they were like right this is happening, da-da-da, like we're breaking up, and I think in a way that sort of like completely sort of changed me and sort of changed me and made me not very sort of .. emotionally well and like all of that, and it just kept on getting worse and worse after that, yeah, that's pretty much how it started"*

The following portrays an experience of climactic shock around a difficult change of CAMHS workers.

> *"Dee - March, she left at March, and *laughs* funny enough she left a week before .. the worst thing ever possibly, like that could happen to me, erm .. things had been bad with my adoptive Mum and I remember always talking to my first CAMHS worker about it, I would like rant to her about it, and it was su-, just a good way to get everything off my chest, but a week after my first CAMHS worker left, my adoptive Mum kicked me out … No warning, left me with one bag of clothes, and left*

> *me with my adoptive Dad in the caravan, caravan not being as big as this room"*

These two extracts drew attention to Dee's climactic experience overall, not just related to experiences of getting help but more global. She suggested acknowledging a challenging part of life or asking for help when the problem is not critical, is not a possibility. This portrayed that nothing is known or done about a problem until it gets to a definitive culmination. This suggested that drawing attention to disturbances in their early stages is not a culturally normative action in Dee's experience of society.

Callum portrayed his climactic experiences occurring in isolation, which had built up over time within a confined setting. Prior to receiving help from CAMHS, Callum had repeated difficult experiences in closed environments which went unnoticed and any concept of a helpful presence was absent. The only option Callum portrayed as available to him was to withdraw. The following extracts show this in different situations.

> *"Callum - Yeah so it was like, it was really weird because I did live in a large nearby city from that point onward but then er, when they split up my Mum decided to move back here to live with the rest of her family, and it was just like a bit of a weird moment, .. so er, them 2 breaking up and divorcing I dunno what you'd call it, but erm .. I saw like a lot of violence and it was just like a really negative feeling for a long time, which was like weird to see, seeing as erm, I'd never seen like an argument between them 2 before*
>
> *Researcher - So it was quite a shock to the system*
>
> *Callum - Yeah, and I didn't know what was going on, I just knew that something bad was going to happen"*

Here Callum highlighted the lack of any kind of help available to him. This was also evident in the next quote.

> *“Callum - I kind of hide it because I don’t want people knowing that something that’s going on, because then I’ll be targeted again for showing some type of an emotion, so I used to show my anger a lot and people would try and make me more angry so I feel like, if people saw me struggling they would want me to struggle more*
>
> *Researcher - I see, sort of pick on your vulnerability rather than help you*
>
> *Callum - Yeah. It’s just school, because like, no one is kind, it’s like one little thing happens it spreads really quickly and everyone kind of joins in on it”*

Later in his interview, Callum expressed feeling these difficult situations were inescapable which continued to go undetected, contributing to his psychological deterioration. He also depicted a situation where vulnerability was preyed upon, which didn’t come to the attention of any helpful agency.

Within this idea of a culmination, all three young people had a broad experience of difficult situations being met by blind eyes or deaf ears, or perhaps nothing at all. That is until difficulties deteriorated to a crisis, then others possibly realised their plight. This does convey a notion of societal culture where struggle is not recognised until an individual reaches a climactic, emergency state of distress.

Precarious

The experiences within this theme portray the young people's experiences of a fragile existence where they had not reached a crisis point but encountered repeated psychological knocks. At these points there was no consistency to their lives, but a tentative, unsettled existence characterised by changes, movements and confusions. There are overall commonalities in each young person's experiences which are portrayed differently. This, like the previous theme, describes negativity around getting help which is something of an ineffective mismatch rather than a total absence of help. This led to various confusions for the young people through the deficits that these experiences created for them. It also led to various methods to keep hold of their day to day functioning, however fragile they were.

Callum portrayed his fragile functioning prior to a crisis situation such as in the previous theme. There was some changeability and uncertainty to his portrayal due to the repeated changes and movements that occurred. Callum discussed being subjected to life events that threatened his psychological stability, as in the following quote.

> *"Callum - Yeah, which was all like, pretty weird, and then struggled a lot with my behaviour in Year 7, I was really naughty and just being kind of disrespectful and, er, at the time we were living with my Mum's ex, sorry I have a blocked nose, erm, we were living with my Mum's ex and he at this point starting being a bit different with all of us … he was always being horrible to my Mum, and that's one thing I won't stand for after seeing what happened with erm, her and my Dad, so I kind of like from that point just make sure that I didn't want anyone hurting my Mum, so I'd kick off all the time and I'd start punching walls, slamming doors and, just kind of letting loose with my anger a bit."*

This extract also related to later material in the interview, where Callum talked about his own violence, suggesting a level of confusion in him about the purpose and identification of the violence. The various functions of violence emerged in later themes, here it occurred in response to a threat to his own and his family's safety and stability. Callum also spoke about feeling destabilised through another life event, the birth of a sibling, which had an unexpected effect.

> *"Callum - my little brother was born in the autumn, which was like, it was a really weird experience for me I guess, because I always wanted a little sibling but I just kind of didn't want one at that point, and I hate I just hated it, it felt like a trauma to be honest"*

This quote portrays the birth of Callum's sibling as a traumatic knock rather than something enriching. There was further precariousness in Callum's relationships, shown by later descriptions of a friendship group who began to bully and pick on him. Callum continued attending school at this point; but this dynamic shows vulnerable and brittle experiences which he felt were unassisted by others, adding to his frailty.

Albie's precariousness was portrayed in two ways. Firstly he showed a need for others to take control of situations for him, conveying his vulnerability and inability to manage independently. This suggested Albie felt susceptible to something harmful impacting upon him. The following extract is around managing contact with his birth family.

> *"Albie - Errm .. some other things have come up recently and stuff, like birth family have got in contact with me, we went adoption agency, yesterday, because of contact from my biological father, his wife or maybe without his wife will come down from a nearby city, with the idea of putting my needs in front of theirs, and will actually sit in a meeting*

> *with my Mum and Dad. Erm, my adoptive Mum and Dad which are my Mum and Dad anyway, erm .. they'll sort out how to go about doing things. Erm .. what's ok to say, what's not ok to say, other things like that."*

The second way Albie's precariousness occurred was in relation to outside factors. He discussed ineffective attempts to help him by various indiscriminate individuals who seemed to blur into one interchangeable, unhelpful figure. A portrayal of this is follows.

> *"Albie - Yeah, I mean when I've done something bad at home, say .. say .. I can't remember what I was going to say. Like, all these counsellors and social workers I've had in the past, it's always been inconsistent … It's like, there's got to be some sort of consistency"*

Albie frequently talked about 'multiple counsellors and social workers' who came in and out of his life in a seemingly meaningless way without making any helpful impact. He discussed how these individuals' efforts felt ineffective or abusive. Albie described one counselling session as a 'grilling session' which occurred at lunchtime, meaning he didn't have lunch. This portrays something felt to be abusive and depriving. Albie also referred to occasions where he and his family had therapy which was either cut short or perceived to be taken away prematurely. The result was that difficulties continued to persist, or disturbance quickly re-emerged after a brief period of positive change. These ideas touched on deficits, both within Albie and in his environment, connecting to his overall image of frailty and instability.

Dee also portrayed a feeling of needing regular help from others in order to keep herself sustained. She voiced this whilst seemingly feeling precarious in herself, which could be seen as help-seeking, but it is characterised differently. The following extract shows a destitute way of using assistance to cling on to a degree of functioning.

> *"Dee - Well I started cutting and .. I got like really down, I lost sort of all motivation, and I carried on doing the rest of the year, but it just sort of made me, like because there's this thing in my school called the student support service which you go to if you just want to sit there for 10 minutes or whatever, I started going to there and it just kind of got in a habit of everyday just sort of like sitting in there, and not really doing that much work."*

Dee did not use resources around her to catalyse improvement, but to help her keep on going with something of an empty dependency about her. Her instability was also shown through states of confusion where she seemed lost and discombobulated. She frequently experienced repeated knocks, seemingly preventing any positive progress. She portrayed these through painful shocks (like in the quote in the previous section) and the next quote shows her confusion when talking more about the separation of her adoptive parents.

> *"Dee - Well it was kinda hard because they both, after they told me they split up, they stayed in the same house we all lived in the same house for a year, after they got divorced or whatever, so it was like really awkward like the tension was just horrible between them, and .. it just sort of felt like a broken-down family but we were all sort of living in the same house."*

Dee's frailty, like Albie's and Callum's, was heavily influenced by perceived confusing and disturbing acts of others that threatened her sense of stability, further compounding the difficulties that they were all trying to live with. Their disturbances were catalysed by encounters with a blur of unhelpful, changeable figures. This precariousness appeared to be a precursor to the later crises they experienced.

Embroilment

This theme describes a collection of the young people's experiences relating to aggression; in particular, getting caught up in interpersonal exchanges where aggression was the main emotional experience. This includes depictions of being on the receiving end of forcefulness, conflict and aggression. Embroilment conveys the idea that the young people did not seem to consciously choose to engage in such aggressive modes of communication, but found themselves pulled into expressing themselves in this way. This may be attributed to fights for psychological survival, a primitive form of expression as well as ways which conveyed their own experiences of being attacked through the action or inaction of those around them.

How the young people conveyed moments of aggression and conflict appeared connected to the gender divide. Albie and Callum depicted their experiences of aggression in similar ways; externalising their aggression in a seemingly out-of-control way which communicated something from within them. Dee's experiences were both external and internal, although her externalising conflicts were more subtle than the boys'. Dee's aggression, as a result of her conflicts and feeling forced, tended to become directed towards herself rather than towards others. When the aggression was directed at others, it seemed that unless the other was aware of Dee's intentions, it could be missed. This is in contrast to the boys; the explosive external nature of their aggression means it could not be missed.

Starting with Dee, her aggression was most evident in the nature of her verbal communication rather than the content of it. At several points in her interview she laughed in a very striking manner. It was soft, yet firm and the timing of it (usually following a statement) caused the feeling behind the laughter to shine through. Whenever Dee spoke about a conflictual moment, including those trying to help her but with mismatched or poorly timed interventions, she laughed like in the following extract where she talked about going into school after a prolonged period of absence.

> *"Dee - Like, even when I go into school now, some of them ask 'are you new?' and its like no I've been in this school since year 7, and some of them that taught me in year 7 they're like 'are you new?' like 'do you know where you're going?' and it's like yeah I know exactly where I'm going I've been in this school for, for like however many years .. but they just kind of forgot about me because I just wasn't in lessons or I wasn't in school. Yeah my teachers weren't supportive at all [laughs]"*

Dee's portrayal of becoming consumed by her aggression towards her teachers may have served as a protection from the pain she may have felt from being forgotten by them. She hints at this later where she spoke of her biggest fear of being rejected, therefore embroiling herself in conflict served as a method of managing more difficult emotions. Her self-harm had a similar feel to it.

Dee spoke of her self-harm following feelings of anger, which were related to a difficult event. At several points in her interview, Dee talked about some painful 'knocks' such as being kicked out of her adoptive parents' house, which she described with angry contempt. What followed was persistent self-isolation, which occurred alongside habitual self-harm. This seemed to show another situation around closeness to conflict as a way of mitigating other pain.

Moving onto Callum, his embroilment seemed to be somewhere in between Albie and Dee. In a similar way to Dee, Callum talked about some external aggression in response to some pressure he was experiencing. How Callum spoke of his anger in those situations, like Dee, appeared to be a way of trying to ward off more painful feelings.

> *"Callum - I missed most of my lessons in Year 8 so I probably had like a 12% attendance, and the recommended is something like a 94 or something, so that kind of put a lot of pressure on my Mum and me and then I was having arguments with her and it was more punching walls and just everything like that, and this was probably like the lowest that I've ever been, because I was struggling and yet no one knew …"*

Callum also became caught up in conflict in another way; he became engaged in entrenched ways of externalising his aggression. Callum seemed to do this to fight perceived injustices and dismissive contempt from others, which appeared to be fuelled by past life experiences and his drive to protect his mother and siblings. The following extract depicts this when Callum is talking about his step-father.

> *"Callum - this is kind of where I realised that I didn't like him at all, because he started being like really really horrible to my sister and my mum, and I guess you could say he was more horrible to me as well but I wasn't really bothered about that, it was just kind of more the rest of my family and my sister got in arguments with him and she's hit him before just because of how much everything riled up and, erm, I pulled a knife on him once, and it was just like things were getting really out of hand, because like one of the main things that just made me turn was that, he*

> *made my Mum while she was pregnant sleep on a sofa, because she didn't want to be in the same bed with him because of all the arguments …"*

Callum's entrenched conflicts were similar to situations that Albie described. He spoke on a few occasions about fights that he found himself in due to feelings of injustice and misunderstanding, such as an incident where he felt wrongly accused of bullying another young person. In response, Albie became annoyed and went on a verbal attack towards who he perceived as the instigator. In his interview, Albie's anger was evident through subtle yet potent changes in his tone, such as when Albie described perceived injustices on the bus to sixth form.

Albie also expressed a helpless resignation in reference to his aggression, as shown below.

> *"Albie - things weren't good at home, .. I'd get like aggressive at the house, with Mum and Dad, so .. Police were called, I was never arrested or anything like that, never have been. I've never had any criminal .. convictions or anything like that. But like, they were warning me, you've got to calm down and that sort of thing, and all that's stopped now. Errm .. I do hit the occasional door and stuff, err but have been thinking about getting a boxing bag."*

This depiction shows what Albie later called 'taking it out on Mum and Dad', seemingly unsure what incited this. This suggested this kind of angry expression was an instinctual release from within himself, like an eruption of feelings without Albie realising what he was doing. His thought to find a more culturally appropriate way to express these feelings (through boxing) suggested something of a hopeless resignation that aggression comes out of him fighting; all he could do is direct it in the least harmful way. There was hopefulness as well through Albie's recognition of his aggression and his wish to modify it.

Segregate

Like embroilment, this is another area of shared experiences for the young people where they had not reached a climactic point, nor were they holding onto a fragile level of functioning. Segregate, like embroilment, showed the young people using different ways of managing which did not mean they were moving towards a breaking point, but were using actions like compartmentalisation to provide healthy but limited ways of operating.

Callum's portrayals of segregation appeared in several different ways. The first is depicted in Callum's second quote from the 'embroilment' theme, where he talked about how it didn't matter if he was on the receiving end of attacks from others, but it did if his sister and mother were. This suggested that in order to manage these attacks, Callum placed his mother and sister in a more important position than himself, sacrificing his own wellbeing. He did this at other points in the interview when sharing that the most important thing to him was his mother's happiness.

Callum also separated himself from others in another way. Perhaps as a result of the conflicts he found himself in (detailed in the 'embroilment' theme), he distancesd himself from new people due to uncertainty about their intentions towards him. He suggested this in his first encounter with his child psychotherapist, saying he didn't want to attend sessions as it had been pointless. This may have been more self-protective than putting himself in harm's way to protect others, but consequently meant he may have not engaged with something potentially helpful.

The final way Callum segregated was striking. He talked insightfully in the following quote.

> *"Callum - I've found out that, a lot of things I focussed on unintentionally are the negatives, because for, it's er like a weird addiction to putting myself down, and it's not one I'm proud of or happy with just kind of, I just do it …"*

Here Callum demonstrated how he compartmentalised his perceptions of the intentions of others by focusing on the negatives. It also gave the impression of something familiar to Callum; he knew how to manage relationships with others when he perceived them in a negative light, so by separating things off he could continue his partially healthy functioning. Dee maintained her degree of partially healthy functioning through different methods.

Throughout her interview, Dee seemed to suggest that she sequestered herself away from others in order to avoid a collapse in functioning. There are two aspects to how Dee demonstrated this; she withdrew from others in order to avoid feelings of overwhelm from what she perceived a premature closeness. The other, more complex way Dee segregated from others, was through her expectation of a seamless, instant connection with another and anything less felt inadequate.

This second aspect came across at several points in Dee's interview, particularly when talking about several female workers she encountered at different times. Dee portrayed the idea of an all-encompassing connection in the following quote.

> *"Dee - it's like when I have therapy or whatever, like CAMHS, I need someone that I will automatically just feel open to just blurt everything*

> *out, but with her I sort of was like 'what do I say? like do I say this, do I say that?' and we just didn't have a click relationship .."*

Dee spoke at several points about how she felt previous workers in school were going too fast for her and coming onto sensitive material too quickly, for example sharing thoughts about her adoption. However, Dee didn't share this with the workers, which could be thought of as healthy confrontation, instead she withdrew. Alongside this, Dee had an idea that she needed a female figure that 'provided her with everything that she needs'. She mentioned this several times, becoming critical and dismissive of those that did not provide this, and defensive if this way of functioning was challenged. This came across when Dee talked about the child psychotherapist she saw;

> *"Dee - she sort of tells me things that I, that I don't want to hear, its like, personally she doesn't know anything about my life, she's been with me what 4 months and my first CAMHS worker was with me for like 2 and a bit years, and she doesn't, she doesn't get anything in my eyes, but she had the nerve to say to me, erm, your birth Mum was a fantasy and the only reason that it went downhill with your adoptive Mum is when your Mum died, your fantasy died as well so you had to deal with reality, and I was like you don't say that to someone, and that's when I really started disliking her, because I was .. you're not gonna help me doing that"*

This extract showed Dee's sequestered functioning through undesirable challenges experienced in the therapeutic relationship, giving rise to emotional hurt which instigated withdrawal from the relationship. This could have gone differently, where healthy confrontation may have provided invaluable learning for Dee and the child psychotherapist, however this was not possible.

The way Albie used compartmentalisation in order to maintain a level of good functioning was through two main methods; both centring around aggression. The first was to appear detached from the effect of his own aggression, both on himself and others. Albie also normalised his aggression at some points in his journey, for example when talking about primary school Albie described himself as a naughty child, saying he got into trouble but this was normal for a boy, then seemed dismissive about discussing it further. This appeared a method of preserving some positivity from earlier childhood rather than acknowledging his difficulties.

Considering Albie's detachment from the effects of his aggression, the following extract shows his reliance on physical processes rather than considering the psychological effects of his actions when describing his expulsion following an accusation of him bullying another student.

> *"Albie - My parents said they kicked me out, because, I didn't attend lectures because of my anxiety and stuff, which is and isn't my fault, but erm I was told there and then, shouted that erm I was targeting this kid, and er she said you've done that Friday, you've done that Monday and I was like did I do anything over the weekend? She was like no. I was like well, on the real though, I mean realistic if I was targeting someone, .. I wouldn't have apologised, I wouldn't have taken it down as soon as you asked me to, and I would have done something over the weekend. If you target someone, you don't leave, it's common sense you don't stop suddenly, .. it's constant, you bully someone it's constant, I don't do that I never would."*

Albie suggested that being accused of bullying felt a particularly sensitive issue for him, however he didn't elaborate on this. This may have fuelled his reactions when accused of bullying another student, however the extract demonstrates Albie segregating the effects of his aggression in order to preserve some positivity.

Mutuality

This final theme encompasses how each young person portrayed positive points in their journeys. The nature of this theme is consistent for all three young people; they seemed to feel great positivity and appreciation for various experiences of couples coming together in a benign and supportive way. There are different connotations of this; it could be two people coming together to support and nurture the young person, or it can be the young person coming together with someone else in order to nurture themselves with the other's help.

Considering Albie's experience, he spoke positively about his adoptive Mum and Dad who he consistently quoted as a couple that he felt very supported by. Albie also talked about another couple, a child psychotherapist and an eco-therapist who were both working with him simultaneously. He again talked with great appreciation for this second couple due to the progress he made as a result of the help they provided him, as demonstrated by the following quote.

> *"Albie - What's great about the child psychotherapist is she makes links, so I'll play a song and she'll say is this how you're feeling, is it this, that and the other. I mean the child psychotherapist is absolutely brilliant, and the eco-therapist does just the same but in different ways, but he's also not afraid to say I think you're .. telling me lies. He uses different language but, you know what I mean he's not afraid to say to me, I think*

> *you're lying to me. Or cut the, cut the bull you know .. he's done that, he's not afraid to do that which is what I like about him. I don't want him to think he's treading on eggshells. It's absolutely brilliant, I mean."*

The positivity in this extract comes from the warm way that Albie described the workers he clearly felt helped by, but that it still involved disagreements and conflicts which became enriching experiences that Albie learnt from without the need to defend himself.

Callum had a similar sense of feeling supported by couples coming together to help him, although he talked about a wider variety of nurturing couples. He first spoke about this on a more organisational level when discussing CAMHS and school coming together, describing a positive experience of organisations coming together to learn about his difficulties. This resulted in the alleviation of some educational pressure for him, in turn alleviating pressure between him and his mother.

Callum spoke positively about the benefit he found from seeing his child psychotherapist as shown in the following two extracts.

> *"Callum - going to CAMHS made me realise like if I actually open up about how I'm feeling then it helps more"*

> *"Callum - the child psychotherapist would give me suggestions on how to calm myself down or um, things to channel it on, and he also helped me find out a lot about myself which I didn't know, so it was just kind of like a lot of things have been uncovered about myself I didn't know"*

Callum also spoke about feeling helped by his mother's new partner, a different sort of father figure compared to those he previously experienced. This new partner is someone Callum felt helped to calm the embroiled conflicts between him and his mother, whilst also trying to understand Callum's perspective. He also felt the benefit of his mother's happiness with her new partner. A final sense of positive coupling is that Callum discovered a love of music. Through previous counselling Callum discovered a celebrity musician who inspired Callum to use music creatively for psychological soothing. Not only does this portray an idea of helpful couplings, but the benefit of live connections, which in turn create more live connections.

Dee's positive connections were similar to Callum's; there were a range of helpful couplings she described. Dee talked positively about how her friend and her friend's mum have always been there for her; persistence appears to be the central phenomenon Dee valued in those supporting her. This may relate directly to the loss of her birth family and the subsequent breakdown of her adoption.

Dee did not give a sense of valuing emotional closeness in her interview, perhaps this was too overwhelming for her as discussed previously. What she seemed to find of positive benefit was the physical presence of another, as described below.

> *"Dee - CAMHS every sort of time I saw them, and I had like fresh cuts, they would always sort of look at it, sort of give me advice on how to like clean it, and make sure it wasn't infected for me, but I feel CAMHS were really like, sort of good with that*
>
> *Researcher - Ok*
>
> *Dee - Like really sort of good to make sure I was ok, it was like they didn't want me doing it obviously but you know, it helps people in some ways so, they just sort of like stuck by me, yeah."*

This extract also shows the value she felt from others just physically helping to soothe her pain. Dee shows this again when she discussed her hopes for future treatment and help.

> *“Researcher - Was there any other hopes you would have for kind of future work*
>
> *Dee - Erm ..*
>
> *Researcher - Generally*
>
> *Dee - If they could make me sort of better, *laughs*, you know, like its been so long I just want to be like better and I want someone to not give up on me if you get what I mean.”*

This further portrays Dee’s hopes from a helpful figure to help with her pain and not give up on her. This quote seemed to encapsulate this feeling, also providing a pertinent point to end the analysis of the young people’s interviews and move onto to the parental figures interviews.

Parental Figures

The content of the parental figure interviews were gathered into five overarching themes, as with the young people's. However, each of these themes were weighted differently due to content as some themes were not applicable to all participants. The specifics of this will be detailed in the appropriate exploration for the theme. The parent/carer participants consisted of two single interviews and one couple interview respectively; Anne, Connie, Brian and Bea. The themes detailed next are as follows; 'catastrophe', 'discordant', 'discontent', 'abecedarian', 'enriching'.

Catastrophe

This theme applies to all three interviews, however it contains more content from Brian and Bea. Their interview contained a great deal of hostility and dissatisfaction, with positivity significantly lacking. Anne and Connie demonstrated a spread of experiences rather than something more concentrated.

The theme of catastrophe refers to a broad sense of encountering extreme circumstances such as confrontations with near-death and violence, which required a fight for survival.

Brian and Bea conveyed a multitude of catastrophic experiences. These occurred within several different scenarios which involved confrontation with near-death involving both of their children. Brian and Bea spoke repeatedly in frustrated and heated ways about their experiences of getting help for Beth. Their complaints were mainly around the prescribing of medication, but also the significant demands they felt were placed on them. These two strands of their experiences appeared connected, as their near-death experiences were related to one of their children's substance misuse difficulties.

> *"Brian – We had a weekend where we had to call the paramedics out three times. Her brother had overdosed I think is the correct*
>
> *Bea – Yeah but the first time he overdosed, erm, Beth found him and he was upstairs in his bedroom*
>
> *Researcher – She was the first one to find him?*
>
> *Bea – Yeah, yeah*
>
> *Brian – And we're talking blue*
>
> *Bea – And I was there, Brian was at work, no but he was slumped, he was blue*
>
> *Researcher – Wow*
>
> *Bea – And we had to drag him, lay him on the floor and do CPR, Beth was calling the ambulance I was doing CPR for quite a long time, she was young*
>
> *Brian – Three times in a weekend, it was er erm, it wasn't a suicide attempt from her brother, he was a drug addict*
>
> *Bea – It was just an overdose of a drug that was around at the time, erm and she witnessed this three times in a weekend*
>
> *Brian – Yeah, that was the straw that*
>
> *Bea – Yeah that was a couple of, yeah that was a couple of years ago, … I really think that that just made a massive impact on her.*
>
> *Brian – That intensified what went on didn't it*
>
> *Bea – But the year before there was a fire in her brother's bedroom and we were out for a year as well that must've unsettled her."*

This extract vividly portrays a powerfully intimate deathly experience that encompassed the whole family. Brian and Bea gave the impression enduring the experience left them with a particular sensitivity to the topics of drugs and medication, which led to conflict. This comes through in the following extract.

> *"Brian – And going on with the CAMHS thing, we've got so many letters from so many different people, every week, they're introducing someone new and that new person has prescribed a new drug to her, and my daughter and me fell out in the car on the way home, never happens, but she was arguing the point of the drug because she had spent twenty minutes talking about it with a stranger and she was adamant it was what was the way forward, so it's a little bit, it could be the way forward, but we've done a lot of monitoring and looking into it now and we don't think it is, you know, but we're not seeming to be given the option, seeming to be saying take this*
>
> *Bea – So easy to prescribe a child …"*

Complaints around this topic were frequent during Brian and Bea's interview. Beth's prescribed medication caused particularly heightened states for them; it is important to note that medication was always referred to as 'drugs'. Their complaints were intense and at one point I felt I had to remind Brian and Bea this was a research interview, and the process of formal complaint was separate.

Anne's catastrophic experiences were related to ongoing difficulties caring for Albie when he reached crisis points. These cumulative crises had potentially catastrophic implications for Anne, Albie and their family. Anne spoke of feeling they had to reach catastrophe in order for professionals to recognise that support was needed.

> *"Anne – It, the whole lot has been reactive, it's not been proactive. It's right crisis, let's do this, crisis, let's do this, you know all the phone calls I have made I don't know how many phone calls I have made, you know asking for support because we can see things are starting to unravel, can you please put something in .., but it hasn't happened until the crisis. You know and you know, so .. you know we've, .. we got to a point where, umm, .. you know, we really thought that our family had come to an end. We came to a point where we thought we were gonna have to, … ask for Albie to be removed from our home because the violence was so huge, and at that point suddenly you know we get, .. we get more from CAMHS, we get you know, people start suddenly start to say 'oh my goodness', and that that's the way it's been, you know. Albie still hasn't had some life story work, you know and now he's searched for his family on Facebook. Now we're having to deal with that that he's had contact from 8 family members from his birth family, you know. Trying to get the answers that he should've been given years ago, through life story work, so again now we're dealing with another crisis. So that is my, that is my overall overriding message, that nothing has happened until we got to crisis. You know and the damage it's done to our family, you know erm, you know it's it's …"*

Anne's narrative suggested difficulties don't register in the minds of others until crisis point, where they 'suddenly' get more help. This occurred despite Anne requesting help several times. This highlights the desperation Anne and her family felt, shown by her uncertainty about continuing to care for Albie.

Connie's catastrophes were having to repeatedly manage Callum's violence. Connie described Callum getting into a fight or flight state of mind during times of violent outbursts. She indicates these situations couldn’t be modified but had to be endured, as follows.

> *“Connie - He used to go up and down, quite a lot, like one minute he would be fine and the next minute he would just flare right up. Erm, ..*
>
> *Researcher - What does a flare up look like?*
>
> *Connie - Whew, erm it’s quite scary actually it scares me sometimes, erm you just literally you can’t you can’t talk to him, if you talk to him you’re making it worse, erm he just goes red in the eyes, erm he shakes, it’s just a completely different, different person altogether, it’s quite scary, erm I try like he did it the other day actually and I just got my two little ones in the car and just left the house, because if you go on at him I end up getting hurt or something gets thrown or a hole gets put in a wall. So it’s best just to walk out because you can’t talk to him you can’t calm him down if he’s in that rage he’ll just go at you.”*

This extract suggests similarity between Connie’s and Anne’s experiences, however conveyed differently. Both encompassed reaching a crisis point due to their child’s repeated violence, enduring this without support. Anne also needed help to prevent a family breakdown. All parental experiences of catastrophe featured a fight for survival, where they all fell into despair and conflict as a result. They all also conveyed a sense of absent, reactive or mismatched help.

Discordant

This theme relates to states of alienation, division and disconnection, broadly representing feelings of separateness and segregation that the parental figures felt from their young people or professionals. Here, families were not in an acute fight for survival, but using maladaptive mechanisms which involved separateness in order to manage.

Connie spoke about how Callum kept some things to himself in order to preserve Connie’s own happiness, sometimes by forsaking his own. This divisiveness in their relationship was also fuelled by Connie’s own struggle to understand Callum, as shown in the following extract.

> *“Connie - So he has had some struggles definitely, but I thought everything was ok until it just all went bang*
>
> *Researcher - Ok. So Callum didn’t tell you straightaway do you think?*
>
> *Connie - What about the bullying?*
>
> *Researcher - About the bullying and about how hard he was finding it do you think or*
>
> *Connie - He told me about the bullying but he didn’t tell me about other things, he kind of keeps himself to himself when it comes to things like that, all he says to me is that as long as it makes you happy I’ll go with it*
>
> *Researcher - Right ok*
>
> *Connie - So he’s very much about keeping me happy, and doesn’t really talk about himself*
>
> *Researcher - Ok ok. That, that was that was back then, is that the same now?*
>
> *Connie - He does try to talk to me, but I don’t get a lot of what he says, like he says he hears voices, erm and with his sleep his sleep pattern is really difficult, erm I do sit and listen but because, I just don’t understand it. So he kind of thinks that I’m not taking an interest which I am but I just struggle with it.”*

Connie portrayed a multi-layered discordance between herself and Callum when it came to openly sharing his struggles, or when shared understanding is attempted between them. This attempt at mutual reflection resulted in divisiveness which maintained the separateness between them.

Anne's disconnections were related to the professionals around her. She described navigating difficult moments in Albie's life as an adopted child which required professional support to help them all through. However, what actually happened were disconnections between Anne and professionals, resulting in fragmentation for Albie and hopelessness in Anne.

> *"Anne - When Albie was 8, his birth mother died. And so, and we were, and I was told over the phone and we were told to tell Albie and retrospectively we understand now that was the wrong thing to do and we should've said no, we're not telling him you need to tell him but we did as we were told and we sat down and we told Albie and erm, … Albie didn't really express anything. We asked him what he wanted to do and he said he wanted to make a card for his birth mother, to put with in the coffin so he made a card, I told a social worker he made a card … basically to cut a long story short they, the social workers didn't keep in touch with the birth family they had the funeral and we still had the card. And so, erm so then you know I said to Albie shall we, we can attach it to a balloon, a helium balloon, we could bury it and plant a tree on it and he just flew off in a rage and didn't do anything. And from that point on the violence got a lot worse and it was all directed towards me."*

This situation shows the powerful effects that such divisions can have for both caregivers and young person. Scenarios like this could be opportunities for growth through helpful connections, however further discord and separateness was experienced. Unfortunately this kind of scenario was repeated several times for Anne, Albie and their family, which undoubtedly contributed to the painful culmination described in the previous theme of ‘catastrophe’.

Finally, Brian and Bea’s discordance was something of an amalgamation of Connie’s and Anne’s. In a similar way to Connie, Brian and Bea seemed disconnected from Beth’s psychological disturbance. However, the nature of the disconnection between Brian, Bea and Beth seemed related to Beth’s sibling’s substance misuse difficulties. The following extract shows my attempts to explore when Brian and Bea first noticed Beth’s difficulties.

> *“Researcher – At the point of moving … ?*
>
> *Bea – Well a little while after really, she was experiencing a few little things*
>
> *Brian – Yeah, I remember I think it was when you first moved into the flat, and then you had the issues and you kept it between you and Beth for a while, so it was around that time because I was unaware at that time wasn’t I*
>
> *Bea – Yeah, well I just thought it was just, a little, a thing she was going through not helped by puberty and the fact that we’d moved away from the family home, although she was keen to do that, it was doing that as a safeguarding for Beth, whilst still, Brian still erm, protecting and looking out for her brother. We thought to divide and conquer we could save both children really didn’t we, it’s not really how it worked out.”*

This quote shows some compartmentalisation and disconnection from the psychological effects of a disturbing situation. Soon after this time Beth attempted suicide, causing Brian and Bea to realise how affected Beth was. Brian and Bea seemed to hold onto this disconnection in their interview; repeatedly describing a lack of focus on physical health from mental health professionals. They felt if a greater emphasis was placed on physical health, it would rid Beth of her psychological difficulties. This emphasis seemed evidence of further disconnect from Beth's difficulties, who by the time of interview, had multiple suicide attempts with no significant improvement in her mental health despite a multitude of resources afforded to her over a prolonged period. Brian and Bea's avoidance of confronting Beth's disturbance in full could have been to mitigate the pain involved in confronting the alarming situations they all endured.

Further discordance in Brian and Bea was seen when describing Beth's child psychotherapist's attempts to convey Beth's anxieties, their response was they had never seen it and so struggled to believe it. This reaction implies Brian and Bea's struggle to embrace Beth's disturbances were re-created when the child psychotherapist alerted them to Beth's struggles. Compartmentalisation and division seemed to feature in Brian, Bea and Beth's relationships in a multi-layered way.

Discontent

The theme of discontentment is depicted differently in each interview. Each of the parental figures gave voice to the multiple ways people can feel a sense of discontent in their lives. This theme portrays various unsatisfactory and disturbing feelings not only in the parents and carers, but in the whole family through what appeared as a rippling or fissioning movement.

Anne spoke about ongoing difficulties in separateness between Albie and herself, suggesting a consistent uncertainty about how safe separateness was. This was demonstrated mainly when Albie impulsively and unwittingly put himself in risky situations. Albie often embroiled himself in conflicts, disappearing for several hours without warning. These situations produced significant anxiety in Anne and the regular occurrence of this fuelled the feeling of insecurity in separateness. This wasn't isolated to adolescence; Anne described Albie beginning primary school being characterised by anxiety and defiance, keeping Anne feeling anxious and on edge. Exploring this highlighted an uncertainty and fragility which began in the first moments of adopting Albie, as shown in the following quote.

> *"Anne - Well we adopted Albie when he was 3 .. erm very soon .. he started showing high levels of anger and violence in the home basically. Hmm you know very, bed times were really difficult erm and it was hard for us because as adopters we hadn't been trained in this you know. … You know before we adopted Albie, you know so we didn't understand the presenting behaviours um, and um yeah, so so yeah he was violent. He erm, bed times it would take 2, 2 1/2 hours to get him settled down into bed at times and as I was reading the penultimate page of the book he would start to get up and he didn't want it to end. And so he would get violent because he didn't want me to leave him you know. … He over attached to me, erm wouldn't allow me out of his sight erm. He was hyper vigilant erm, he I mean he didn't but then when he came to us he didn't have social skills, he barely spoke, he had about 20 words, he didn't have any play skills, yeah it was a lot to deal with."*

Anne described a very challenging beginning to caring for Albie, which seemed to ripple throughout later life experiences as shared briefly above. Anne described discontent in the lack of preparation she had prior to the adoption. It did not initially come across as discontentment, but more the seeds of dissatisfaction which emerged later in the interview. This manifested in continued disgruntlement with services around them, and the continual struggle in parenting Albie. Assembling these experiences conveyed Anne's discontent in both her experiences of being a parent and the support afforded to her.

Brian and Bea's dissatisfaction is similar to Anne's in that it rippled and fissioned from a seminal experience. In Brian and Bea's case it was the traumatic, near-death experiences associated with Beth's sibling's substance misuse struggles. The previous theme began to explore Brian and Bea's disconnection from the painful trauma the whole family experienced, embracing this disconnect appeared the central phenomena for the parents' discontent. The dynamic below gives some evidence for this.

> *"Brian – Yeah. And obviously when we was all thrown into when the house was, erm, the fire and was all thrown into the accommodation that's when it sort of, it become more apparent, .. and you couldn't*
> *Bea – You couldn't pretend, you couldn't*
> *Brian – Couldn't put it elsewhere*
> *Bea – Couldn't deal with it privately and then .. Beth it was, it was there, it was very explicit*
> *Brian – Beth was getting to the age where she was wanting to be involved, you know*
> *Bea – Wanting to know, nosy young lady, young girl, girls want to know a little bit more I feel anyway yeah, and erm, we just couldn't, we couldn't hide it really could we and we were caught between trying to support her brother and trying to look after and keep Beth safe. It was just a*

> *really hard situation, didn't want to throw her brother to the wolves and erm save Beth, we wanted to save both of them."*

This depicts the resentment around Beth's distress forcing both parents to grasp the emotional aspect of their shared traumatic experiences, rather than 'deal with it privately' or 'put it elsewhere'. The discontent is shown through their thoughts of Beth being a 'nosy girl', suggesting this is seen negatively rather than a healthy drive for knowledge. The sense of discontentment and resentment came across throughout the interview in a fissioning way similar to Anne. This was evident in Brian and Bea's repeated denial of Beth's mental health problems, their focus on her physical health, and the aggression directed at the child psychotherapist who reminded Brian and Bea of the emotional impact of their past traumas.

Connie's discontent didn't fission from a seminal experience, but from discomfort and bewilderment at some of Callum's behaviours. Connie spoke about how Callum took her clothes into his bedroom, conveying confusion about why he did this. In a divisive, avoidant way this was not spoken about, which for Connie, exacerbates the discombobulation. This unspoken confusion may have included feelings of discontentment about Callum's theft of her clothes.

Connie conveyed disgruntled, confusing feelings when discussing Callum's relationship to cleanliness, shown in the next quote.

> *"Connie - Yeah he will spend hours in the shower but if you, if you go into his bedroom especially like now there is just food everywhere, wrappers everything …*
>
> *Connie - … and I'm like you can't do that you can't have a shower and then go back into a dirty room, but yeah. He's got no, no kind of respect in*

> *in his surroundings if that makes sense. But then if a friend comes over he'll clean his room …*
>
> *Researcher - How, did he help you to make sense of why there was the, you know the cleanliness of himself but not ..*
>
> *Connie - Oh this is just what I've come up with, I haven't spoken to him about it*
>
> *Researcher - Oh ok*
>
> *Connie - I have, I have said to him that he needs to not spend quite so long in the shower, but he don't, he will literally spend an hour in there"*

In a similar way to Brian and Bea, Connie saw the inconsistencies in Callum's cleanliness in a disgruntled and negative way. The difference between Connie and Brian and Bea is that Connie was a single parent solely responsibility for her home, which Callum did not assist with. Possibly the more important aspect to her disaffection was that again, they do not discuss it. The resulting disconnection between them seemed to fuel Connie's dissatisfaction and discontent.

Abecedarian

The theme of 'abecedarian' highlights an idea of learning about primitive roots, specifically the parental figures' appreciation of encouraging signs of growth and development in their young people. These subtle signs required cultivation and encouragement in a simple, gentle way.

This theme does not apply to all parental figures; it does not include any material from Anne. Anne's interview content lacked a sense of cultivation; progressing from delicate and fragile ideas in the previous theme, to feelings of hope and enrichment relevant to the next theme. It is pertinent to highlight the theme of 'abecedarian' contained the most hopeful content from Brian and Bea's interview; as the next theme of 'enrichment' did not apply to them.

Beginning with Brian and Bea, their recognition of Beth needing nurturing and gentle encouragement was a challenge to keep hold of. Recognising the need to provide positivity for Beth appeared as occasional punctuation marks in amongst many potent complaints and grievances that occupied the majority of their interview. There were two quotes that portrayed Brian and Bea's recognition that Beth required nurturing in order to cultivate positivity within her. The first is around her choice of college course.

> *"Brian – She's got college signed up for the new year …*
>
> *Bea – She's got college signed up for September, that's a completely different college that's one in her home town to do with animal welfare, wildlife animals which will be brilliant for Beth."*

Here Brian and Bea had an idea that Beth chose something unexpected, but the choice to study care was important for her growth. This moment could have been missed as it was surrounded by complaints about Beth's previous withdrawal from education, lack of activity and motivation.

The second quote felt more hopeful; it involved Beth expressing positivity and enjoyment which Brian and Bea recognised and encouraged.

> *"Brian - I heard her say lately because she used to say that she never has any fun, really enjoyed this it was the best day ever, this and that and she's beginning to say that and it's like you point it out to her that was the first time you sort of said that, even though she might have gone, you know doing what she wanted to do she can come back and go,*

> *when she went to a festival and it just didn't kick off you know, she's now more positive …"*

This was an encouraging sign for Brian, Bea and Beth in terms of cultivating hope and positivity in the first moments they appeared.

Connie showed some similarities to this due to her abundance of complaints about Callum which were interrupted by occasional moments of understanding his need for nurture. Connie demonstrated more nurturing moments than Brian and Bea where she recognised Callum showed some improvement and positivity. The main area this emerged was through socialisation and friendships.

> *"Connie - So, yeah. But literally he just sits in his room, friends come over, because I always allow people to come over because I think you're not getting any socialisation in school or out of school but I let friends sleep over quite a lot, so that he is getting interaction with kids. Otherwise he just wouldn't have anything."*

Here Connie recognised the importance of maintaining Callum's social relationships, which was conveyed by her understanding this may require flexibility in her parental boundaries. Despite the impact of Callum's difficulties, Connie was able to hold onto a consistent understanding of the need to cultivate some positivity for Callum.

This penultimate theme highlights some encouraging signs of the parental figures' cultivating some positivity and hopefulness for their young people. This may encourage the emergence of more positive experiences for the young people, which will also enrich the parents and carers.

Enriching

This final theme conveyed a pronounced sense of appreciating young people's content and enriching moments, which felt uplifting for the parental figures. The material for this theme came predominantly from Anne, which acknowledged two aspects; the use of learning and thinking to encourage growth, and enrichment found through helpful, supportive connections. Connie also recognised the psychological benefits of Callum’s connections with others. As discussed before, this final theme was entirely absent in Brian and Bea’s interview.

Anne mentioned an understanding of Albie’s mental health was helpful for both of them. This occurred through informative psychological diagnoses, but also from helpful discussions with professionals who showed some understanding of Albie. These experiences provided Anne some relief from struggle. An example is the next quote where Anne discussed a change in Albie through a helpful experience in a new school.

> *“Anne - He was at an independent primary School, and as I say there were 7-8 children and he just everything came together and he started to learn, I mean you know its its we, we … it was a balance I suppose of having the medication and um having a far more nurturing environment where they were prepared to listen to me and where they allowed him to err, erm express his anxiety. You know if he, if he the head teacher was fantastic and if he needed to climb up a tree and sit there for half an hour just to process things, she let him do it. And then he would come down and he talk to somebody and then he would go back into the classroom, you know so umm.”*

This extract gives a sense of growth through effective provision which enabled learning, which was beneficial to both Albie and Anne. This leads into the other part of this theme.

The second part to ‘enrichment’ came from helpful connections with others that provided positive opportunities for the young people, which was appreciated by the parental figures.

Anne spoke several times about Albie’s positivity regarding the therapeutic work he was receiving. There was some dubiousness interspersed in Anne’s positivity, mainly around not knowing the content of Albie’s sessions. This could be related to Anne and Albie’s difficulty in securely separating, however not all positivity was tinged with difficulty.

> *“Researcher - I’m getting the impression you’re feeling quite positive about that? At the moment how things are looking*
>
> *Anne – Yes yes, yeah I am because when Albie finishes his sessions with the child psychotherapist and with the eco-therapist he is, he is motivated, he is upbeat, and that he gets in the car and that he talks non-stop about things he has discussed with the child psychotherapist, well what he chooses to tell me, but he is open about it, you know. We’ve talked about this, and you know I’ve realised that, .. so that’s really good. Yeah.”*

In this quote Anne portrayed acceptance of not knowing which didn’t compromise her appreciation of Albie’s positive connections with others. This implied growth from more comfortable moments of separation happened in amongst more insecure moments. In a similar way, Connie’s moments of connection were interwoven with difficult experiences, for example despondency about Callum's future opportunities. However, she remained able to appreciate Callum's helpful connections, as shown below.

> *"Connie - Callum would be very wary at the beginning, but towards the end he spoke, I think he really did open up to the child psychotherapist, like he would sit and cry and he said that he did find the child psychotherapist really helpful and useful and he looked at things in different ways, erm, he was very positive for Callum."*

This is another example of a parental figure finding enrichment through their young person finding positive connections with others. It is important to appreciate these positive moments existed in the interviews amongst more challenging experiences. Despite this, these moments were both enriching and encouraging, as shown by the aforementioned extracts.

Discussion

Despite the small number of participants, the data analysis illuminated an abundance of rich experiences. Unfortunately, these are predominantly negative and fractious for both groups, evident by emergent factors such as aggression, depression, irritability and dissatisfaction in the young people, and frustration and disillusionment in the parental figures. These factors appeared connected to experiencing repeated psychological struggles, poorly matched interventions and enduring significant obstacles to accessing help. Initially it appeared difficult for the young people to elaborate on their journeys, which could be connected to their descriptions of finding it hard to engage with CAMHS due to struggling to find appropriate and timely help.

Some interesting aspects emerged when considering the results in comparison with the findings from the background literature. The commonalities were around the struggle to access effective help, a lack of understanding of how services operate, but also of finding helpful live connections when engaged with helping agencies. Previous research spoke of irritability as a central factor in depressed adolescents, this was certainly present in all of the adolescent participants in this study. There was some insinuation in Dee's material of the inverse relationship suggested in one previous study between suicidality and help-seeking, however this was not enough to be anything more than suggestive. The differences however were wider ranging. This study's participants did not directly discuss the negative impact of stigma, a significant common factor in background studies. However stigma could have been a factor in the bullying, isolation and marginalisation that each of the young people spoke about. Aspects of culture did not directly emerge, which in this study would be white westernised culture, however the difficulty in recognising or addressing psychological struggle prior to a crisis could have some relation to British cultural norms such as the 'stiff upper lip' and 'keep calm and carry on'. Previous literature also commented on how sexuality and gender, particularly masculinity, impacts on lived experiences and help-seeking, however these were not central factors in this study. Conversely, this study had more male participants than female, but only one out of four parental figures were male. An interesting aspect to this study was that all adolescent participants' had different care statuses, from living with biological parents to temporary foster care, to long term adoption. Although there was no overt differences illuminated in their lived experiences and help-seeking, further exploration in this area may uncover something more.

The material from the data analysis will be further thought about using appropriate psychoanalytic theories to give further insight on the participants' states of mind before gathering final thoughts and conclusions.

Applying Psychoanalytic Theory

It is important to keep in mind that some of the material in the young people's individual interviews may have been specific to their individual care circumstances, however the overarching themes brought together the commonalities in their experiences. It is also important to consider the young people and parental figures who felt unable partake in the study, and what they conveyed with their reluctance.

Young People

Initially it is pertinent to consider the young people who chose not to participate, as they comprised almost three quarters of the identified suitable participants. Their reluctance conveyed that participation was too overwhelming, perhaps partly due to feeling too unwell to discuss their journeys, and partly due to the significant wait for treatment, wishing just to proceed with that. These young people's disinclination implied a lack of reflective space in their lives to consider their psychological journeys, and that reflecting is something to be fearful or wary of. A psychoanalytic understanding is there is felt to be an absence of an available psychological container for these participants to place or deposit their experiences in, as conceptualised by Bion (1962). The lack of a suitable psychic receptacle could also relate to the long waiting times they experienced which facilitated a deterioration in their states of mind; the antithesis of containment.

The young people's overarching themes seemed to occur on a sliding scale of phenomenological experience, which appeared as a continuum of experience. Each theme seemed to occur at various points along this continuum.

At one end of the continuum is 'culmination', which gathered the climactic points in their journeys. A common factor each young person described, in reaching a climax, was their difficulties were not adequately supported or recognised by people around them. This occurred despite the young people experiencing adverse circumstances and their mental health deteriorating. The phenomenological aspect is the young people did not think others were thinking about them and were unable to recognise the impact of the adverse events on their mental wellbeing. There is also more implied; the network of people around the young people didn't recognise their deterioration. Considering this psychoanalytically, the young people did not experience any form of psychological containment (Bion, 1962) for their disturbances. This lead to all of them reaching a negative climactic point in their lives due to a lack of recognition or psychological holding.

The second theme of 'precarious' was a precursor on the continuum to climax. Here the young people conveyed some partially healthy functioning by being able to do things such as attending school, however, distressing circumstances continued to occur in parallel. All young people showed fragility when their healthier functioning wasn't bolstered by effective support. In a psychoanalytic sense, the young people were attempting to manage overwhelming and painful situations by using various actions as a ‘second skin’ function described by Bick (1986). The actions such as hopeless dependency and violence, were ways of psychologically holding themselves together (acting as a psychic skin) in order to prevent feelings of overwhelming distress which could result in psychological collapse. However, this action seemed limited in its effectiveness.

Moving further along the young people’s continuum is the theme of ‘embroilment’. This theme was characterised by embroilment in aggressive, conflictual situations as a way of managing the ongoing, difficult dynamics around them. This theme was positioned here as the young people did not appear as fragile as in the previous theme, but appeared to be consumed by ways of behaving and managing that were of concern, in this case predominantly aggression. These actions were used as methods of psychological survival, and can be attributed to the Kleinian psychoanalytic concepts of projection and projective identification (Klein 1946, Klein 1955). In the cases of directing the conflict and aggression to those who were perceived to have wronged the young people, they were projecting their internalised abusers and aggressors outwards towards others who subsequently became identified as these internal abusers and aggressors. The other circumstances where the young people talk of ‘taking it out on…’ could be understood as the projection of their violent experiences of pain and distress onto others around them in order to be rid of such hurtful experiences. The nature of 'embroilment’ is negative as it involved engagement in conflict; a possible precursor to further deterioration along the continuum. However if young people learnt from their uses of projection and projective identification, this could be a healthy developmental experience for them.

Moving towards the healthier end of the continuum is the theme of ‘segregation’. This theme is somewhere in the middle similar to embroilment as it is not associated with a climax, nor is it associated with completely healthy functioning. This theme related to the compartmentalisation of some of their disturbances in order to maintain a degree of healthy functioning. It is similar to ‘embroilment' as it involved a change to how difficulties are recognised, albeit in a different way. ‘Embroilment’ involved the young people entangling themselves in various conflictual relations, whereas ‘segregation’ showed the young people distancing themselves from others who put them in touch with their unwanted or overwhelming difficulties. This psychological process can be thought about using Klein’s (1946) ideas about psychological splitting. Splitting refers to early psychic processes when an infant feels fear about attaching itself to someone due to being unable to consider others containing both good and bad aspects; they become solely one or the other. Where good and bad cannot be integrated together, the bad or unwanted parts are projected out in order to hold onto the good parts. This seems to be something akin to what each of these young people are doing as they are all unable to fully integrate the more difficult parts of themselves, which results in them splitting off and projecting out these parts. As with embroilment, this is a process that could lead to further deterioration, however it could lead to positive enrichment through learning about the process.

The final theme of ‘mutuality’ relates to the most positive aspects of the young people’s interviews and occupies the most hopeful place on the continuum, conveying their hopes for positive development. The action of achieving development is consistent for all three young people; through supportive connections with helpful people. Considering Bion’s (1962) idea of containment, he described an infant finding psychic containment from their mother who did not just fire back their aggressions and complaints (which Bion calls ‘beta elements’) but provided what Bion described as ‘alpha function’ through digesting their aggressive communications and offering them a more manageable form of it. This facilitates the process of psychological holding.

Parental Figures

As with the young people, the phenomena and themes from the parental figures seemed to form a continuum of experience. The parental continuum came across in a slightly different way as their individual experiences applied to some, but not all of the themes. This could be related to differences in the psychological positions of the participants, resulting in them occupying different positions on the continuum.

Before proceeding further, the parental figures who didn't partake in this study require acknowledgement. All but one of the participants who withdrew or declined at various stages were young people. The individual parental figure who withdrew participation did so through fear of participation influencing some legal proceedings. As with the young people who withdrew, this parent portrayed a sense that participation would not be a containing (Bion, 1962), well held, thoughtful experience, but something that may cause negative ripple effects to other aspects of life.

The first theme of 'catastrophe' was similar to the young person's theme of culmination as both involved a crisis point which gave rise to high levels of concern, anxiety and panic. Thinking more psychoanalytically about these experiences, there may be several appropriate ideas that relate to each participant's catastrophic phenomena, which is beyond the scope of this paper. The most appropriate broad theory is again Bion's (1962) ideas around containment, applicable in a similar way to the young people. None of the parental figures' portrayals of their crises gave the impression of the presence of an available container for their distress, aggression or disturbance. The lack of a container gave rise to the climactic points that they all experienced.

The next theme of 'discordance' related to disconnection between the parental figures and their distress and from their young people, having some similarities to the young people's themes of 'segregation' and 'precarious'. All parental figures portrayed an experience of divisiveness which appeared a precursor to catastrophe. Precariousness referred to the disconnections and discordance which served as a protective function for the parental figures' fragile moments. Segregation refers to the various moments the parental figures were cut off from difficult experiences; a deliberate act of splitting these off in order to relieve themselves of painful feelings. The most appropriate psychoanalytic theory that encompass all these aspects is Klein's (1946) idea of projection due to the presence of psychologically projecting out negative and painful states in order to rid themselves of these as a protective measure to ensure psychic survival (as previously described in the young people's 'segregate' theme).

The next theme on the parental figures continuum of experience is 'discontent', which has a strong relationship to the young person's theme of embroilment. As with embroilment, discontent is related to the psychoanalytic concept of projection (Klein, 1946), albeit in a slightly different way which incorporates the idea of introjection. Introjection involves psychologically taking back in experiences which were previously projected out (Klein, 1946). Whereas 'embroilment' was related to the action of projection, 'discontent' seemed to be around the potential return of those uncomfortable experiences, which would enable them to be taken in (or introjected) in a different way. The parental figures seemed to encounter a premature confrontation with experiences they previously projected out, hence their feeling of discontent implying a difficulty with securely re-introjecting these experiences at that moment. If the parental figures become able to successfully take in their difficult experiences, they would be able to positively learn from this.

The next theme of 'abecedarian' is the first theme that does not apply to all participants. It is also the only theme that had no relationship to any of the young person's themes as it appeared related to being in a caregiver's position. Abecedarian related to noticing something positive in the young person's life in order to encourage growth and development, which occurred due to the parental depressive concern for their young person in line with Klein's (1940) idea of the depressive position. The depressive position is a psychological state where concern and reflection are possible despite how disturbing the content may be (Klein, 1940). This theme did not apply to the couple who participated as they remained in more persecuted, split-off and projective states of mind in line with the paranoid-schizoid position (Klein, 1946), and until they are able to move to more depressive states, positive movement seemed difficult for them. Abecedarian can be broadly related to the psychoanalytic idea of the epistemophilic instinct (Klein, 1928), whereby despite the presence of complicated impulses and ideas present in the young people, the parental figures could recognise the presence of some healthy desire to learn, grow and develop which required encouragement and nurture.

The final theme on the parental continuum is the most positive theme, 'enriching'. As with the young people's theme of mutuality, enriching can be related to the psychoanalytic concept of containment (Bion, 1962). The containing relationship that the young people found themselves in helped to contain their disturbances, also providing containment for their parental figures. The parental containment related to their young person feeling a benefit from the relationship, which in turn helped relieve the anxiety they felt at times.

Comparing Data Sets

The themes from both data sets had both strands of convergence and divergence. Considering the similarities, the information from both groups occurred on a broadly homogenous continuum from negativity towards something more wholesome and positive. The specifics of each grouping's themes along their continuums showed variation in the movement from negativity to positivity. The various psychoanalytic theories applied to each theme assists in highlighting these variations.

Looking at the negative end of the scale, both groups had parallels in their most challenging times which was shown by their themes of ‘catastrophe’ and ‘culmination’ demonstrating a lack of psychological containment. After this, the variations between the two groups began to show. The young people’s themes moved between those where they attempted to hold themselves together, masking their struggles through to the following themes that highlighted the use of splitting and projective processes as ways of coping. The most positive end of the scale showed young people benefitting from containment through others helping to modify their distress. The parental figures had a different movement despite having similar content to the young people’s middling themes. Generally the parental figures spent less time in fractious ways of relating (e.g. splitting, projection) than the young people, demonstrating more positivity through finding warmth in seeing growth in their young people through the helpful connections they made.

The differences between the groups could be thought about in relation to the adolescent process. Adolescence is a developmental stage characterised by the re-emergence of psychic conflicts from early childhood which require working through. This occurs as young people seek to attain independence from parental figures in order to develop their own identities, which will assist in the movement to young adulthood. Parental figures may have worked through these struggles in their own adolescence, meaning the movement to learning and containment could come easier to them. There was greater variance in the parental figures experiences which related to participation as a single parent or as a couple; the two single parents were more aligned with one another than either were with the couple.

Final Thoughts and Conclusions

In order to consider what the concluding thoughts about this project may be, it is necessary to first return to the study's aims to consider the research question;

'*What can be learned from an understanding of the lived experience of treatment journeys into psychotherapy through interviews with adolescents and their carers?*':

- To gather phenomenological data pertaining to young people and families' lived experiences of help-seeking.
- To add to the evidence base of young people and families lived experiences of seeking help.
- To gain further understanding of the influencing factors on lived experiences, both internal and external.
- To understand the implications these experiences may have for helping services who work with young people and their families.

This research process has been able to convey valuable phenomenological data of the adolescent participants, as well as those who care for them. This was achieved regardless of the complex and challenging socio-political circumstances that heavily influenced their journeys, in particular their ability to access help. The ability to convey this data has been facilitated by conducting as neutral a process as reasonably possible, which will be further considered in a later section on strengths and limitations.

As discussed in the study's introductory sections, CAMHS generally such as the service where the study was conducted has undergone a turbulent period in recent years. As the earlier media articles highlighted, CAMHS are subject to chronic underfunding and staffing difficulties which have impacted on the services' ability to meet the demands of the population they serve. The result is significant waiting times to gain access, as well as higher levels of disability and disturbance required to gain entry to CAMHS. The data that emerged from this study aligns with this viewpoint, but also suggests something more.

The experiences conveyed by both young people and parental figures are predominantly negative; they convey a sense of ongoing fragility in their functioning and struggle with some attempts to get support which is then largely ineffective and inadequately matched to the nature of their difficulties at that point in time. There was some hopefulness present through meaningful connections with helpful people or helpful couples, however the broad message was that a crisis and culmination point would inevitably occur. This process gave rise to emotional experiences such as anger, frustration, denial, hopelessness and despair. These experiences are not just in relation to difficulties in accessing CAMHS, but in accessing help generally over the course of the young people’s minority years. None of the participants conveyed a short or straightforward journey to finding support. Due to the long time period and the multiple services these young people have encountered, the difficulties cannot be solely located with CAMHS but with an overarching cultural problem in the helping professions being able to provide effective support. This was supported by the psychoanalytic understandings of the phenomenological data, which highlighted the lack of containment or secure psychological holding. This was a universal phenomenon that applied to all participants as well as those who declined participation. What can be understood from their inevitable culmination is this was influenced by the lack of available support, and the lack of recognition of the disturbance. The impact of these circumstances and experiences suggest the emergence of a ‘crisis state of mind’, whereby a crisis point must be reached through a breakdown in functioning in order for difficulties to be recognised and considered as needing help. It also suggests the question of whether, unless you reach a crisis point, you are even considered to be experiencing significant adversity. Having to reach such a crisis state suggests not. This ‘crisis state of mind’ is the result of a set of cumulative experiences over a considerable period of time as detailed in the continuum of experiences elicited from both data sets. This idea is likely to be able to be generalised to other areas and regions as shown in the media articles as there are many regions that complain of poor support and poor access to services.

In terms of building the evidence base around young people and their families' lived experiences, this study has provided some valuable contributions. It highlights the cumulative effects of barriers and challenges to accessing help which should not be underestimated, as they can gather together in distinct sets of circumstances such as those displayed in this study, which place individuals in disturbing psychological positions such as a 'crisis state of mind' and the paranoid-schizoid position. The phenomenological voice of this study's participants conveyed a powerful and disturbing message about the challenges they faced in their individual journeys in trying to find help. The use of psychoanalytic theory has contributed to further understanding these journeys through illuminating the nature of the various states of mind the participants found themselves in. Hearing and understanding the voices of individuals such as these participants is vital if the impact of changes in service provision is to be fully appreciated, however painful it may be.

Limitations of this Project

Although this study has produced some rich and meaningful experiential data, there are some inherent limitations in it. The small number of participants from a rural, sparsely populated county who are all of white British heritage mean that generalisability with the wider population is limited. The long and difficult recruitment process highlighted a significant number of suitable young people who did not feel able to take part. This significant number of refusals limits the generalisability of this study.

When thinking about methodological limitations, the small number of participants resulted in limited data saturation. This is turn meant the data analysis process flowed between a single case study to more overarching descriptions. In order to achieve greater data saturation and a more consistent overarching data analysis, higher participant numbers would be needed.

Future Implications

This project has highlighted concerning and alarming experiences within the young people and their carers who have taken part. The influencing factors for this require attention. The most prominent of these is the worrying state of CAMHS, which as previously highlighted is getting significant attention. The shortcomings of CAMHS will require further attention and improvements in order for young people and their families, such as those who took part in this study, to have better experiences in services. The participants also provided a strong message that they felt they would have benefitted from accessing substantial treatment earlier in their lives, which should have been considered in accordance with their level of need at the time. Addressing these service-level clinical implications may also enable greater participation in future research.

Considering future research, this should be aimed at gathering a greater number of participants from a range of areas. This would aim to facilitate more diversity in the demographics of the participants, which would enable better generalisability from the results. This could include further consideration of care status and how this influences lived experiences of help-seeking. A bigger, more diverse sample size would also help to understand the accuracy of the results of this study and allow consideration of cultural factors, as suggested by previous research. Future studies may also wish to recruit different age ranges of participants in order to understand whether the findings of this study are applicable to other age groups.

Considering specifically about how to recruit greater numbers in future, this project highlighted the turbulent state of CAMHS as a complicating factor to encourage participants to engage in a research project about individual experiences of treatment journeys and help-seeking. If the researcher had solely identified himself as a researcher completing doctoral study rather than also being an employee of CAMHS, the more neutral position of an academic researcher may have enabled more potential participants to take part.

Although the findings of this study did not directly suggest stigma as a significant influencing factor, a significant number of previous studies have discussed the continued presence of stigma around mental health and how this prevents individuals from seeking help. Stigma requires continued focus and attention to be aware of it and combat it, particularly for males. Previous studies frequently suggest greater psycho-education programmes and better accessibility as methods to address the effects of stigma.

There are also theoretical considerations to think about. The application of psychoanalytic theory highlighted a consistent lack of containment the participants felt in the majority of their experiences, as shown in the data analysis. This is supported, albeit from the professional's perspective, in Briggs's (2018) thoughts about containment lost in CAMHS. The absence of containment also supports Emanuel's (2002) notion that the network around a young person can add another layer of deprivation due to the presence of complex unconscious processes which have yet to be understood. It is important to note that Emmanuel's paper thought predominantly about children in care, the commonality to this paper could relate to two thirds of this study's participants being looked after or adopted. Lastly, the participants' strong voice around needing earlier intervention adds to the abundance of previous literature about the clinical and developmental benefits of early intervention.

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Appendix 1 - Literature Searching Process

On 20th September 2020, the following method was used to search for literature pertaining to this study.

Firstly, the following terms were input into the EBSCO Host database searching tool:

Search Item	Search Term
1	lived experience
2	experience
3	Item 1 OR Item 2
4	treatment
5	getting help
6	seeking help
7	Item 4 OR Item 5 OR Item 6
8	psychotherapy
9	Item 3 AND Item 7 AND Item 8

These terms were inputted with the following limiters:

- Academic Journal articles only.
- Adolescent age range.
- Young adult age range

The terms with the aforementioned limiters were then used to search the following databases:

- APA PsychINFO

- APA PsychBOOKS
- Psychology and Behavioural Sciences Collection
- PEP Archive
- Education Source
- ERIC
- SocINDEX with Full Text
- MEDLINE
- eBOOK Collection
- Library
- Information Science and Technology Abstracts
- CINAHL

The results of these searches yielded a total of 3,055 articles. These articles were then individually explored by the lead researcher to assess for suitability for inclusion into a literature search. The following are the broadly applied criteria:

- Any study not involving adolescents or parents of adolescents was excluded.
- Any study that attempted to ascertain lived experiences whilst in treatment or post treatment was excluded, pre-treatment lived experiences were included.

The application of all of these criteria also twenty-three results. Five of these results were inaccessible in the academic databases, by broad internet searching or from the British Library. The remaining eighteen results were included in the literature review.

Appendix 2 - Research Study Proposal

What can be learned from an understanding of the lived experience of treatment journeys into psychotherapy through interviews with adolescents and their carers?

Key Words

adolescent, depression, lived experience, treatment journey

Aims

Young people find their way into psychoanalytic child psychotherapy through an abundance of different journeys of clinical treatment for their psychological difficulties. This study aims to gather an understanding of the individual emotional experiences and differing states of mind these young people and their carers navigate throughout their treatment journeys.

The main aim of this study is to recruit a set of adolescents whom are beginning psychoanalytic psychotherapy (PP) for their depression, who each have experienced differing treatment journeys prior to engaging in PP. Gathering the data of these experiences from both the young peoples' and carers' perspective will hopefully provide a rich and varied data set which would be analysed in order to understand any themes and patterns in these experiences.

This aim would be achieved through a study without specific agenda other than to provide an unbiased vehicle for a collection of experiences to be voiced and explored.

Background and Rationale

Clinical treatment of young people has a significant presence in current national media (The Guardian 2016, Schools Week 2017). A strained workforce in CAMHS as an outcome of commissioning limitations alongside increasing demand has resulted in an increased challenge in providing effective treatment. This has also resulted in increased waiting times in order to access services, children becoming more unwell with higher associated risks before getting treatment. This current context for services has also resulted in a push for more time limited treatment, such as short-term psychoanalytic psychotherapy (STPP) for adolescent depression.

Adolescents are a difficult client group to engage with (Bronstein and Flanders, 1998). There has been an abundance of research in recent years into the approaches and experiences of working with this client group from varying perspectives. Bronstein and Flanders (1998) explore adaptions to traditional psychoanalytic technique in order to engage adolescents in psychotherapy with their varying and fluctuating states of mind. There has also been recent research into adolescents' perceptions of the causes of their depression (Midgley et al., 2017) as well as adolescents' aims and experiences within psychotherapy for their depression (Midgley et al. 2016, Weitkamp et al. 2017). Stapley et al. (2017) has also researched into parents' and caregivers' experiences of caring for depressed adolescents whilst receiving treatment within CAMHS.

A significant number of recent research into adolescent psychotherapy has been centred around the development of STPP. This has been focused around a recent randomised control trial into evaluating the effectiveness of STPP when compared to other brief psychological treatments (Goodyer et al., 2017). Within the varying studies into new treatment approaches such as STPP, there has been some qualitative studies exploring the experiences of young people within their treatment, as previously stated. Whilst these studies may have included unconscious influences left from the treatment journey of the young person, no study has sought to gather a specific understanding of this journey and its influences through previous treatment prior to psychotherapy.

The author has been unable to find any research looking into carers' experiences of their young peoples' treatment journeys, only the aforementioned study pertaining to their experiences caring for a depressed young person generally.

Adolescents find their way into psychotherapy through an abundance of different routes and channels, both within the health sector and through other organisations. Some of these routes are direct and brief, others can be more prolonged for various reasons. The differing aspects and influences of these journeys will be internalised by the adolescent and their caregivers in a multitude of ways. Conducting research into this area will give the nuances of their journeys a voice, as well as providing space for exploration and understanding.

Taking into account the lack of research into this perspective, and the increasingly limited services currently in the UK, a study into the treatment journeys of young people will provide a valuable perspective on access and experience of services.

Methodology

This study will explore the experiences of both adolescents' and their caregivers' of the young person's treatment journey into psychotherapy.

Prior to research being conducted, the author (a child psychotherapist in specialist doctoral training) will conduct a literature review in order to attain comprehensive knowledge of the current scope of research in this area. This will be undertaken by searching all relevant database collections of research (such as PsychINFO) electronically in order to search for the most relevant literature. The specific databases that will be used will be defined within the literature search itself. This search will involve utilising a search strategy incorporating boolean operators which will allow a wide search using different permutations and evolutions of the main key words in this study. This literature review will be formally documented with the study.

This research study will be conducted in a generic county-wide CAMHS service in a rural, sparsely populated area of England. The main author and researcher is employed in the psychotherapy team within the CAMHS service, which is run by the same NHS Trust across the county. Despite all of the child psychotherapists (both qualified and trainees) working in different geographical locations across the county, regular communication is maintained. This close networking will be utilised for the purposes of this study, as agreed by the lead child psychotherapist.

Inclusion and Exclusion Criteria

All of the participants will have current open referrals to CAMHS and have been referred internally for psychotherapy through another CAMHS professional. They will be of adolescent age range, between the ages of thirteen and eighteen years of age. The young person will have a diagnosis of depression from a CAMHS psychiatrist. However, if this has not occurred but the professional(s) involved with the young person acknowledge they are working with a young person suffering from depressed mood then this is also acceptable. The latter of these can be confirmed through the use of routine outcome measures, namely the revised children's anxiety and depression scale (RCADS), which can indicate clinically significant levels of depression, which is actively used in our services countywide. Young people will not be excluded on the basis of any co-morbid mental health difficulties, or because of the use of medication, nor because of their looked after status. This will allow for any parental figure to take part as well regardless of the caring arrangement. The only criteria for this is that they need to be a primary caregiver for the young person.

Recruitment

Participants for the study will be recruited at point of referral into psychotherapy within CAMHS. At point of recruitment all participants will complete a written consent form. I aim to recruit ten adolescents from across the county as well as ten sets of their primary caregivers, a one year time-frame should allow for this to be achieved. For this one year period (earlier if maximum data set has been achieved), any adolescent referred for psychotherapy for their depression will be asked by the psychotherapist who picks up the referral to meet me for an informal interview, as well as requesting the same from their caregivers. I will prepare a brief information sheet for participants, which I will then distribute to my psychotherapy colleagues in order to hand them to potential participants at point of initial conversation about the study. Participation will be completely voluntary, and it will be made clear that declining to participate will not affect treatment in any way. In order to eliminate bias, any young person I am allocated to work with will not be offered to participate in this study.

Data Collection

The data will be collected through each young person and carer engaging in one interview with the author. Interviews will be semi-structured in nature. This will allow for some structure to engage the young person / caregiver through basic questions such as; when psychological difficulties began, previous support / treatment accessed, time and type of engagement in CAMHS. These questions can then allow for the individual experience to emerge through their reactions (such as intonation, non-verbal cues, language utilised), which can then be further explored by the interviewer with the use of non-structured questions.

These interviews will each be separately recorded, and then transcribed for data analysis. Once all of the interviews have been conducted and transcribed, they will be separated into adolescent data and caregiver data in order to be subjected to qualitative analysis separately.

Data Analysis

The data this study endeavours to collect humanistic, experiential data. This means that any form of quantitative data collection or analysis would not adequately meet the aims of the study. Qualitative data analysis would most effectively and naturally suit the humanistic interview data to be collected.

In terms of specific qualitative analysis, the author will utilise interpretive phenomenological analysis (IPA). The author has selected this methodology as it is felt that it is most suited to the data set, and what kind of data is to be gathered, namely understanding the individual experience of the adolescents and their caregivers. This methodology would allow for the natural experience or phenomena to emerge from the data, as opposed to attempting to extract a theory from the data such as with a grounded theory methodology (Langdridge and Hagger-Johnson, 2013). IPA would allow for the individual perspective to emerge without the shadow of answering a clinical question (e.g. clinical effectiveness, a comparison, etc), but producing phenomenological data pertaining to the exploration of their treatment journeys into CAMHS.

The removal of the potential influence of the author as the therapist for the adolescent / caregiver removes potential to bias the data. In order to attain as unbiased phenomenological analysis as possible, the author will need to be aware of their own feelings on various perspectives of working within the same service as is providing treatment to these individuals, and be mindful this may influence my interpretations.

For example, their own feelings regarding working for the NHS in its current state, as well as how that permeates into this service. Being mindful of this will hopefully minimise any potential unconscious collusion or opposition to grievances and praises within each individual perspective.

Once analysis has been completed, each data set will be written up as two separate pieces of work but will both inform the research question from two separate but complementary perspectives.

Strengths and Limitations

The main strength of the study is that it will give voice to naturalistic, human experience that could not be achieved through major studies of clinical effectiveness such as randomised controlled trials. It will also give an unbiased voice to experiences of treatment that will be of great value in today's pressured health service, which could influence future treatment pathways both internally within CAMHS and externally.

These points are also the study's limitations. It does not aim to provide any information relating to treatment efficacy, or to directly contribute to any service development or evaluation. The experiences of the participants of this study will be predominantly white British (due to the demographic of the county), which can limit its generalisability, but hopefully the results could be generalisable in other aspects; looked after status for example.

Ethics

The study will be undertaken within the service I currently work for, which already conducts regular research within the service itself. My NHS Trust has its own research governance policy which I will use as a guide, as well as consulting with the Trust's research and development team. I have already spoken with both the service's lead child psychotherapist and the clinical lead for adolescent depression, both of whom are supportive of this study.

In terms of the participants, as the data will be collected data from NHS clients specifically for the use of research then ethical approval will need to be sought from my NHS Trust's research ethics committee, and if needed from my academic NHS Trust.

In terms of ethical dilemmas occurring during this study, as all participants will be current referrals within CAMHS and none of them will be treated by the author, I do not envisage significant dilemmas. If any participant would have been previously seen by the author, they would also need to be excluded from participation due to the bias involved in the author interviewing them but also being a direct influence on their treatment journey.

If any participant has any specific complaints or concerns regarding their past treatment then they would be directed in two ways. If their complaint did not involve any safeguarding concerns, then they would be encouraged to make a formal complaint to the trust's complaints department, or the relevant agency whom they received support / treatment from previously. If there was a safeguarding concern that had not been previously disclosed, then the author would make a safeguarding referral immediately following the interview, which the participant would be informed of. In the event of a participant wishing to complain about anything relating to this study, they would be directed to the author's research supervisor in the first instance. This information will be made clear on the information sheet handed to potential participants prior to engagement in the study.

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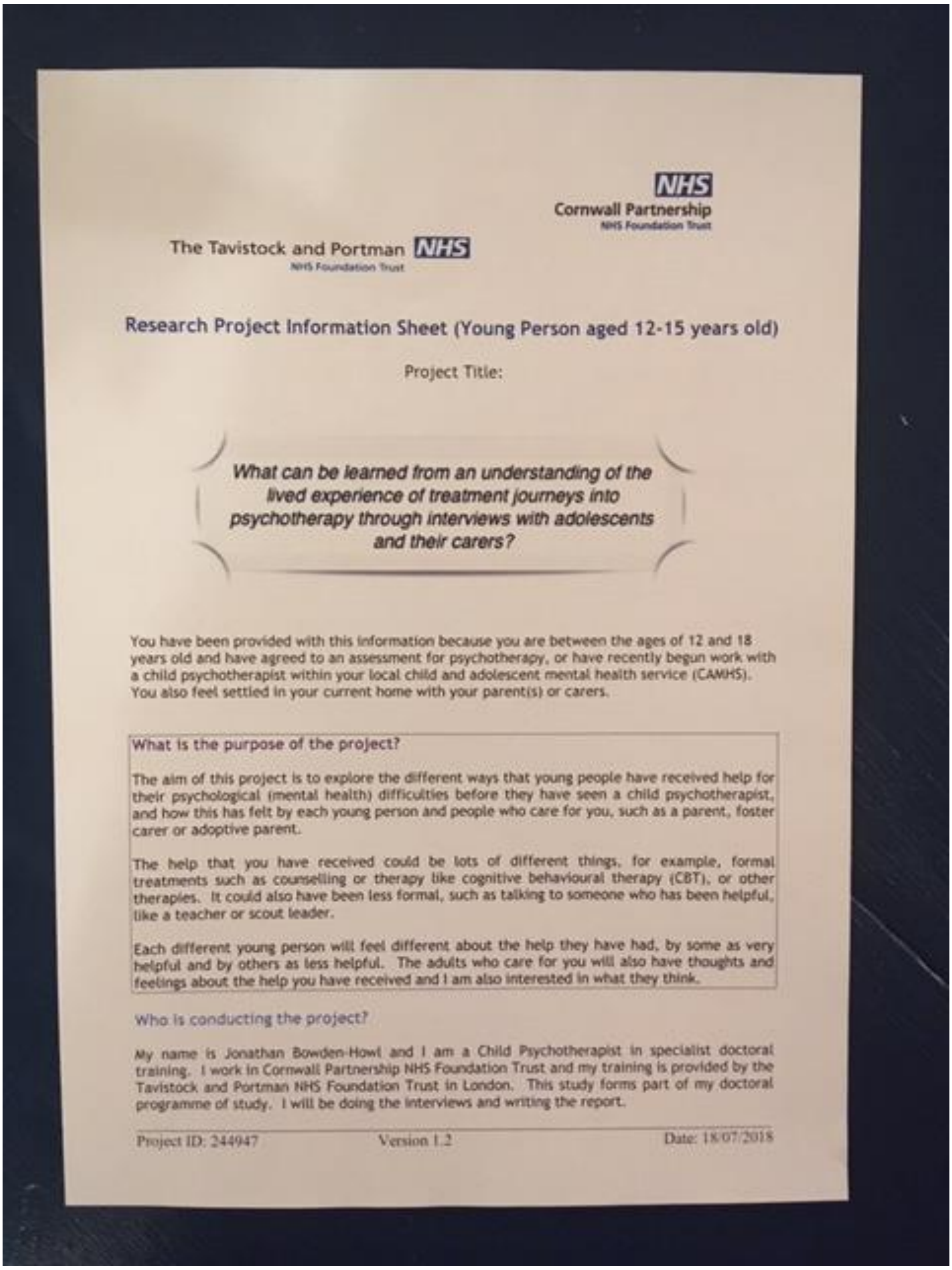
Appendix 3 - Public Facing Documentation

Information Sheet for Young People between 12 and 15 years of age:



NHS
Cornwall Partnership
NHS Foundation Trust

The Tavistock and Portman NHS
NHS Foundation Trust

Research Project Information Sheet (Young Person aged 12-15 years old)

Project Title:

What can be learned from an understanding of the lived experience of treatment journeys into psychotherapy through interviews with adolescents and their carers?

You have been provided with this information because you are between the ages of 12 and 18 years old and have agreed to an assessment for psychotherapy, or have recently begun work with a child psychotherapist within your local child and adolescent mental health service (CAMHS). You also feel settled in your current home with your parent(s) or carers.

What is the purpose of the project?

The aim of this project is to explore the different ways that young people have received help for their psychological (mental health) difficulties before they have seen a child psychotherapist, and how this has felt by each young person and people who care for you, such as a parent, foster carer or adoptive parent.

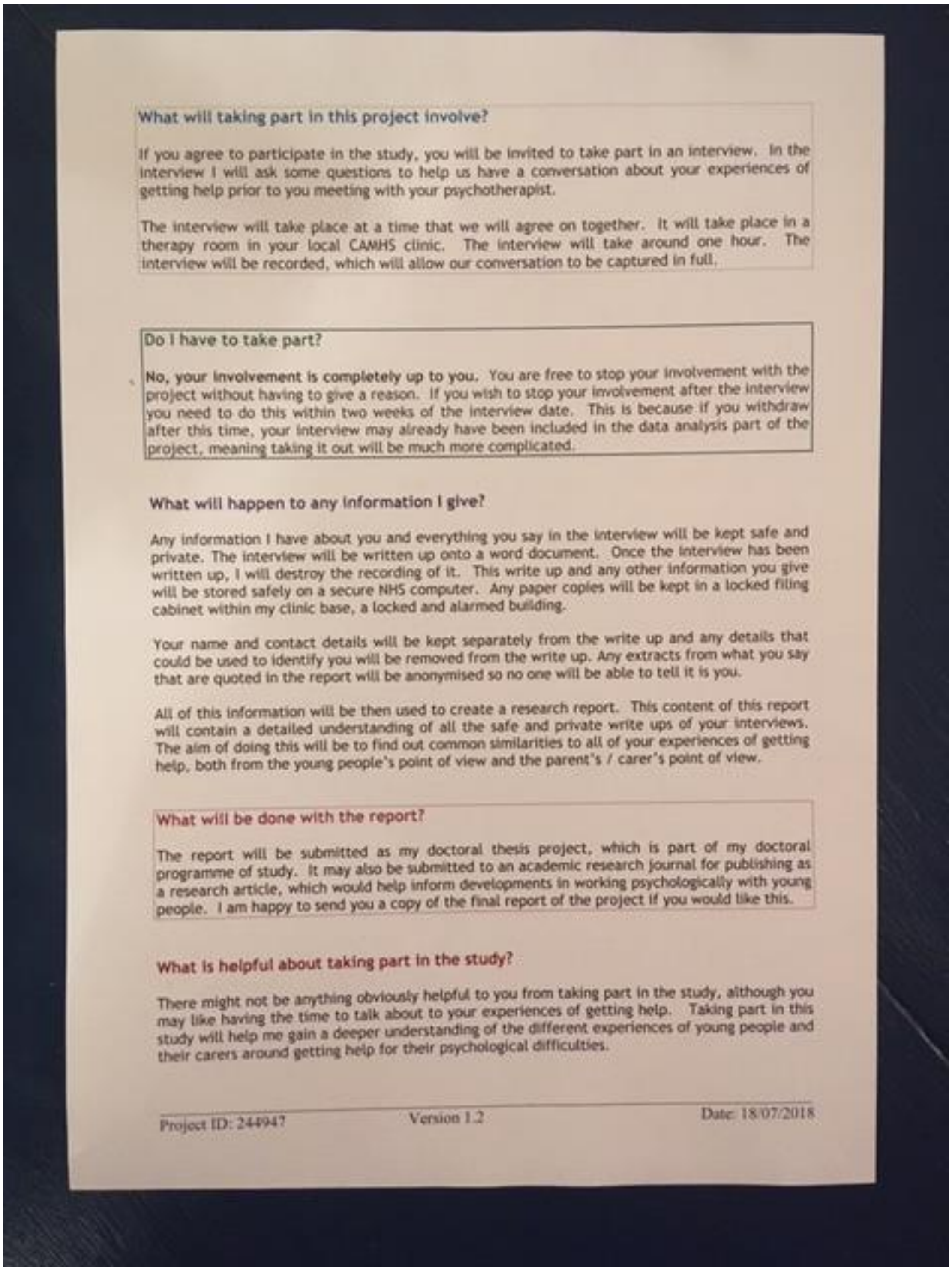
The help that you have received could be lots of different things, for example, formal treatments such as counselling or therapy like cognitive behavioural therapy (CBT), or other therapies. It could also have been less formal, such as talking to someone who has been helpful, like a teacher or scout leader.

Each different young person will feel different about the help they have had, by some as very helpful and by others as less helpful. The adults who care for you will also have thoughts and feelings about the help you have received and I am also interested in what they think.

Who is conducting the project?

My name is Jonathan Bowden-Howl and I am a Child Psychotherapist in specialist doctoral training. I work in Cornwall Partnership NHS Foundation Trust and my training is provided by the Tavistock and Portman NHS Foundation Trust in London. This study forms part of my doctoral programme of study. I will be doing the interviews and writing the report.

Project ID: 244947 Version 1.2 Date: 18/07/2018



What will taking part in this project involve?

If you agree to participate in the study, you will be invited to take part in an interview. In the interview I will ask some questions to help us have a conversation about your experiences of getting help prior to you meeting with your psychotherapist.

The interview will take place at a time that we will agree on together. It will take place in a therapy room in your local CAMHS clinic. The interview will take around one hour. The interview will be recorded, which will allow our conversation to be captured in full.

Do I have to take part?

No, your involvement is completely up to you. You are free to stop your involvement with the project without having to give a reason. If you wish to stop your involvement after the interview you need to do this within two weeks of the interview date. This is because if you withdraw after this time, your interview may already have been included in the data analysis part of the project, meaning taking it out will be much more complicated.

What will happen to any information I give?

Any information I have about you and everything you say in the interview will be kept safe and private. The interview will be written up onto a word document. Once the interview has been written up, I will destroy the recording of it. This write up and any other information you give will be stored safely on a secure NHS computer. Any paper copies will be kept in a locked filing cabinet within my clinic base, a locked and alarmed building.

Your name and contact details will be kept separately from the write up and any details that could be used to identify you will be removed from the write up. Any extracts from what you say that are quoted in the report will be anonymised so no one will be able to tell it is you.

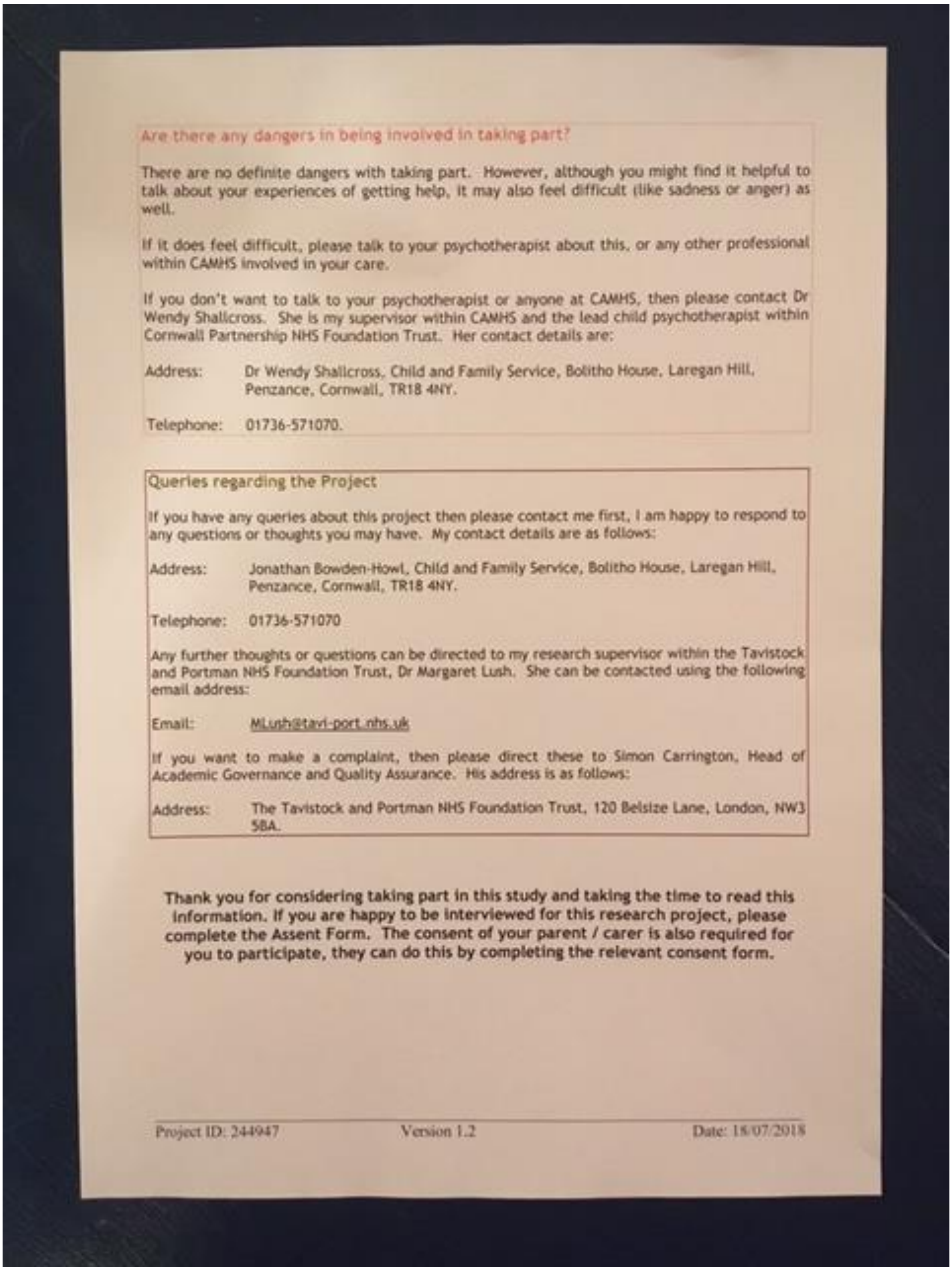
All of this information will be then used to create a research report. This content of this report will contain a detailed understanding of all the safe and private write ups of your interviews. The aim of doing this will be to find out common similarities to all of your experiences of getting help, both from the young people's point of view and the parent's / carer's point of view.

What will be done with the report?

The report will be submitted as my doctoral thesis project, which is part of my doctoral programme of study. It may also be submitted to an academic research journal for publishing as a research article, which would help inform developments in working psychologically with young people. I am happy to send you a copy of the final report of the project if you would like this.

What is helpful about taking part in the study?

There might not be anything obviously helpful to you from taking part in the study, although you may like having the time to talk about to your experiences of getting help. Taking part in this study will help me gain a deeper understanding of the different experiences of young people and their carers around getting help for their psychological difficulties.



Are there any dangers in being involved in taking part?

There are no definite dangers with taking part. However, although you might find it helpful to talk about your experiences of getting help, it may also feel difficult (like sadness or anger) as well.

If it does feel difficult, please talk to your psychotherapist about this, or any other professional within CAMHS involved in your care.

If you don't want to talk to your psychotherapist or anyone at CAMHS, then please contact Dr Wendy Shallcross. She is my supervisor within CAMHS and the lead child psychotherapist within Cornwall Partnership NHS Foundation Trust. Her contact details are:

Address: Dr Wendy Shallcross, Child and Family Service, Bolitho House, Laregan Hill,
Penzance, Cornwall, TR18 4NY.

Telephone: 01736-571070.

Queries regarding the Project

If you have any queries about this project then please contact me first, I am happy to respond to any questions or thoughts you may have. My contact details are as follows:

Address: Jonathan Bowden-Howl, Child and Family Service, Bolitho House, Laregan Hill,
Penzance, Cornwall, TR18 4NY.

Telephone: 01736-571070

Any further thoughts or questions can be directed to my research supervisor within the Tavistock and Portman NHS Foundation Trust, Dr Margaret Lush. She can be contacted using the following email address:

Email: MLush@tavi-port.nhs.uk

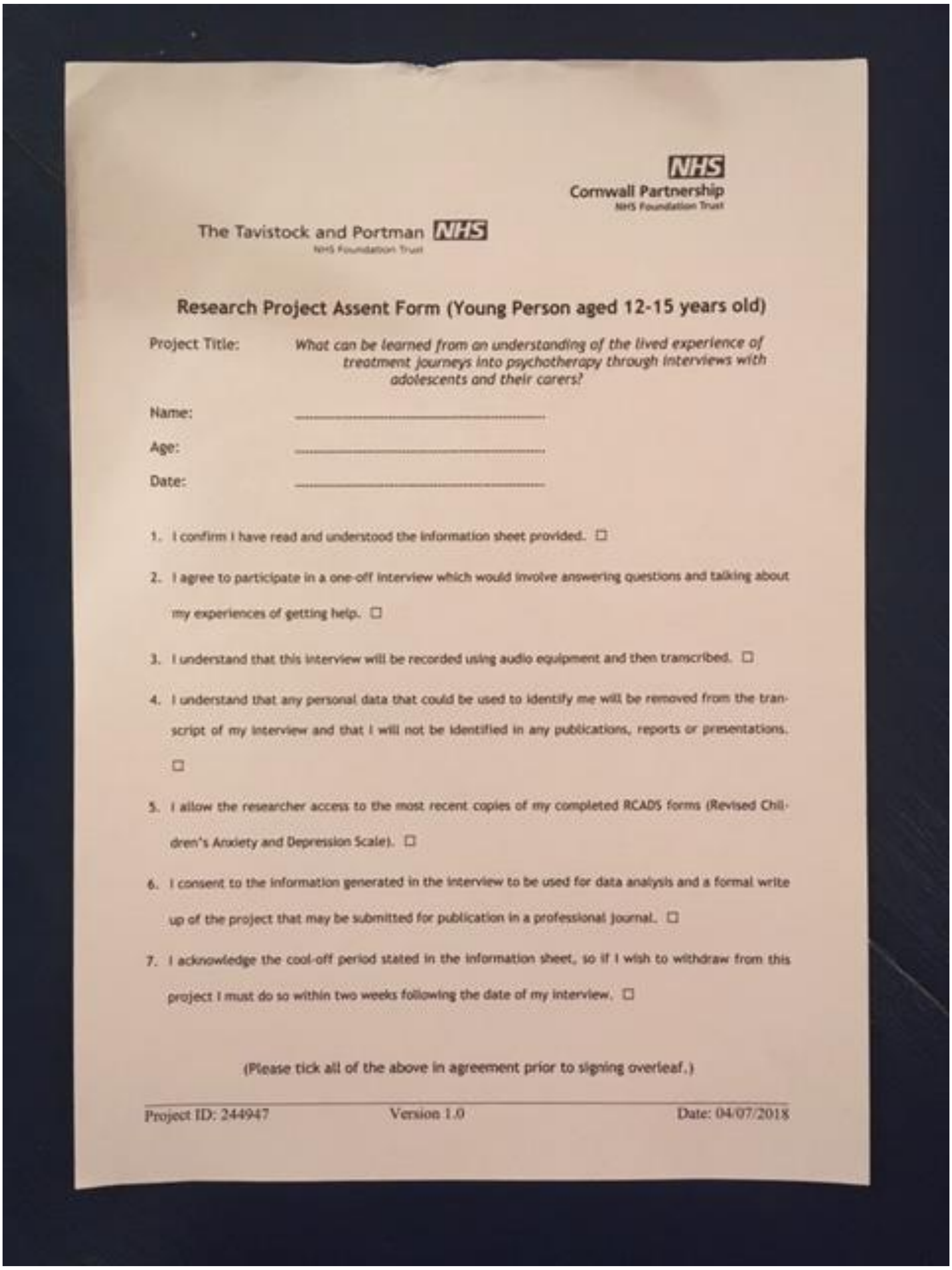
If you want to make a complaint, then please direct these to Simon Carrington, Head of Academic Governance and Quality Assurance. His address is as follows:

Address: The Tavistock and Portman NHS Foundation Trust, 120 Belsize Lane, London, NW3
5BA.

Thank you for considering taking part in this study and taking the time to read this information. If you are happy to be interviewed for this research project, please complete the Assent Form. The consent of your parent / carer is also required for you to participate, they can do this by completing the relevant consent form.

Project ID: 244947 Version 1.2 Date: 18/07/2018

Assent Form for Young People between 12 and 15 years of age:



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NHS Foundation Trust

The Tavistock and Portman NHS
NHS Foundation Trust

Research Project Assent Form (Young Person aged 12-15 years old)

Project Title: *What can be learned from an understanding of the lived experience of treatment journeys into psychotherapy through interviews with adolescents and their carers?*

Name: ……………………………………

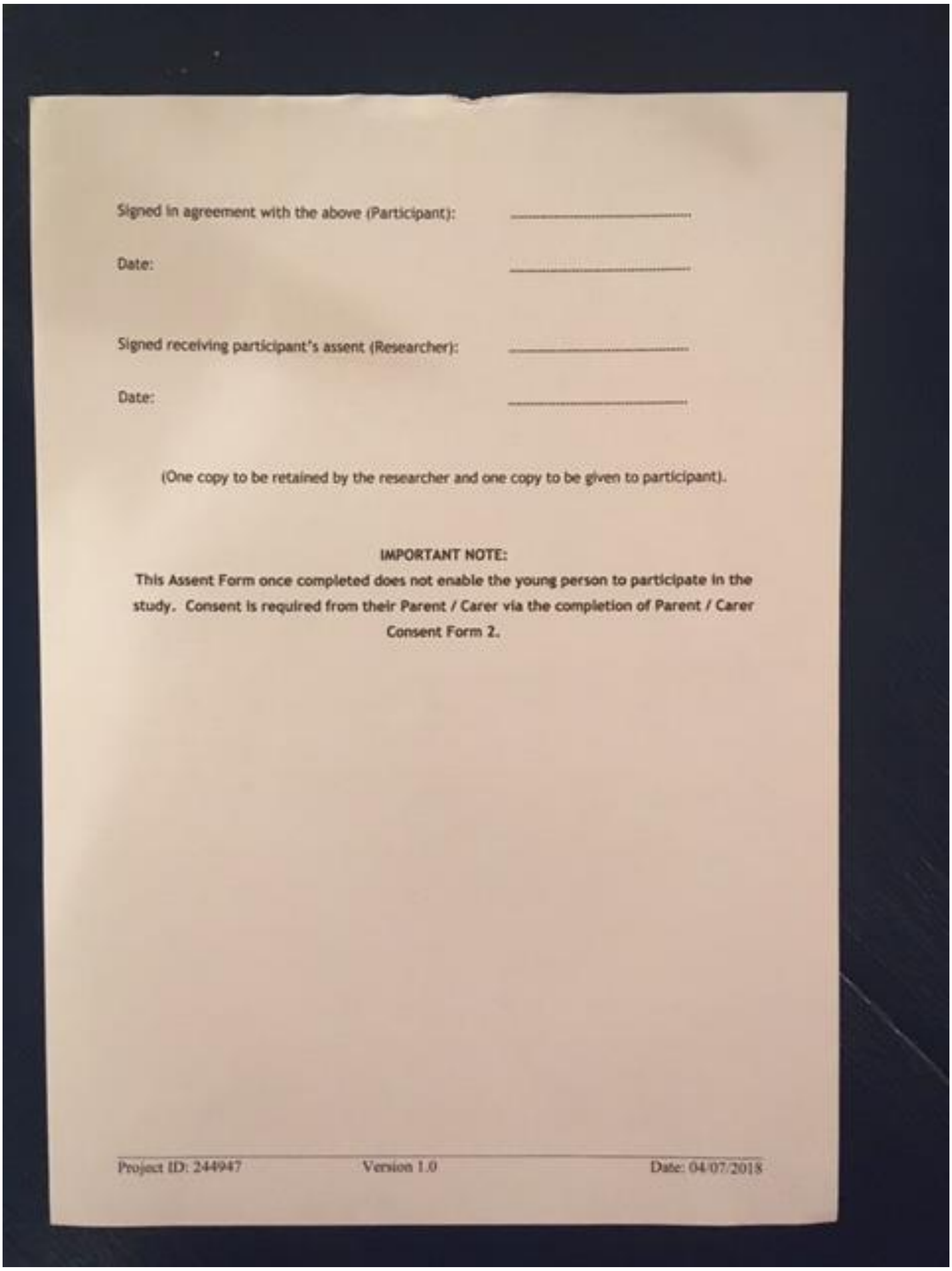
Age: ……………………………………

Date: ……………………………………

1. I confirm I have read and understood the information sheet provided. ☐
2. I agree to participate in a one-off interview which would involve answering questions and talking about my experiences of getting help. ☐
3. I understand that this interview will be recorded using audio equipment and then transcribed. ☐
4. I understand that any personal data that could be used to identify me will be removed from the transcript of my interview and that I will not be identified in any publications, reports or presentations. ☐
5. I allow the researcher access to the most recent copies of my completed RCADS forms (Revised Children's Anxiety and Depression Scale). ☐
6. I consent to the information generated in the interview to be used for data analysis and a formal write up of the project that may be submitted for publication in a professional journal. ☐
7. I acknowledge the cool-off period stated in the information sheet, so if I wish to withdraw from this project I must do so within two weeks following the date of my interview. ☐

(Please tick all of the above in agreement prior to signing overleaf.)

Project ID: 244947 Version 1.0 Date: 04/07/2018



Signed in agreement with the above (Participant): ....

Date: ....

Signed receiving participant's assent (Researcher): ....

Date: ....

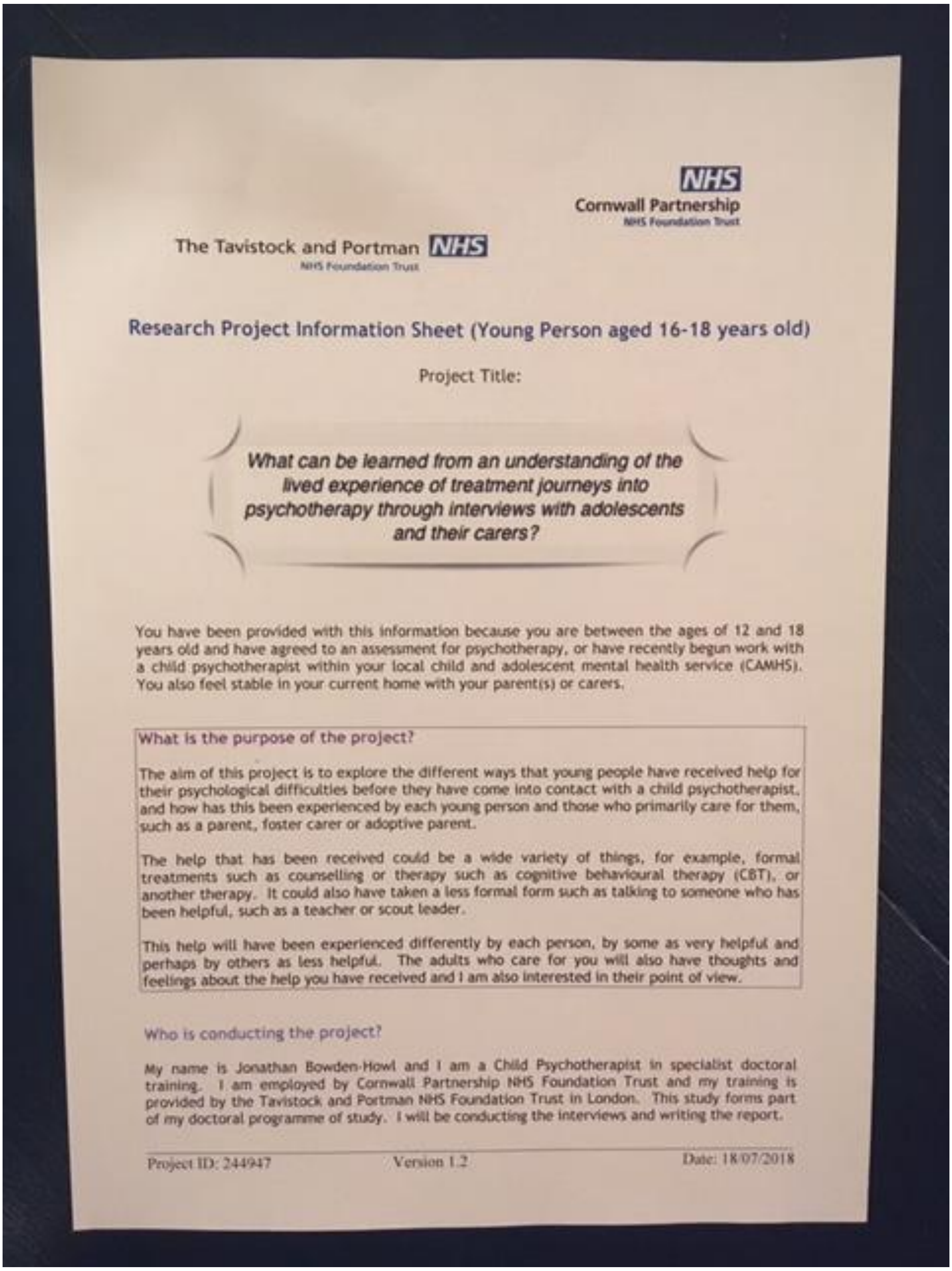
(One copy to be retained by the researcher and one copy to be given to participant).

IMPORTANT NOTE:

This Assent Form once completed does not enable the young person to participate in the study. Consent is required from their Parent / Carer via the completion of Parent / Carer Consent Form 2.

Project ID: 244947 Version 1.0 Date: 04/07/2018

Information Sheet for Young People between 16 and 18 years of age:



NHS
Cornwall Partnership
NHS Foundation Trust

The Tavistock and Portman NHS
NHS Foundation Trust

Research Project Information Sheet (Young Person aged 16-18 years old)

Project Title:

What can be learned from an understanding of the lived experience of treatment journeys into psychotherapy through interviews with adolescents and their carers?

You have been provided with this information because you are between the ages of 12 and 18 years old and have agreed to an assessment for psychotherapy, or have recently begun work with a child psychotherapist within your local child and adolescent mental health service (CAMHS). You also feel stable in your current home with your parent(s) or carers.

What is the purpose of the project?

The aim of this project is to explore the different ways that young people have received help for their psychological difficulties before they have come into contact with a child psychotherapist, and how has this been experienced by each young person and those who primarily care for them, such as a parent, foster carer or adoptive parent.

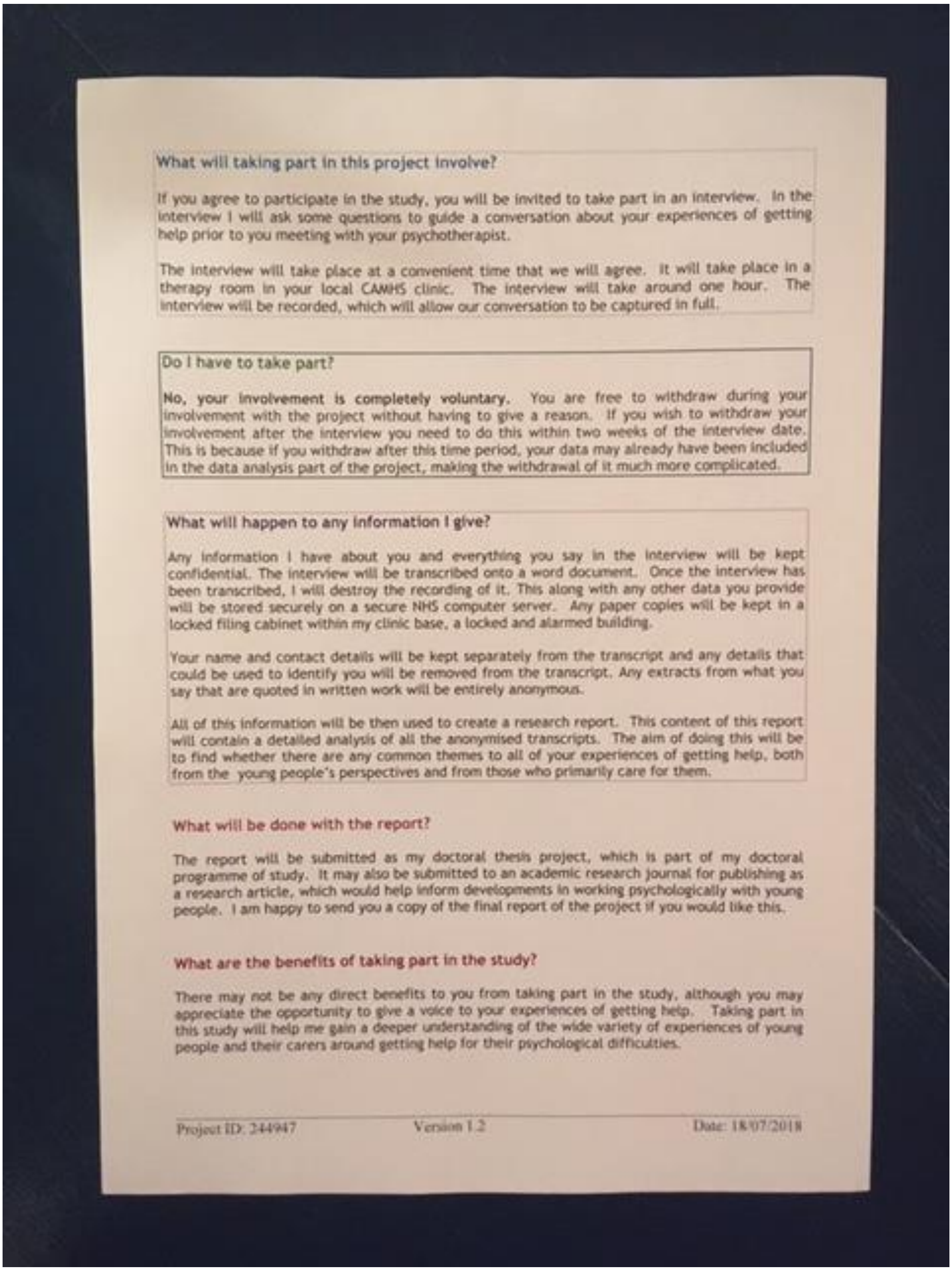
The help that has been received could be a wide variety of things, for example, formal treatments such as counselling or therapy such as cognitive behavioural therapy (CBT), or another therapy. It could also have taken a less formal form such as talking to someone who has been helpful, such as a teacher or scout leader.

This help will have been experienced differently by each person, by some as very helpful and perhaps by others as less helpful. The adults who care for you will also have thoughts and feelings about the help you have received and I am also interested in their point of view.

Who is conducting the project?

My name is Jonathan Bowden-Howl and I am a Child Psychotherapist in specialist doctoral training. I am employed by Cornwall Partnership NHS Foundation Trust and my training is provided by the Tavistock and Portman NHS Foundation Trust in London. This study forms part of my doctoral programme of study. I will be conducting the interviews and writing the report.

Project ID: 244947 Version 1.2 Date: 18/07/2018



What will taking part in this project involve?

If you agree to participate in the study, you will be invited to take part in an interview. In the interview I will ask some questions to guide a conversation about your experiences of getting help prior to you meeting with your psychotherapist.

The interview will take place at a convenient time that we will agree. It will take place in a therapy room in your local CAMHS clinic. The interview will take around one hour. The interview will be recorded, which will allow our conversation to be captured in full.

Do I have to take part?

No, your involvement is completely voluntary. You are free to withdraw during your involvement with the project without having to give a reason. If you wish to withdraw your involvement after the interview you need to do this within two weeks of the interview date. This is because if you withdraw after this time period, your data may already have been included in the data analysis part of the project, making the withdrawal of it much more complicated.

What will happen to any information I give?

Any information I have about you and everything you say in the interview will be kept confidential. The interview will be transcribed onto a word document. Once the interview has been transcribed, I will destroy the recording of it. This along with any other data you provide will be stored securely on a secure NHS computer server. Any paper copies will be kept in a locked filing cabinet within my clinic base, a locked and alarmed building.

Your name and contact details will be kept separately from the transcript and any details that could be used to identify you will be removed from the transcript. Any extracts from what you say that are quoted in written work will be entirely anonymous.

All of this information will be then used to create a research report. This content of this report will contain a detailed analysis of all the anonymised transcripts. The aim of doing this will be to find whether there are any common themes to all of your experiences of getting help, both from the young people's perspectives and from those who primarily care for them.

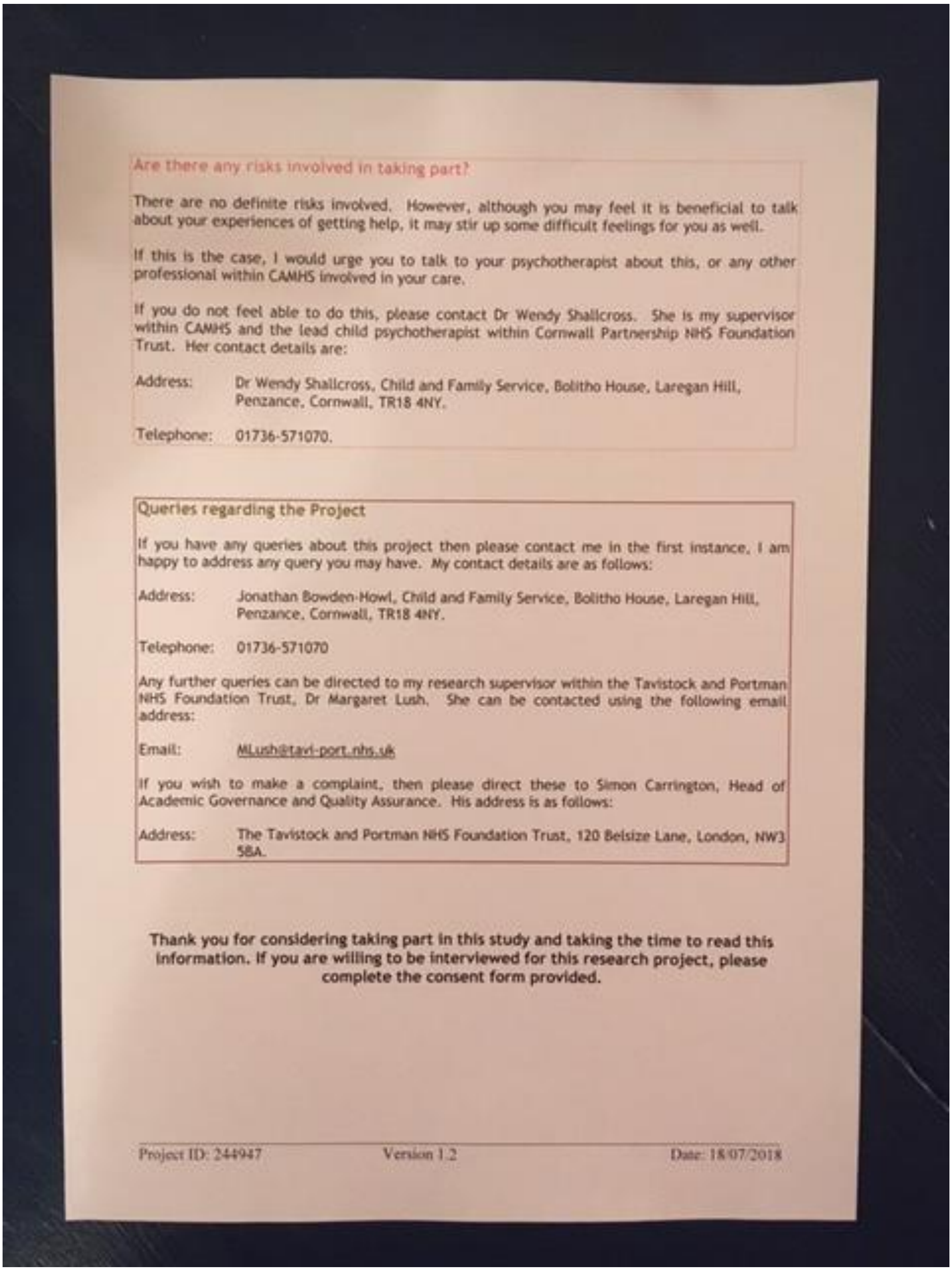
What will be done with the report?

The report will be submitted as my doctoral thesis project, which is part of my doctoral programme of study. It may also be submitted to an academic research journal for publishing as a research article, which would help inform developments in working psychologically with young people. I am happy to send you a copy of the final report of the project if you would like this.

What are the benefits of taking part in the study?

There may not be any direct benefits to you from taking part in the study, although you may appreciate the opportunity to give a voice to your experiences of getting help. Taking part in this study will help me gain a deeper understanding of the wide variety of experiences of young people and their carers around getting help for their psychological difficulties.

Project ID: 244947 Version 1.2 Date: 18/07/2018



Are there any risks involved in taking part?

There are no definite risks involved. However, although you may feel it is beneficial to talk about your experiences of getting help, it may stir up some difficult feelings for you as well.

If this is the case, I would urge you to talk to your psychotherapist about this, or any other professional within CAMHS involved in your care.

If you do not feel able to do this, please contact Dr Wendy Shallcross. She is my supervisor within CAMHS and the lead child psychotherapist within Cornwall Partnership NHS Foundation Trust. Her contact details are:

Address: Dr Wendy Shallcross, Child and Family Service, Bolitho House, Laregan Hill,
Penzance, Cornwall, TR18 4NY.

Telephone: 01736-571070.

Queries regarding the Project

If you have any queries about this project then please contact me in the first instance, I am happy to address any query you may have. My contact details are as follows:

Address: Jonathan Bowden-Howl, Child and Family Service, Bolitho House, Laregan Hill,
Penzance, Cornwall, TR18 4NY.

Telephone: 01736-571070

Any further queries can be directed to my research supervisor within the Tavistock and Portman NHS Foundation Trust, Dr Margaret Lush. She can be contacted using the following email address:

Email: MLush@tavi-port.nhs.uk

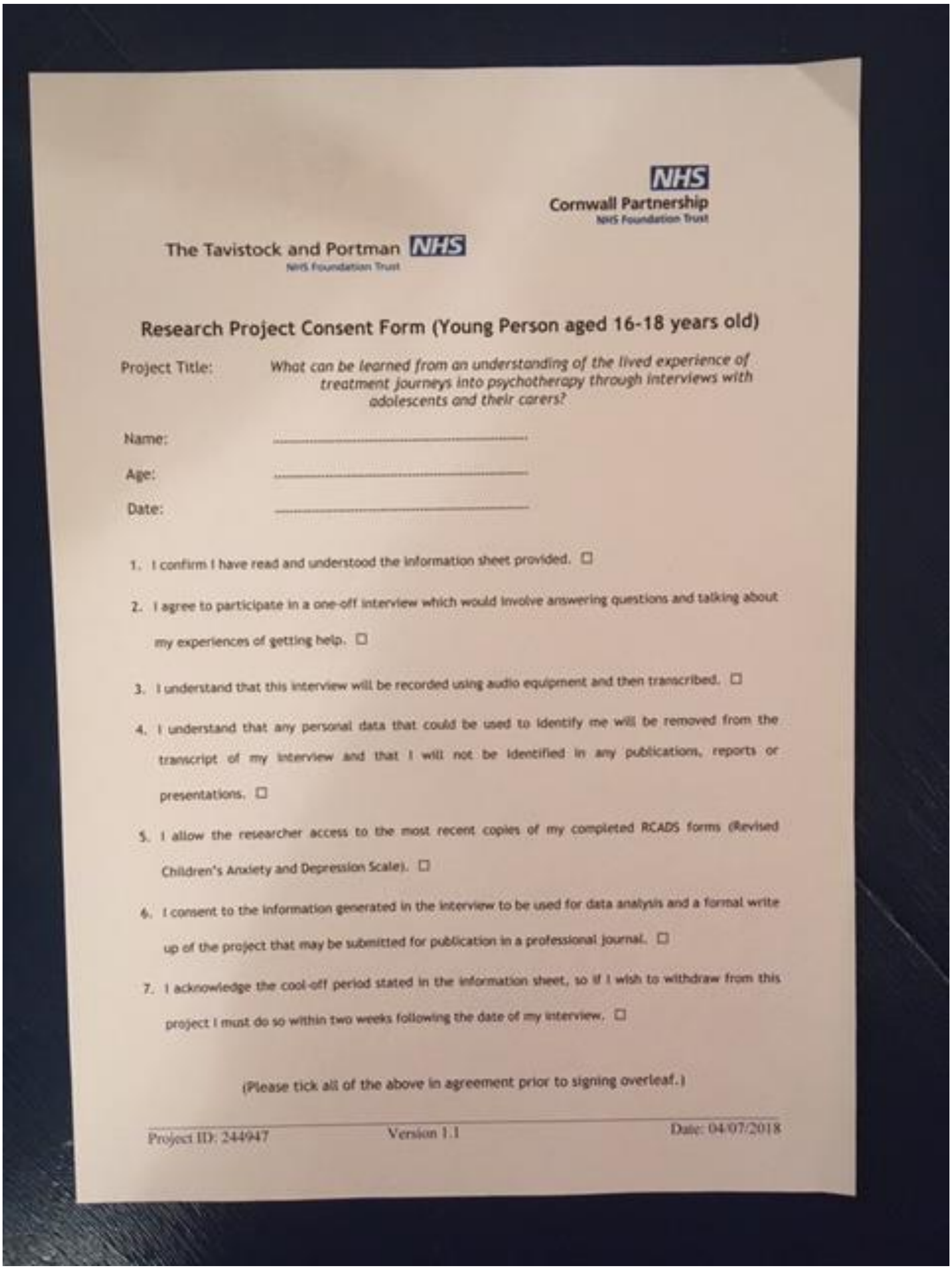
If you wish to make a complaint, then please direct these to Simon Carrington, Head of Academic Governance and Quality Assurance. His address is as follows:

Address: The Tavistock and Portman NHS Foundation Trust, 120 Belsize Lane, London, NW3
5BA.

Thank you for considering taking part in this study and taking the time to read this information. If you are willing to be interviewed for this research project, please complete the consent form provided.

Project ID: 244947 Version 1.2 Date: 18/07/2018

Consent Form for Young People between 16 and 18 years of age:



NHS
Cornwall Partnership
NHS Foundation Trust

The Tavistock and Portman NHS
NHS Foundation Trust

Research Project Consent Form (Young Person aged 16-18 years old)

Project Title: *What can be learned from an understanding of the lived experience of treatment journeys into psychotherapy through interviews with adolescents and their carers?*

Name: ……………………………………………

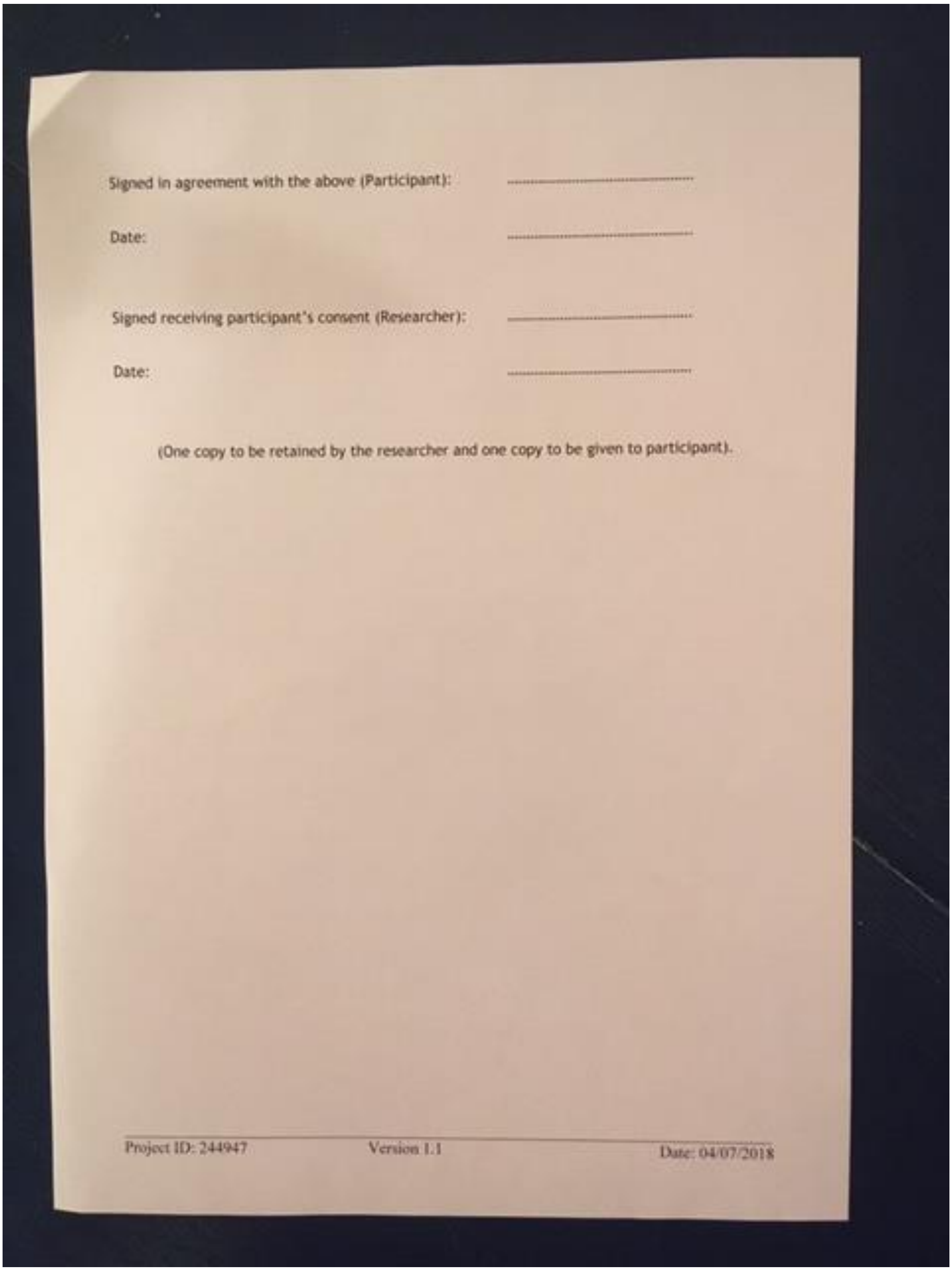
Age: ……………………………………………

Date: ……………………………………………

1. I confirm I have read and understood the information sheet provided. ☐
2. I agree to participate in a one-off interview which would involve answering questions and talking about my experiences of getting help. ☐
3. I understand that this interview will be recorded using audio equipment and then transcribed. ☐
4. I understand that any personal data that could be used to identify me will be removed from the transcript of my interview and that I will not be identified in any publications, reports or presentations. ☐
5. I allow the researcher access to the most recent copies of my completed RCADS forms (Revised Children's Anxiety and Depression Scale). ☐
6. I consent to the information generated in the interview to be used for data analysis and a formal write up of the project that may be submitted for publication in a professional journal. ☐
7. I acknowledge the cool-off period stated in the information sheet, so if I wish to withdraw from this project I must do so within two weeks following the date of my interview. ☐

(Please tick all of the above in agreement prior to signing overleaf.)

Project ID: 244947 Version 1.1 Date: 04/07/2018



Signed in agreement with the above (Participant): ....

Date: ....

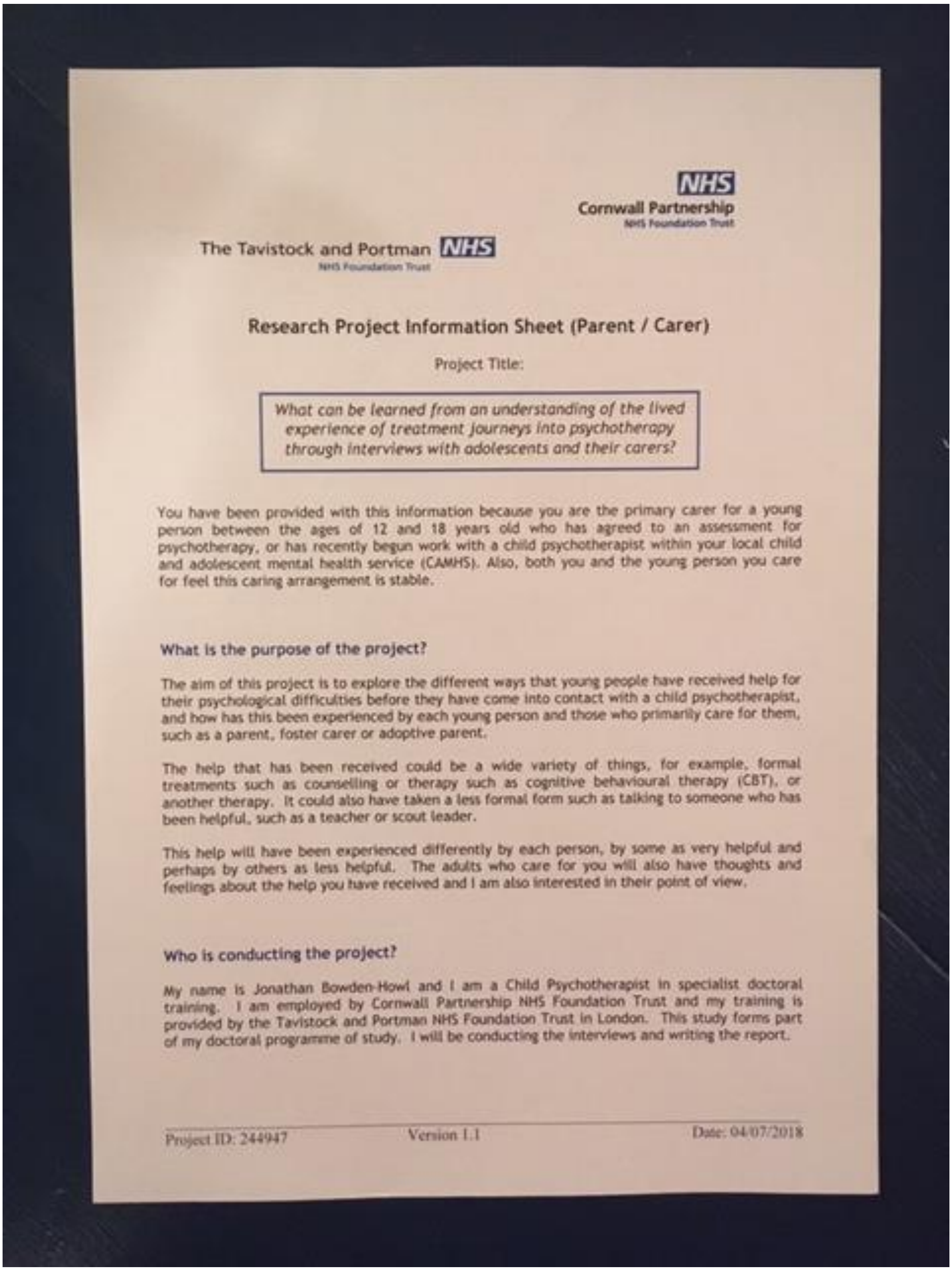
Signed receiving participant's consent (Researcher): ....

Date: ....

(One copy to be retained by the researcher and one copy to be given to participant).

Project ID: 244947 Version 1.1 Date: 04/07/2018

Information Sheet for Parents and Carers:



NHS
Cornwall Partnership
NHS Foundation Trust

The Tavistock and Portman NHS
NHS Foundation Trust

Research Project Information Sheet (Parent / Carer)

Project Title:

What can be learned from an understanding of the lived experience of treatment journeys into psychotherapy through interviews with adolescents and their carers?

You have been provided with this information because you are the primary carer for a young person between the ages of 12 and 18 years old who has agreed to an assessment for psychotherapy, or has recently begun work with a child psychotherapist within your local child and adolescent mental health service (CAMHS). Also, both you and the young person you care for feel this caring arrangement is stable.

What is the purpose of the project?

The aim of this project is to explore the different ways that young people have received help for their psychological difficulties before they have come into contact with a child psychotherapist, and how has this been experienced by each young person and those who primarily care for them, such as a parent, foster carer or adoptive parent.

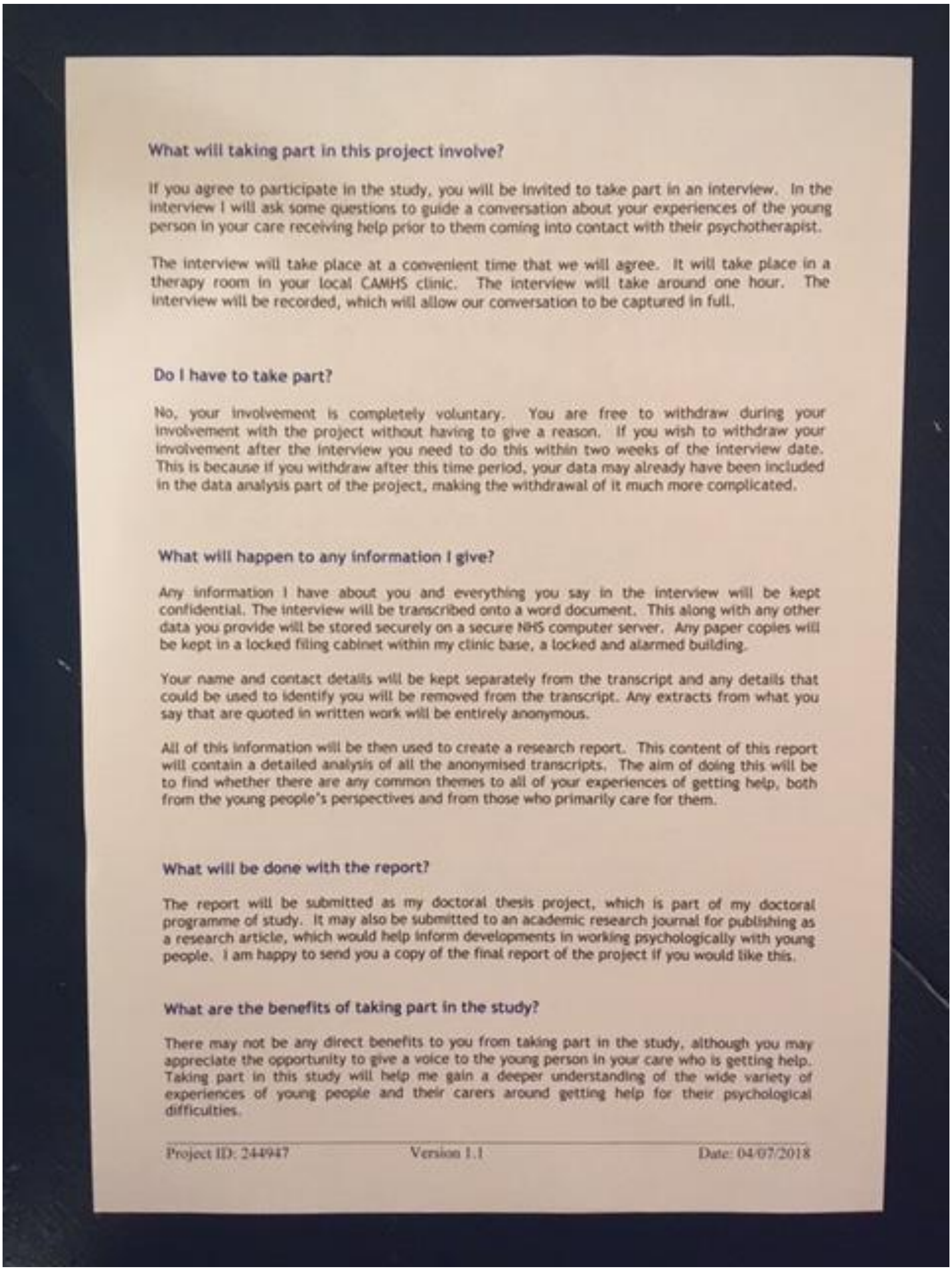
The help that has been received could be a wide variety of things, for example, formal treatments such as counselling or therapy such as cognitive behavioural therapy (CBT), or another therapy. It could also have taken a less formal form such as talking to someone who has been helpful, such as a teacher or scout leader.

This help will have been experienced differently by each person, by some as very helpful and perhaps by others as less helpful. The adults who care for you will also have thoughts and feelings about the help you have received and I am also interested in their point of view.

Who is conducting the project?

My name is Jonathan Bowden-Howl and I am a Child Psychotherapist in specialist doctoral training. I am employed by Cornwall Partnership NHS Foundation Trust and my training is provided by the Tavistock and Portman NHS Foundation Trust in London. This study forms part of my doctoral programme of study. I will be conducting the interviews and writing the report.

Project ID: 244947 Version 1.1 Date: 04/07/2018



What will taking part in this project involve?

If you agree to participate in the study, you will be invited to take part in an interview. In the interview I will ask some questions to guide a conversation about your experiences of the young person in your care receiving help prior to them coming into contact with their psychotherapist.

The interview will take place at a convenient time that we will agree. It will take place in a therapy room in your local CAMHS clinic. The interview will take around one hour. The interview will be recorded, which will allow our conversation to be captured in full.

Do I have to take part?

No, your involvement is completely voluntary. You are free to withdraw during your involvement with the project without having to give a reason. If you wish to withdraw your involvement after the interview you need to do this within two weeks of the interview date. This is because if you withdraw after this time period, your data may already have been included in the data analysis part of the project, making the withdrawal of it much more complicated.

What will happen to any information I give?

Any information I have about you and everything you say in the interview will be kept confidential. The interview will be transcribed onto a word document. This along with any other data you provide will be stored securely on a secure NHS computer server. Any paper copies will be kept in a locked filing cabinet within my clinic base, a locked and alarmed building.

Your name and contact details will be kept separately from the transcript and any details that could be used to identify you will be removed from the transcript. Any extracts from what you say that are quoted in written work will be entirely anonymous.

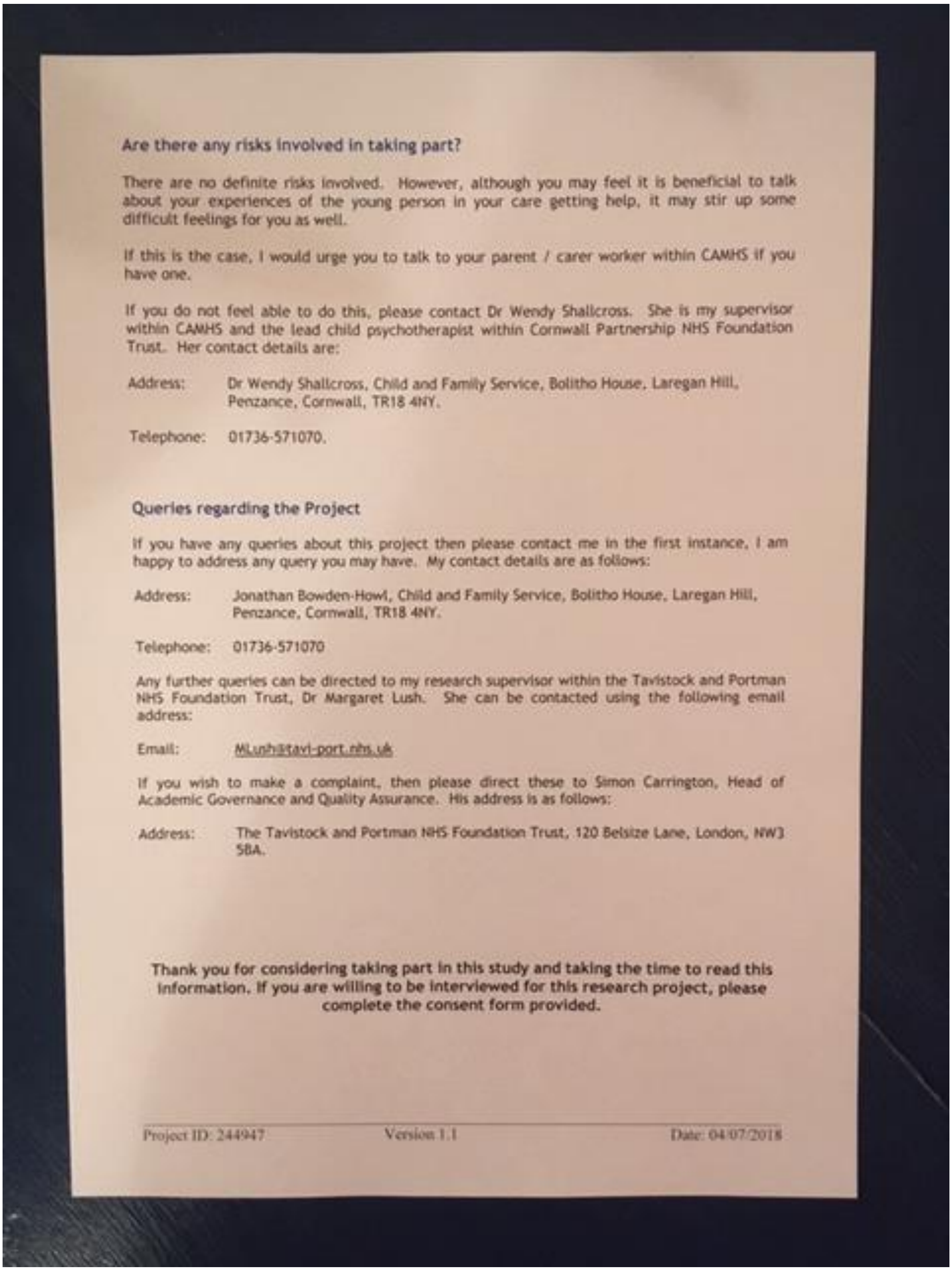
All of this information will be then used to create a research report. This content of this report will contain a detailed analysis of all the anonymised transcripts. The aim of doing this will be to find whether there are any common themes to all of your experiences of getting help, both from the young people's perspectives and from those who primarily care for them.

What will be done with the report?

The report will be submitted as my doctoral thesis project, which is part of my doctoral programme of study. It may also be submitted to an academic research journal for publishing as a research article, which would help inform developments in working psychologically with young people. I am happy to send you a copy of the final report of the project if you would like this.

What are the benefits of taking part in the study?

There may not be any direct benefits to you from taking part in the study, although you may appreciate the opportunity to give a voice to the young person in your care who is getting help. Taking part in this study will help me gain a deeper understanding of the wide variety of experiences of young people and their carers around getting help for their psychological difficulties.



Are there any risks involved in taking part?

There are no definite risks involved. However, although you may feel it is beneficial to talk about your experiences of the young person in your care getting help, it may stir up some difficult feelings for you as well.

If this is the case, I would urge you to talk to your parent / carer worker within CAMHS if you have one.

If you do not feel able to do this, please contact Dr Wendy Shallcross. She is my supervisor within CAMHS and the lead child psychotherapist within Cornwall Partnership NHS Foundation Trust. Her contact details are:

Address: Dr Wendy Shallcross, Child and Family Service, Bolitho House, Laregan Hill,
Penzance, Cornwall, TR18 4NY.

Telephone: 01736-571070.

Queries regarding the Project

If you have any queries about this project then please contact me in the first instance, I am happy to address any query you may have. My contact details are as follows:

Address: Jonathan Bowden-Howl, Child and Family Service, Bolitho House, Laregan Hill,
Penzance, Cornwall, TR18 4NY.

Telephone: 01736-571070

Any further queries can be directed to my research supervisor within the Tavistock and Portman NHS Foundation Trust, Dr Margaret Lush. She can be contacted using the following email address:

Email: MLush@tavi-port.nhs.uk

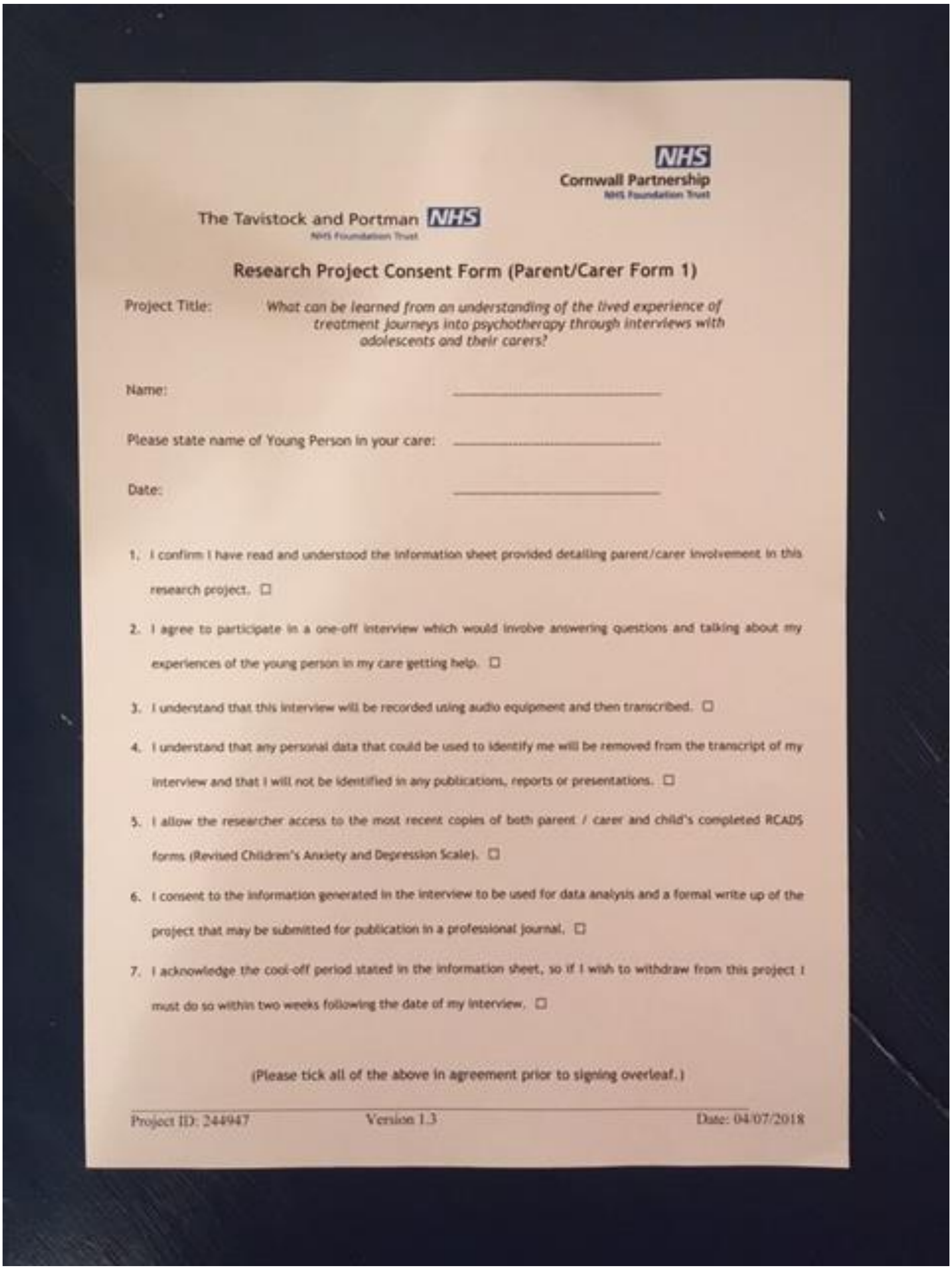
If you wish to make a complaint, then please direct these to Simon Carrington, Head of Academic Governance and Quality Assurance. His address is as follows:

Address: The Tavistock and Portman NHS Foundation Trust, 120 Belsize Lane, London, NW3 5BA.

Thank you for considering taking part in this study and taking the time to read this information. If you are willing to be interviewed for this research project, please complete the consent form provided.

Project ID: 244947 Version 1.1 Date: 04/07/2018

Consent Form 1 for Parents and Carers:



NHS
Cornwall Partnership
NHS Foundation Trust

The Tavistock and Portman NHS
NHS Foundation Trust

Research Project Consent Form (Parent/Carer Form 1)

Project Title: *What can be learned from an understanding of the lived experience of treatment journeys into psychotherapy through interviews with adolescents and their carers?*

Name: ______________________

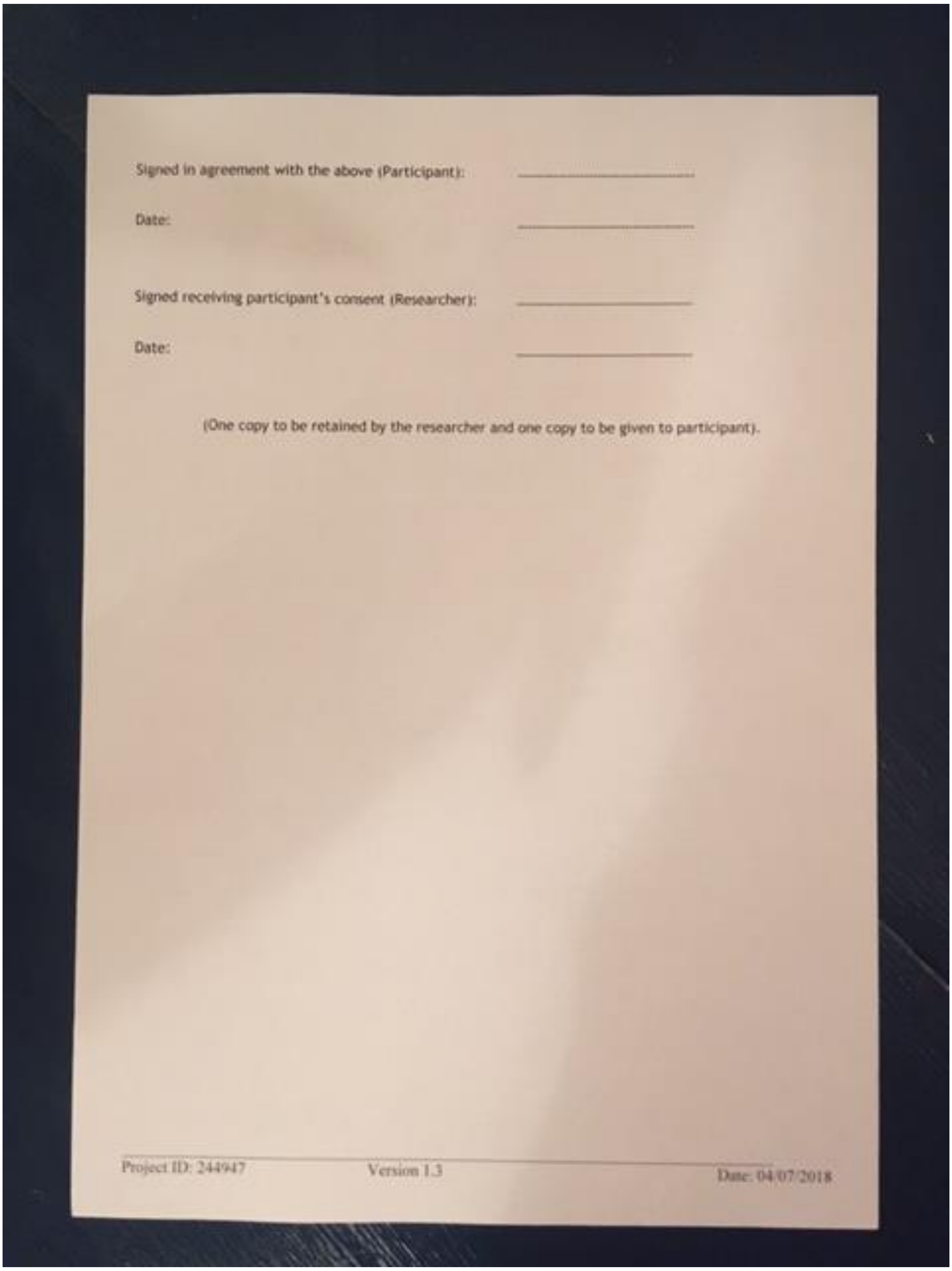
Please state name of Young Person in your care: ______________________

Date: ______________________

1. I confirm I have read and understood the information sheet provided detailing parent/carer involvement in this research project. ☐
2. I agree to participate in a one-off interview which would involve answering questions and talking about my experiences of the young person in my care getting help. ☐
3. I understand that this interview will be recorded using audio equipment and then transcribed. ☐
4. I understand that any personal data that could be used to identify me will be removed from the transcript of my interview and that I will not be identified in any publications, reports or presentations. ☐
5. I allow the researcher access to the most recent copies of both parent / carer and child's completed RCADS forms (Revised Children's Anxiety and Depression Scale). ☐
6. I consent to the information generated in the interview to be used for data analysis and a formal write up of the project that may be submitted for publication in a professional journal. ☐
7. I acknowledge the cool-off period stated in the information sheet, so if I wish to withdraw from this project I must do so within two weeks following the date of my interview. ☐

(Please tick all of the above in agreement prior to signing overleaf.)

Project ID: 244947 Version 1.3 Date: 04/07/2018



Signed in agreement with the above (Participant): ____________________

Date: ____________________

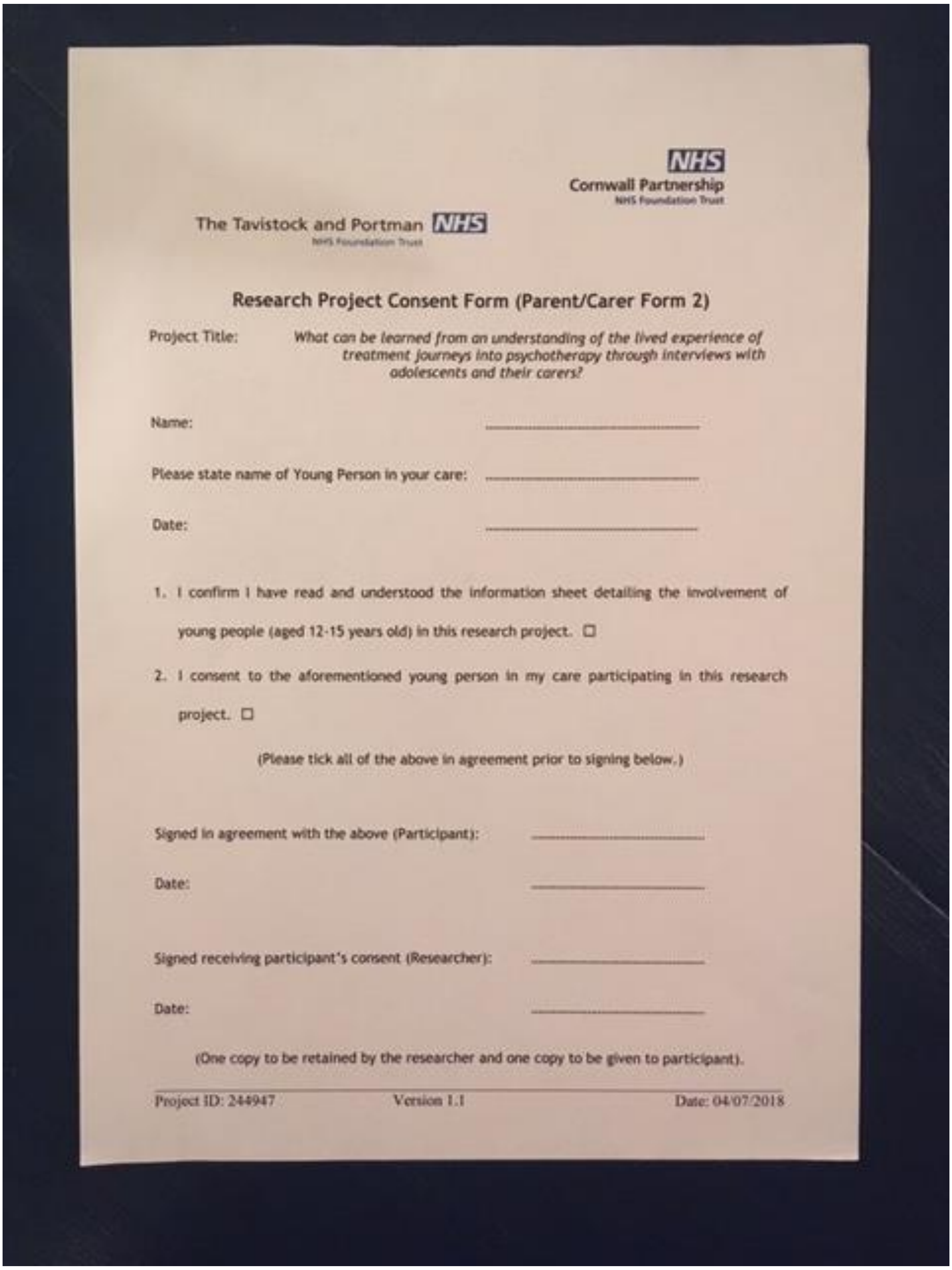
Signed receiving participant's consent (Researcher): ____________________

Date: ____________________

(One copy to be retained by the researcher and one copy to be given to participant).

Project ID: 244947 Version 1.3 Date: 04/07/2018

Consent Form 2 for Parents and Carers:



NHS
Cornwall Partnership
NHS Foundation Trust

The Tavistock and Portman NHS
NHS Foundation Trust

Research Project Consent Form (Parent/Carer Form 2)

Project Title: *What can be learned from an understanding of the lived experience of treatment journeys into psychotherapy through interviews with adolescents and their carers?*

Name: ______________________

Please state name of Young Person in your care: ______________________

Date: ______________________

1. I confirm I have read and understood the information sheet detailing the involvement of young people (aged 12-15 years old) in this research project. ☐
2. I consent to the aforementioned young person in my care participating in this research project. ☐

(Please tick all of the above in agreement prior to signing below.)

Signed in agreement with the above (Participant): ______________________

Date: ______________________

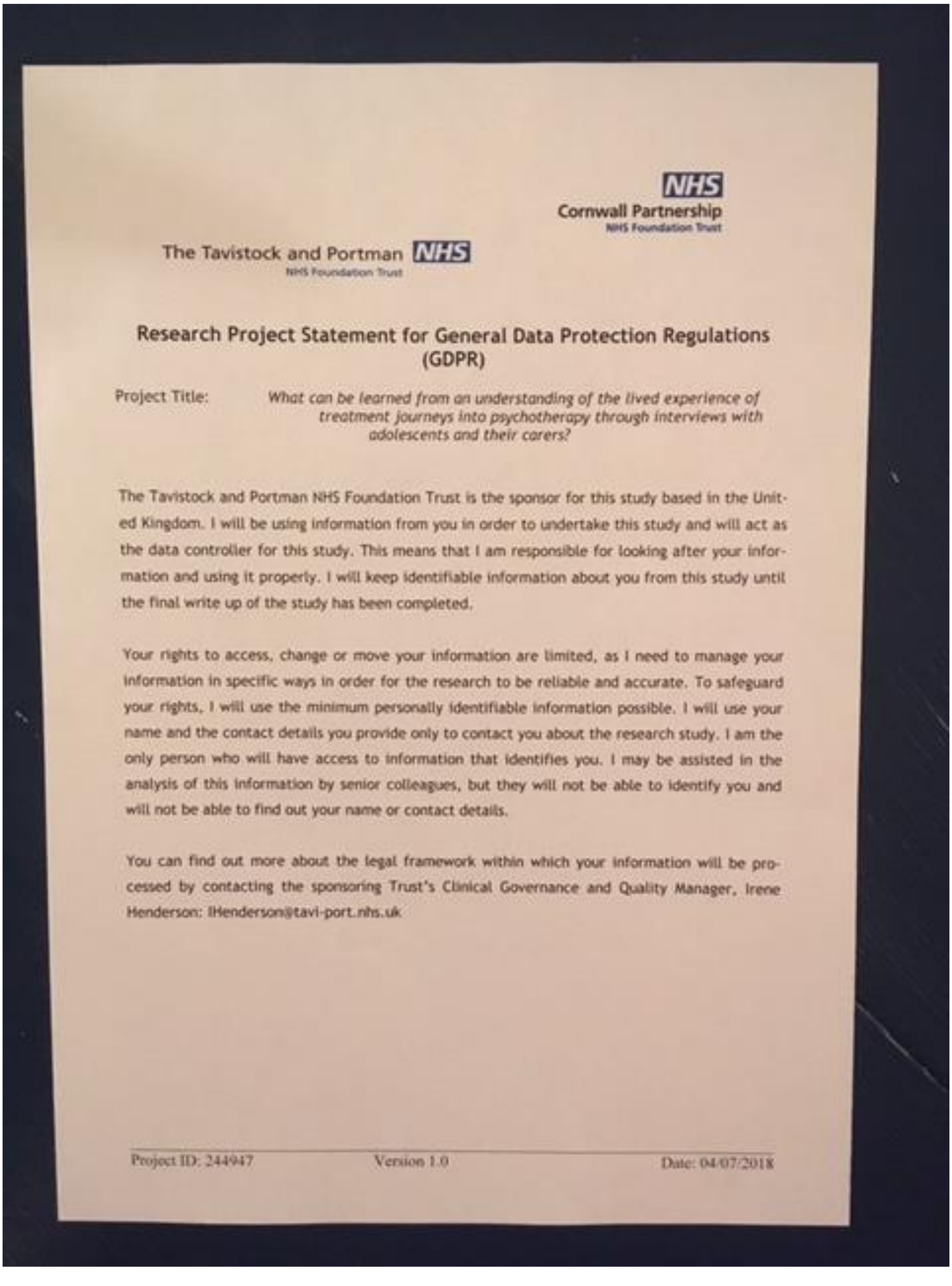
Signed receiving participant's consent (Researcher): ______________________

Date: ______________________

(One copy to be retained by the researcher and one copy to be given to participant).

Project ID: 244947 Version 1.1 Date: 04/07/2018

Information Sheet pertaining to the General Data Protection Regulations:



Cornwall Partnership
NHS Foundation Trust

The Tavistock and Portman
NHS Foundation Trust

Research Project Statement for General Data Protection Regulations (GDPR)

Project Title: *What can be learned from an understanding of the lived experience of treatment journeys into psychotherapy through interviews with adolescents and their carers?*

The Tavistock and Portman NHS Foundation Trust is the sponsor for this study based in the United Kingdom. I will be using information from you in order to undertake this study and will act as the data controller for this study. This means that I am responsible for looking after your information and using it properly. I will keep identifiable information about you from this study until the final write up of the study has been completed.

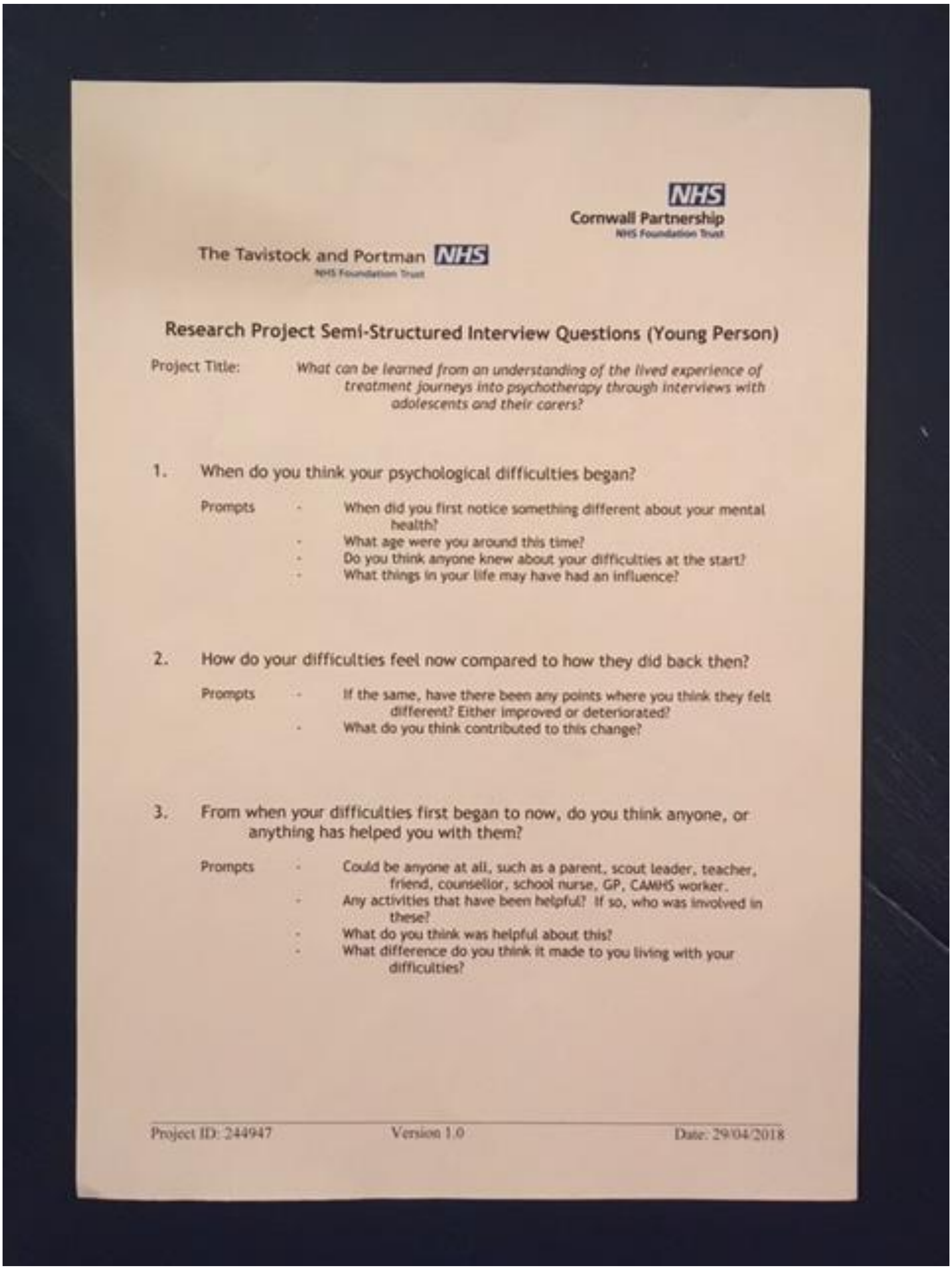
Your rights to access, change or move your information are limited, as I need to manage your information in specific ways in order for the research to be reliable and accurate. To safeguard your rights, I will use the minimum personally identifiable information possible. I will use your name and the contact details you provide only to contact you about the research study. I am the only person who will have access to information that identifies you. I may be assisted in the analysis of this information by senior colleagues, but they will not be able to identify you and will not be able to find out your name or contact details.

You can find out more about the legal framework within which your information will be processed by contacting the sponsoring Trust's Clinical Governance and Quality Manager, Irene Henderson: IHenderson@tavi-port.nhs.uk

Project ID: 244947 Version 1.0 Date: 04/07/2018

Appendix 4 - Semi-Structured Interview Questions

Question Sheet for Interviews with Young People:



NHS
Cornwall Partnership
NHS Foundation Trust

The Tavistock and Portman NHS
NHS Foundation Trust

Research Project Semi-Structured Interview Questions (Young Person)

Project Title: *What can be learned from an understanding of the lived experience of treatment journeys into psychotherapy through interviews with adolescents and their carers?*

1. When do you think your psychological difficulties began?

Prompts
- When did you first notice something different about your mental health?
- What age were you around this time?
- Do you think anyone knew about your difficulties at the start?
- What things in your life may have had an influence?

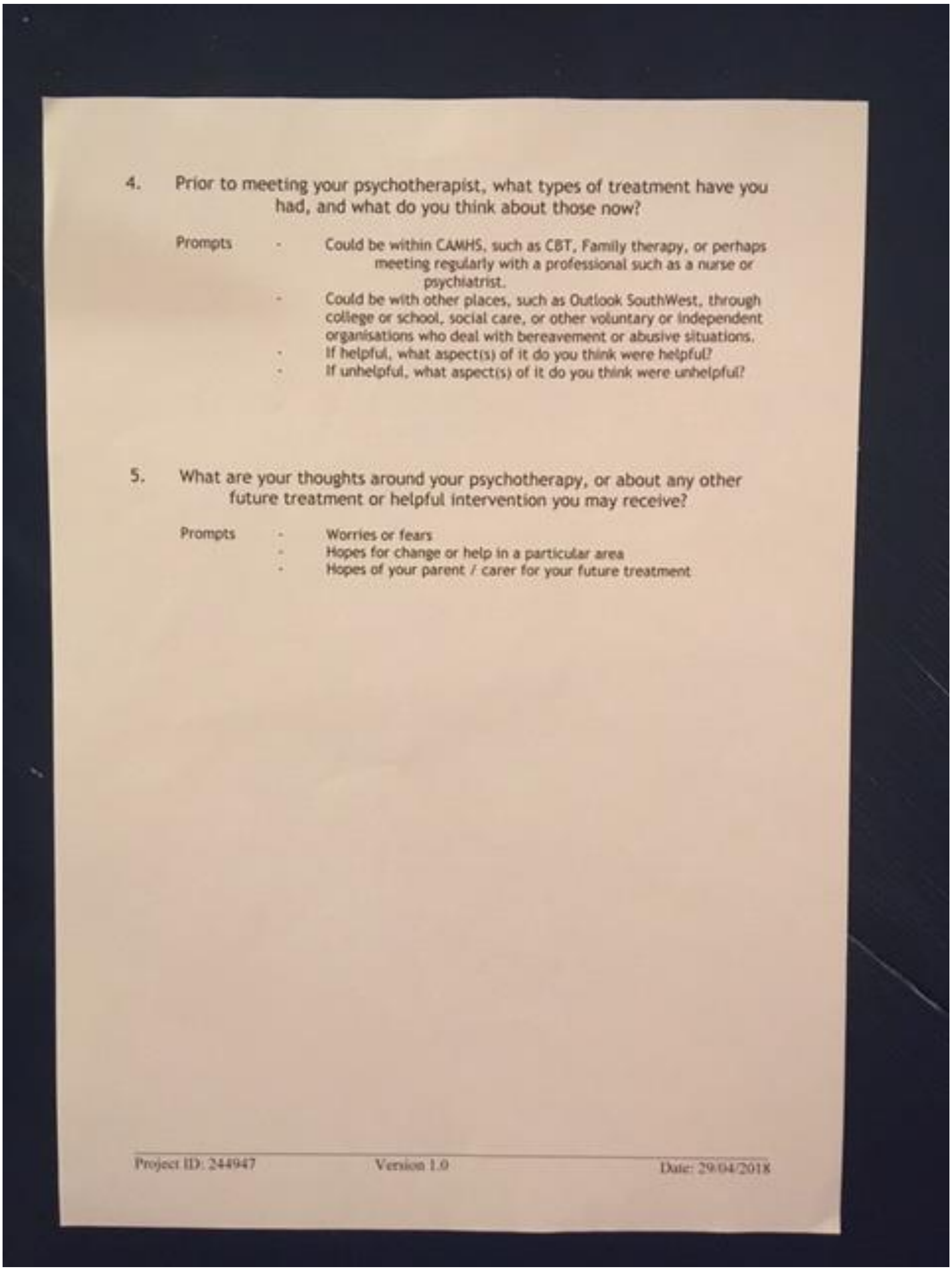
2. How do your difficulties feel now compared to how they did back then?

Prompts
- If the same, have there been any points where you think they felt different? Either improved or deteriorated?
- What do you think contributed to this change?

3. From when your difficulties first began to now, do you think anyone, or anything has helped you with them?

Prompts
- Could be anyone at all, such as a parent, scout leader, teacher, friend, counsellor, school nurse, GP, CAMHS worker.
- Any activities that have been helpful? If so, who was involved in these?
- What do you think was helpful about this?
- What difference do you think it made to you living with your difficulties?

Project ID: 244947 Version 1.0 Date: 29/04/2018



4. Prior to meeting your psychotherapist, what types of treatment have you had, and what do you think about those now?

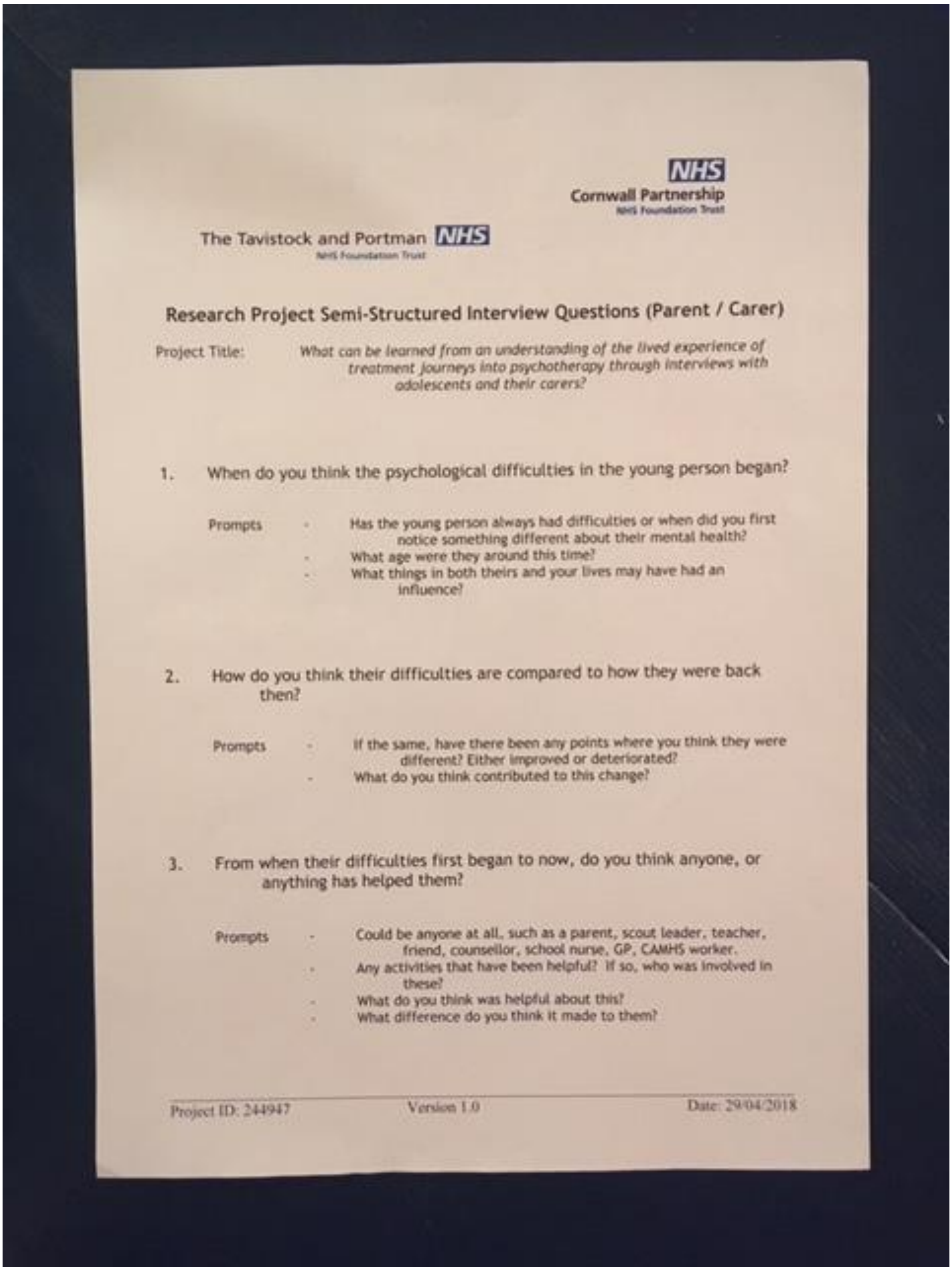
Prompts
- Could be within CAMHS, such as CBT, Family therapy, or perhaps meeting regularly with a professional such as a nurse or psychiatrist.
- Could be with other places, such as Outlook SouthWest, through college or school, social care, or other voluntary or independent organisations who deal with bereavement or abusive situations.
- If helpful, what aspect(s) of it do you think were helpful?
- If unhelpful, what aspect(s) of it do you think were unhelpful?

5. What are your thoughts around your psychotherapy, or about any other future treatment or helpful intervention you may receive?

Prompts
- Worries or fears
- Hopes for change or help in a particular area
- Hopes of your parent / carer for your future treatment

Project ID: 244947 Version 1.0 Date: 29/04/2018

Question Sheet for Interviews with Parents and Carers:



NHS
Cornwall Partnership
NHS Foundation Trust

The Tavistock and Portman NHS
NHS Foundation Trust

Research Project Semi-Structured Interview Questions (Parent / Carer)

Project Title: *What can be learned from an understanding of the lived experience of treatment journeys into psychotherapy through interviews with adolescents and their carers?*

1. When do you think the psychological difficulties in the young person began?

Prompts
- Has the young person always had difficulties or when did you first notice something different about their mental health?
- What age were they around this time?
- What things in both theirs and your lives may have had an influence?

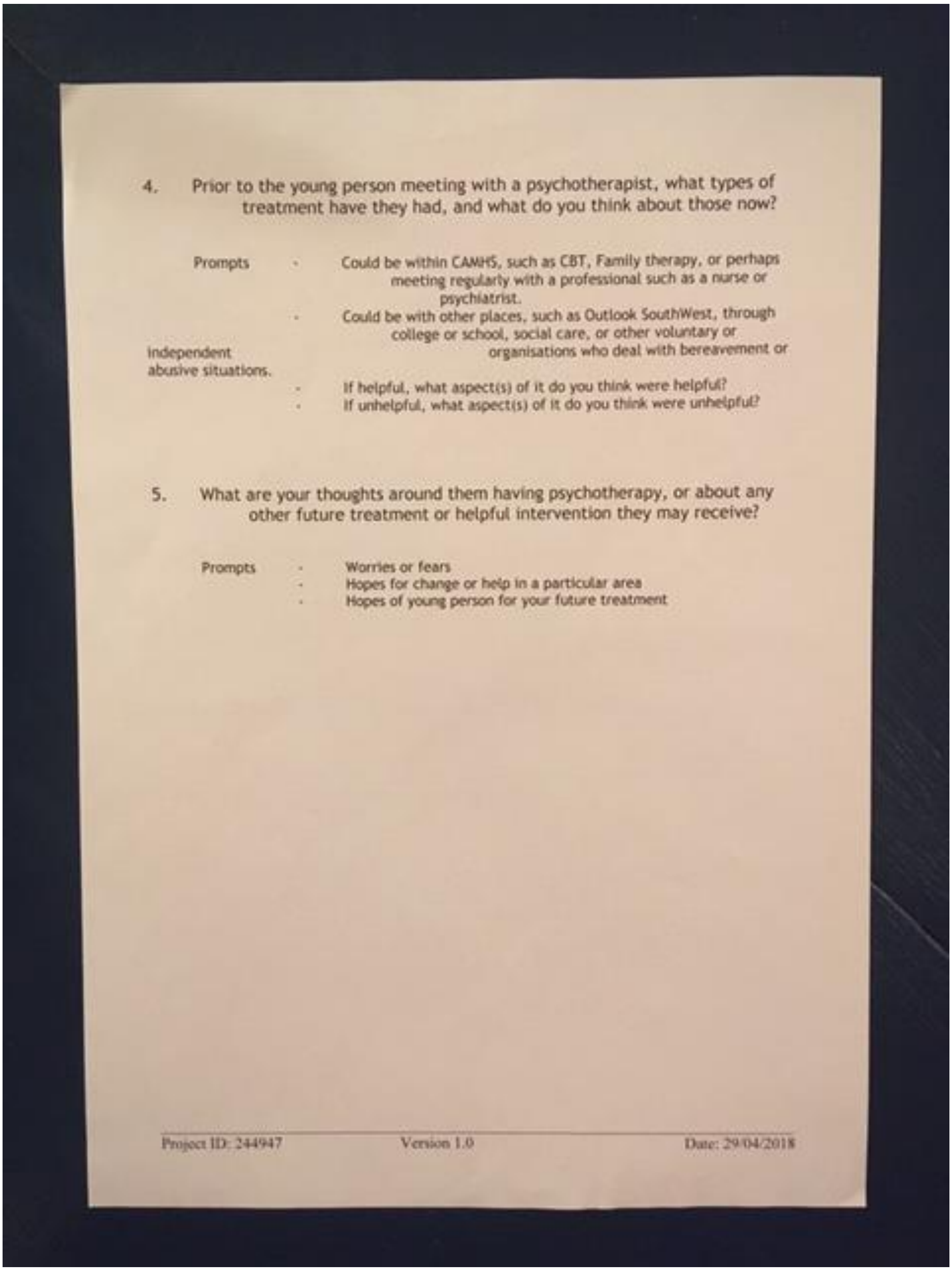
2. How do you think their difficulties are compared to how they were back then?

Prompts
- If the same, have there been any points where you think they were different? Either improved or deteriorated?
- What do you think contributed to this change?

3. From when their difficulties first began to now, do you think anyone, or anything has helped them?

Prompts
- Could be anyone at all, such as a parent, scout leader, teacher, friend, counsellor, school nurse, GP, CAMHS worker.
- Any activities that have been helpful? If so, who was involved in these?
- What do you think was helpful about this?
- What difference do you think it made to them?

Project ID: 244947 Version 1.0 Date: 29/04/2018



4. Prior to the young person meeting with a psychotherapist, what types of treatment have they had, and what do you think about those now?

Prompts
- Could be within CAMHS, such as CBT, Family therapy, or perhaps meeting regularly with a professional such as a nurse or psychiatrist.
- Could be with other places, such as Outlook SouthWest, through college or school, social care, or other voluntary or organisations who deal with bereavement or independent abusive situations.
- If helpful, what aspect(s) of it do you think were helpful?
- If unhelpful, what aspect(s) of it do you think were unhelpful?

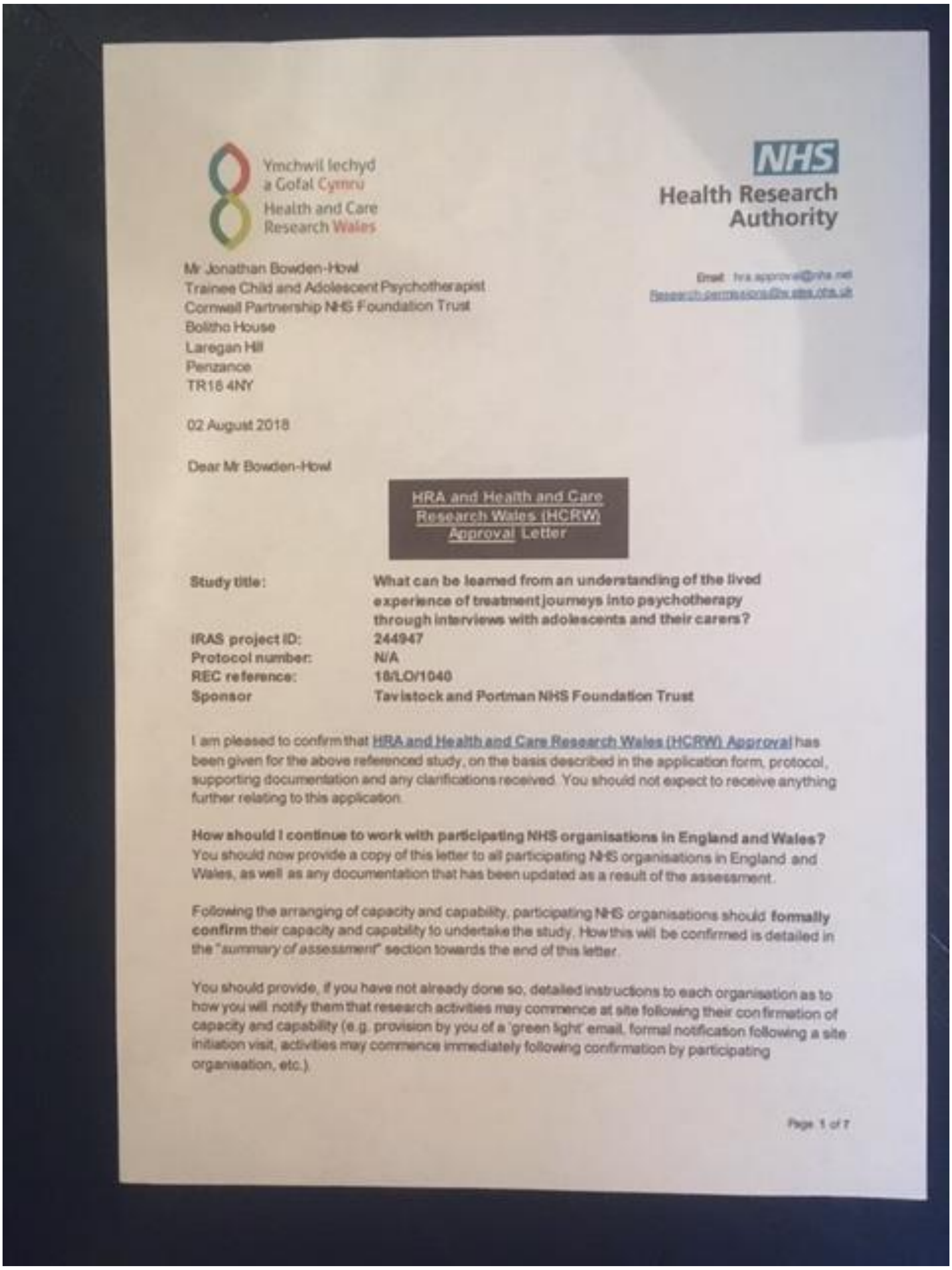
5. What are your thoughts around them having psychotherapy, or about any other future treatment or helpful intervention they may receive?

Prompts
- Worries or fears
- Hopes for change or help in a particular area
- Hopes of young person for your future treatment

Project ID: 244947 Version 1.0 Date: 29/04/2018

Appendix 5 - Ethical Approval Documentation

Letter detailing Health Research Authority approval:



Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

Mr Jonathan Bowden-Howl
Trainee Child and Adolescent Psychotherapist
Cornwall Partnership NHS Foundation Trust
Bolitho House
Laregan Hill
Penzance
TR18 4NY

02 August 2018

Dear Mr Bowden-Howl

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**What can be learned from an understanding of the lived experience of treatment journeys into psychotherapy through interviews with adolescents and their carers?**
IRAS project ID:	**244947**
Protocol number:	**N/A**
REC reference:	**18/LO/1040**
Sponsor	**Tavistock and Portman NHS Foundation Trust**

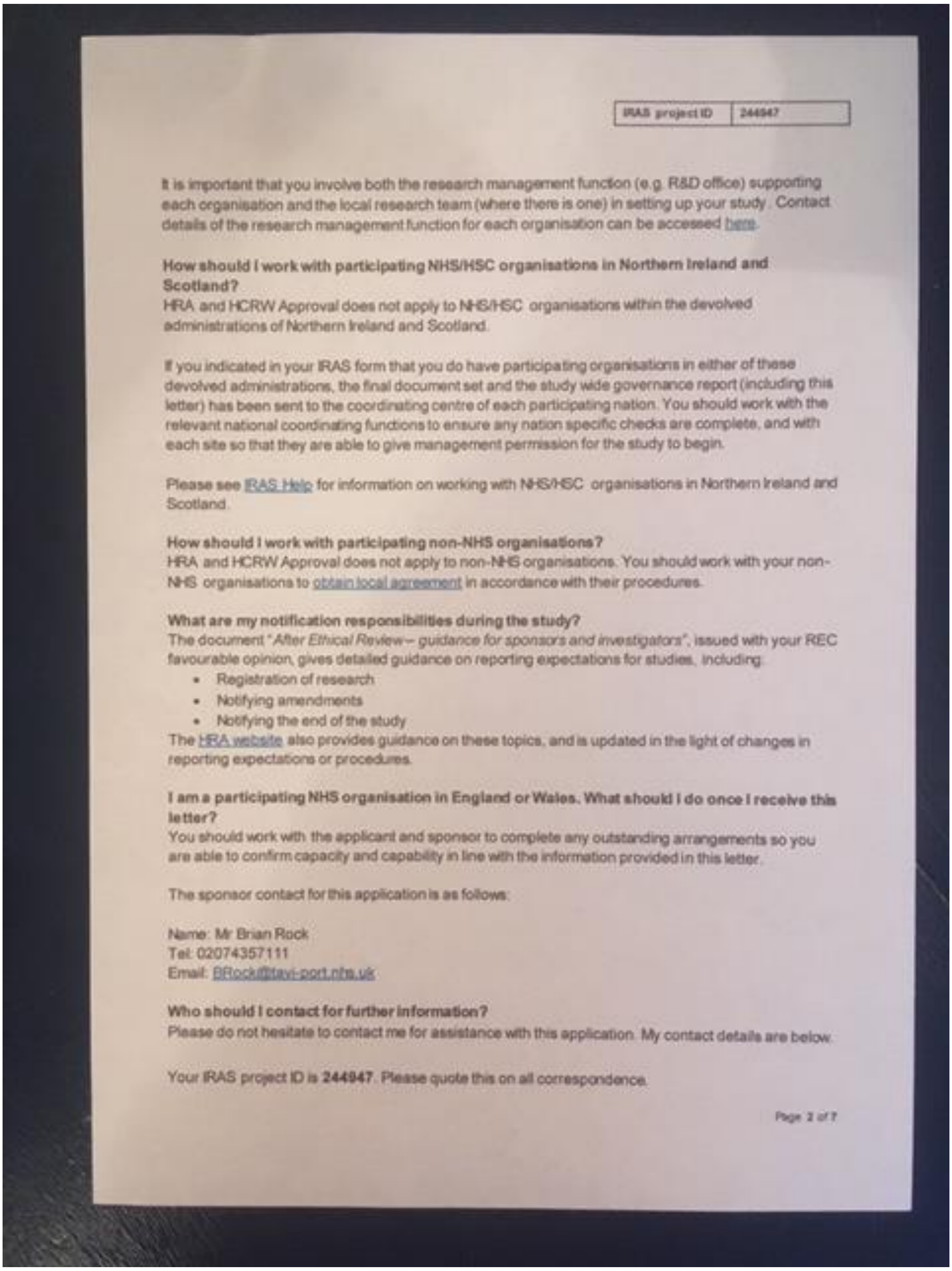
I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

Page 1 of 7



It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?
The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

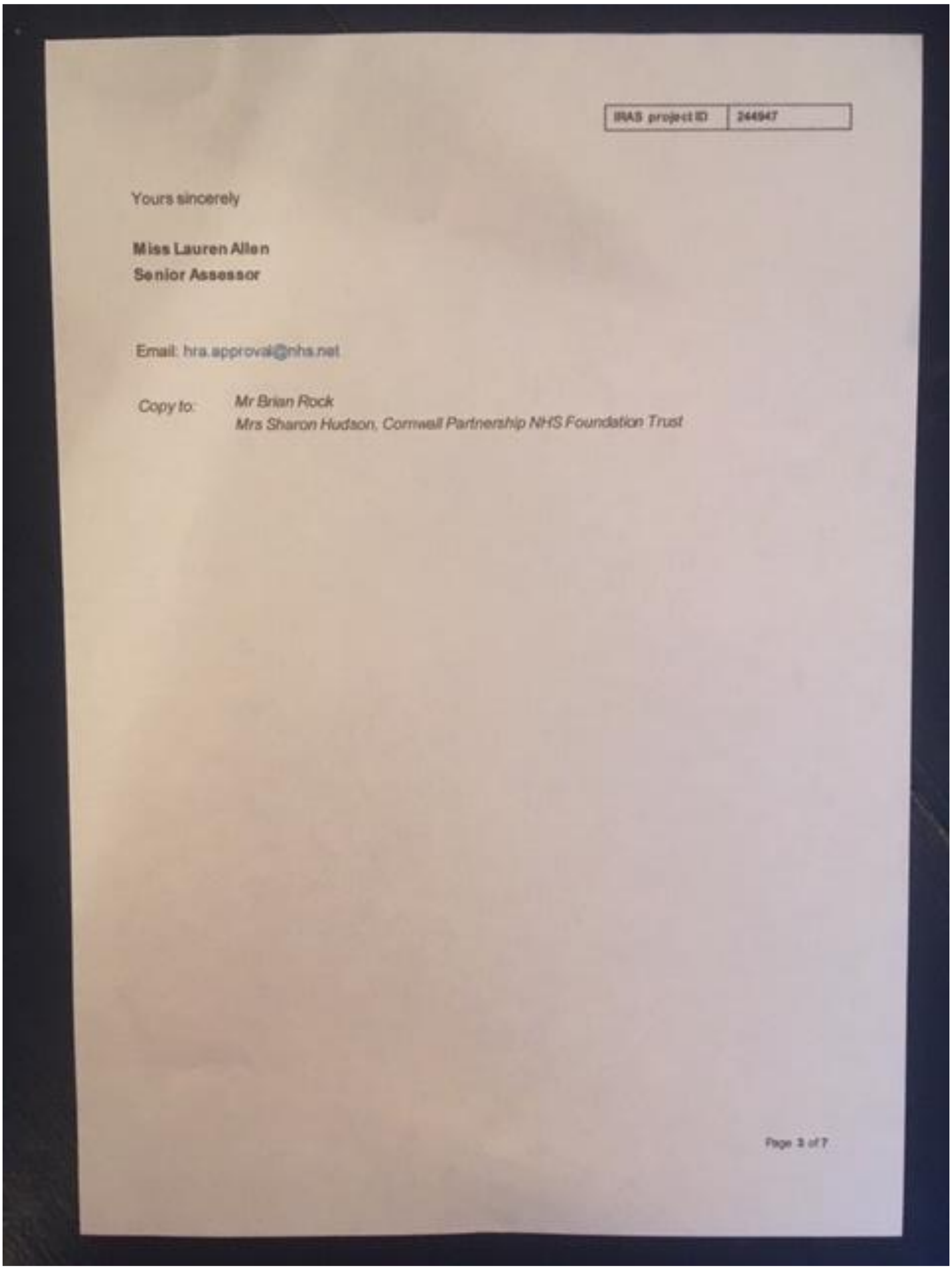
I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?
You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: Mr Brian Rock
Tel: 02074357111
Email: BRock@tavi-port.nhs.uk

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **244947**. Please quote this on all correspondence.

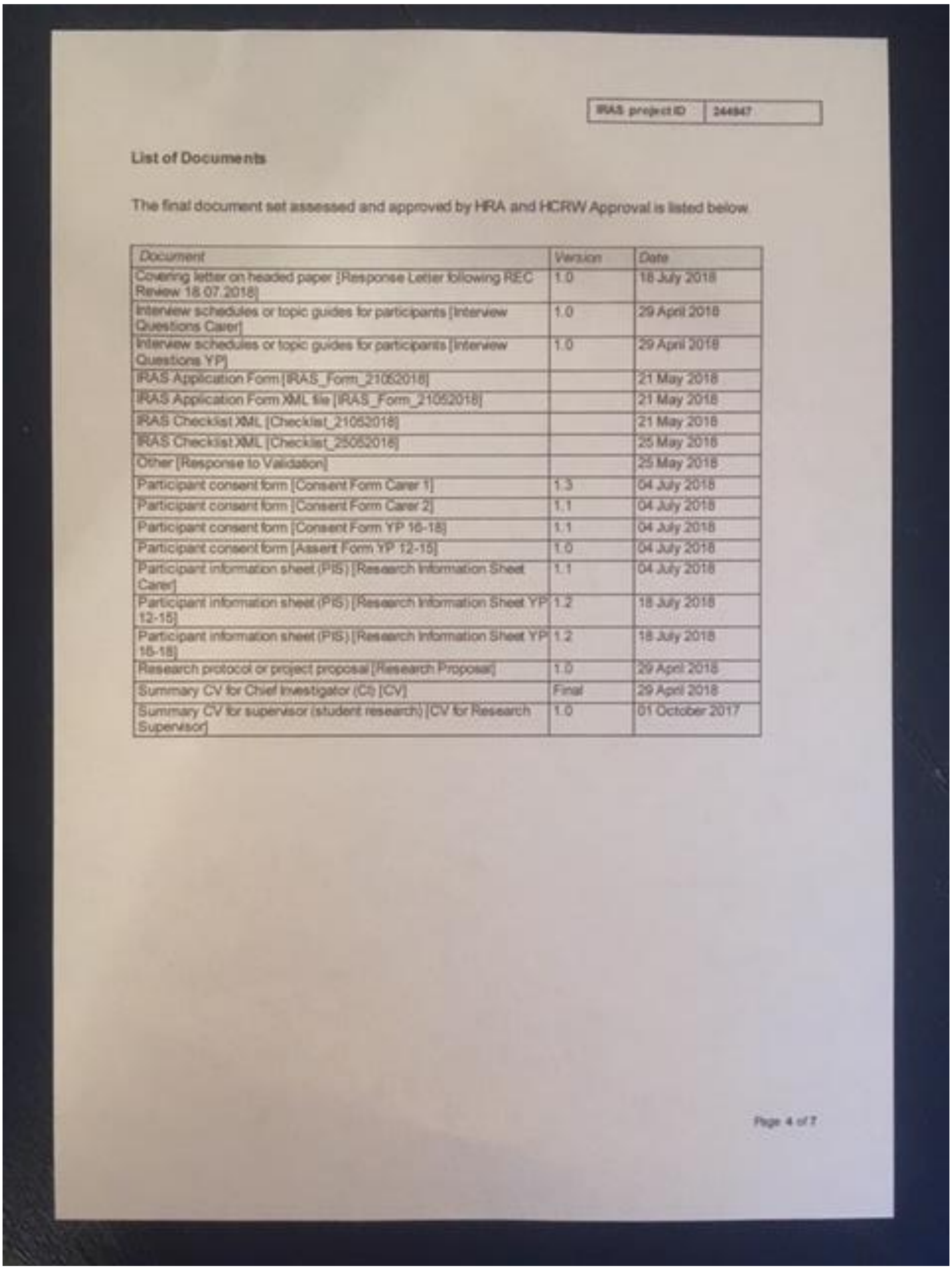


Yours sincerely

Miss Lauren Allen
Senior Assessor

Email: hra.approval@nhs.net

Copy to: *Mr Brian Rock*
Mrs Sharon Hudson, Cornwall Partnership NHS Foundation Trust



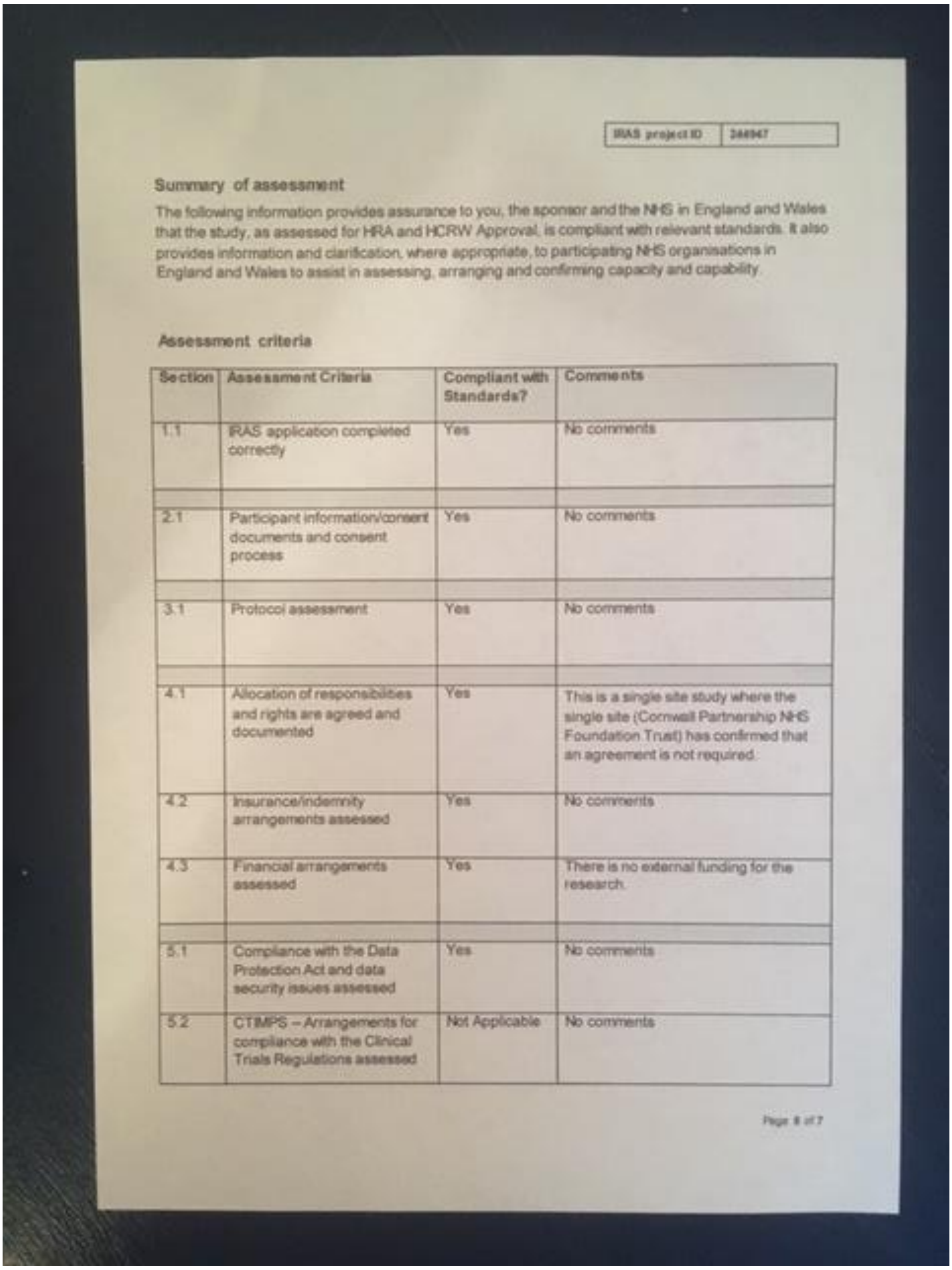
IRAS project ID	244947

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below

Document	*Version*	*Date*
Covering letter on headed paper [Response Letter following REC Review 18.07.2018]	1.0	18 July 2018
Interview schedules or topic guides for participants [Interview Questions Carer]	1.0	29 April 2018
Interview schedules or topic guides for participants [Interview Questions YP]	1.0	29 April 2018
IRAS Application Form [IRAS_Form_21052018]		21 May 2018
IRAS Application Form XML file [IRAS_Form_21052018]		21 May 2018
IRAS Checklist XML [Checklist_21052018]		21 May 2018
IRAS Checklist XML [Checklist_25052018]		25 May 2018
Other [Response to Validation]		25 May 2018
Participant consent form [Consent Form Carer 1]	1.3	04 July 2018
Participant consent form [Consent Form Carer 2]	1.1	04 July 2018
Participant consent form [Consent Form YP 16-18]	1.1	04 July 2018
Participant consent form [Assent Form YP 12-15]	1.0	04 July 2018
Participant information sheet (PIS) [Research Information Sheet Carer]	1.1	04 July 2018
Participant information sheet (PIS) [Research Information Sheet YP 12-15]	1.2	18 July 2018
Participant information sheet (PIS) [Research Information Sheet YP 16-18]	1.2	18 July 2018
Research protocol or project proposal [Research Proposal]	1.0	29 April 2018
Summary CV for Chief Investigator (CI) [CV]	Final	29 April 2018
Summary CV for supervisor (student research) [CV for Research Supervisor]	1.0	01 October 2017

Page 4 of 7



IRAS project ID	244947

Summary of assessment

The following information provides assurance to you, the sponsor and the NHS in England and Wales that the study, as assessed for HRA and HCRW Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England and Wales to assist in assessing, arranging and confirming capacity and capability.

Assessment criteria

Section	Assessment Criteria	Compliant with Standards?	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	This is a single site study where the single site (Cornwall Partnership NHS Foundation Trust) has confirmed that an agreement is not required.
4.2	Insurance/indemnity arrangements assessed	Yes	No comments
4.3	Financial arrangements assessed	Yes	There is no external funding for the research.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments

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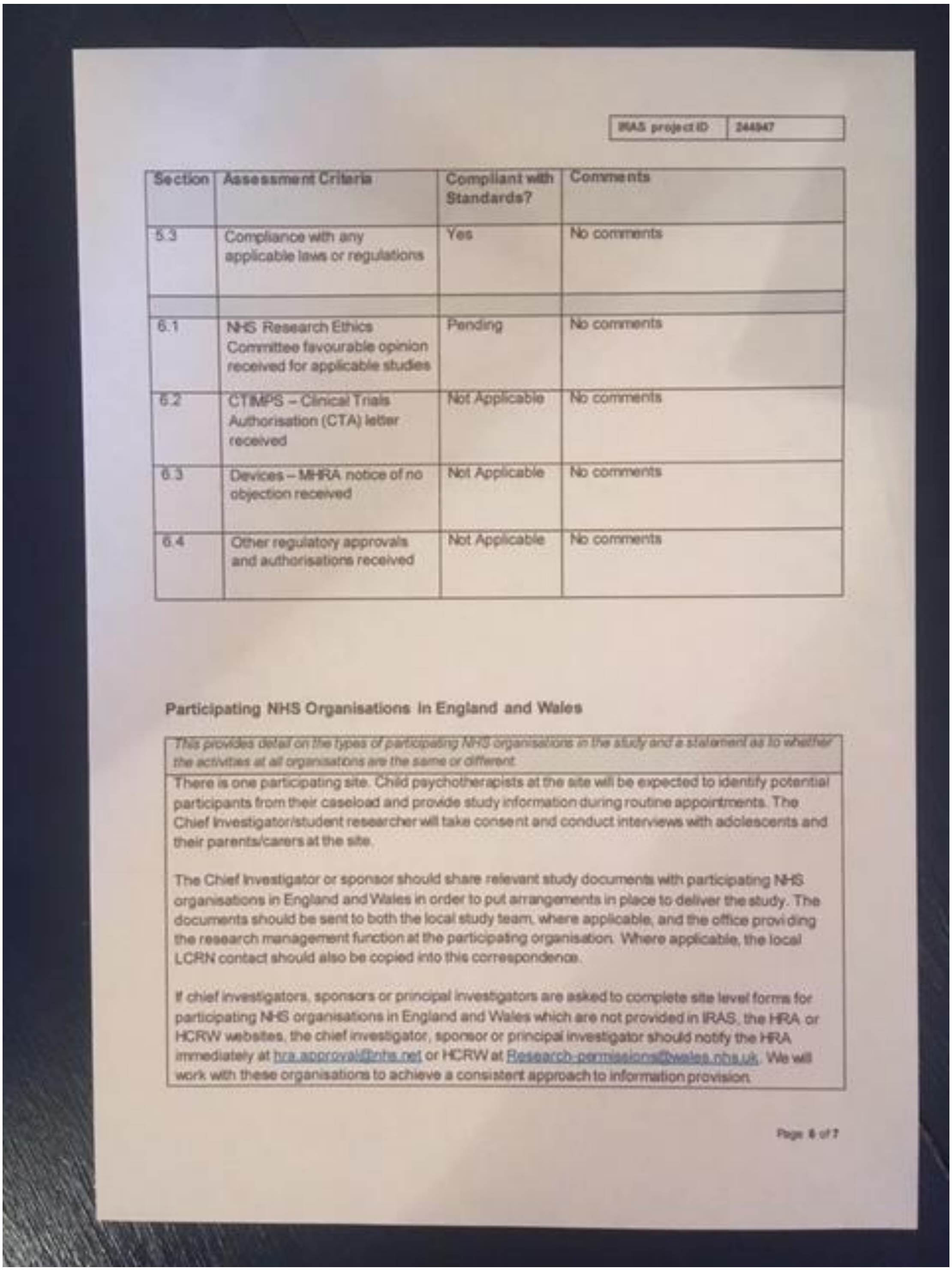

IRAS project ID	244947

Section	Assessment Criteria	Compliant with Standards?	Comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Pending	No comments
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England and Wales

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different

There is one participating site. Child psychotherapists at the site will be expected to identify potential participants from their caseload and provide study information during routine appointments. The Chief Investigator/student researcher will take consent and conduct interviews with adolescents and their parents/carers at the site.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England and Wales in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. Where applicable, the local LCRN contact should also be copied into this correspondence.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England and Wales which are not provided in IRAS, the HRA or HCRW websites, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net or HCRW at Research-permissions@wales.nhs.uk. We will work with these organisations to achieve a consistent approach to information provision.

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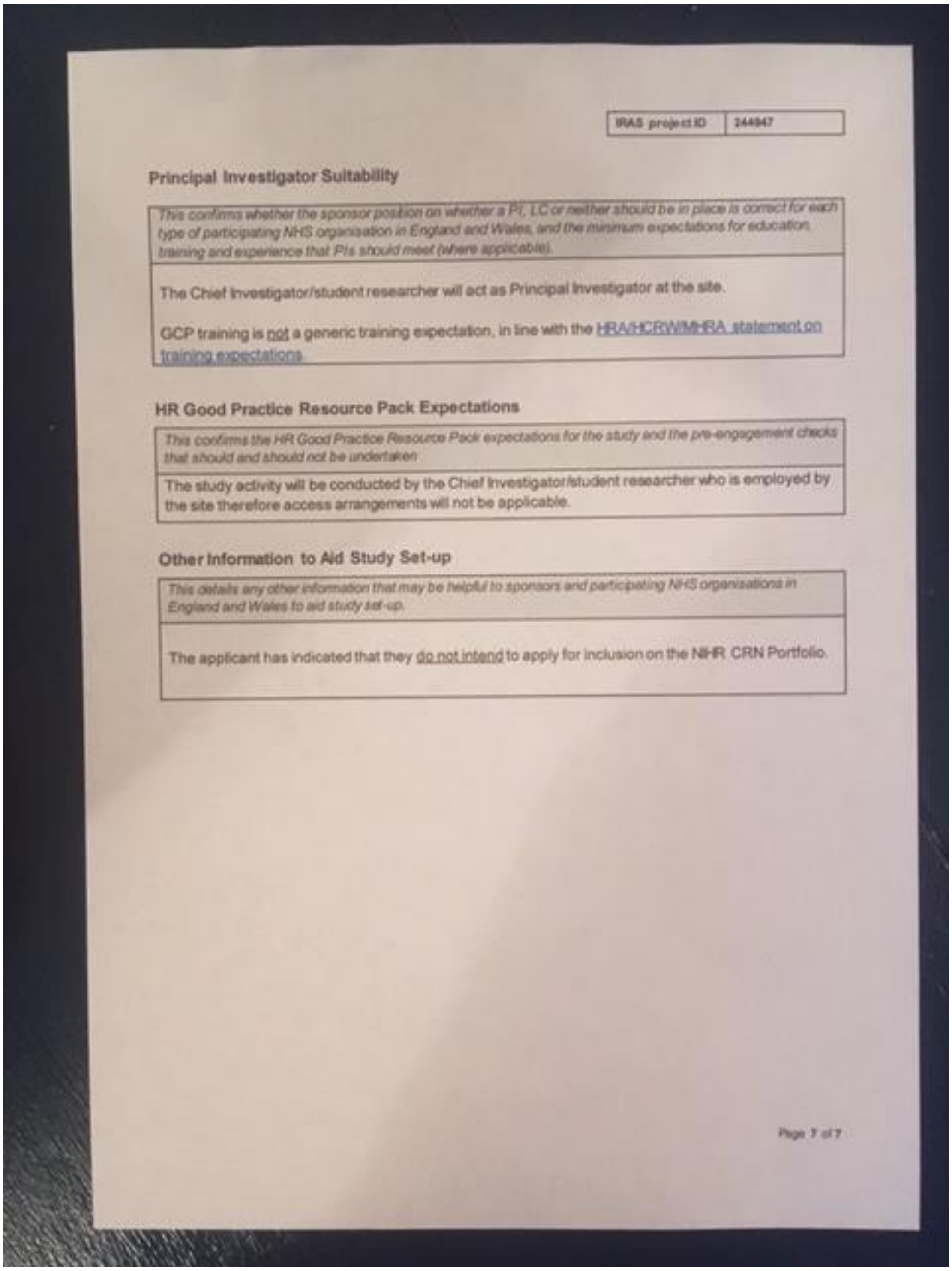


IRAS project ID	244947

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and Wales, and the minimum expectations for education training and experience that PIs should meet (where applicable).
The Chief Investigator/student researcher will act as Principal Investigator at the site. GCP training is not a generic training expectation, in line with the HRA/HCRW/MHRA statement on training expectations.

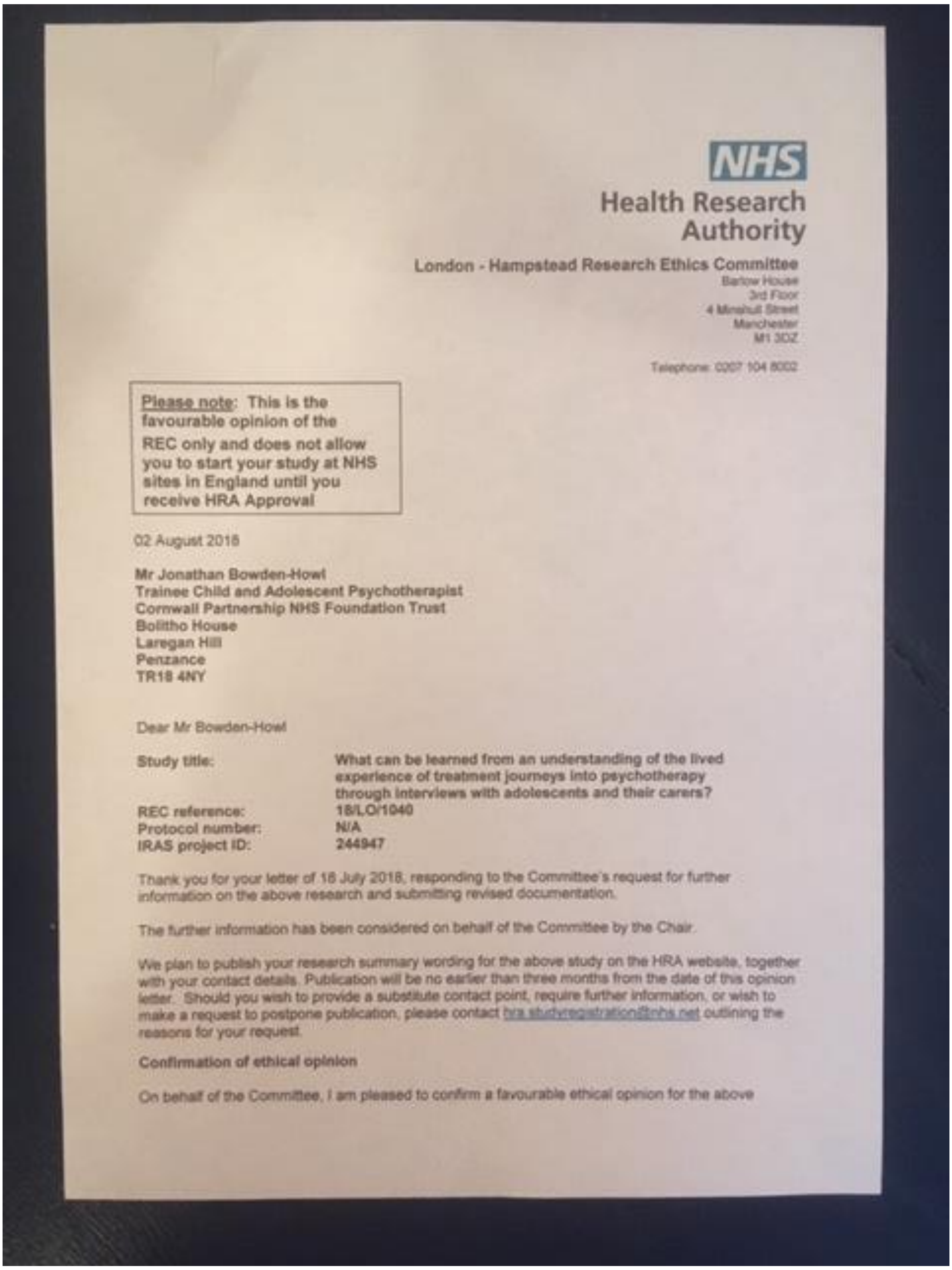
HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken
The study activity will be conducted by the Chief Investigator/student researcher who is employed by the site therefore access arrangements will not be applicable.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales to aid study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Letter detailing NHS Research Ethics Committee approval:



NHS
Health Research
Authority

London - Hampstead Research Ethics Committee
Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ

Telephone: 0207 104 8002

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

02 August 2018

Mr Jonathan Bowden-Howl
Trainee Child and Adolescent Psychotherapist
Cornwall Partnership NHS Foundation Trust
Bolitho House
Laregan Hill
Penzance
TR18 4NY

Dear Mr Bowden-Howl

Study title: **What can be learned from an understanding of the lived experience of treatment journeys into psychotherapy through interviews with adolescents and their carers?**
REC reference: **18/LO/1040**
Protocol number: **N/A**
IRAS project ID: **244947**

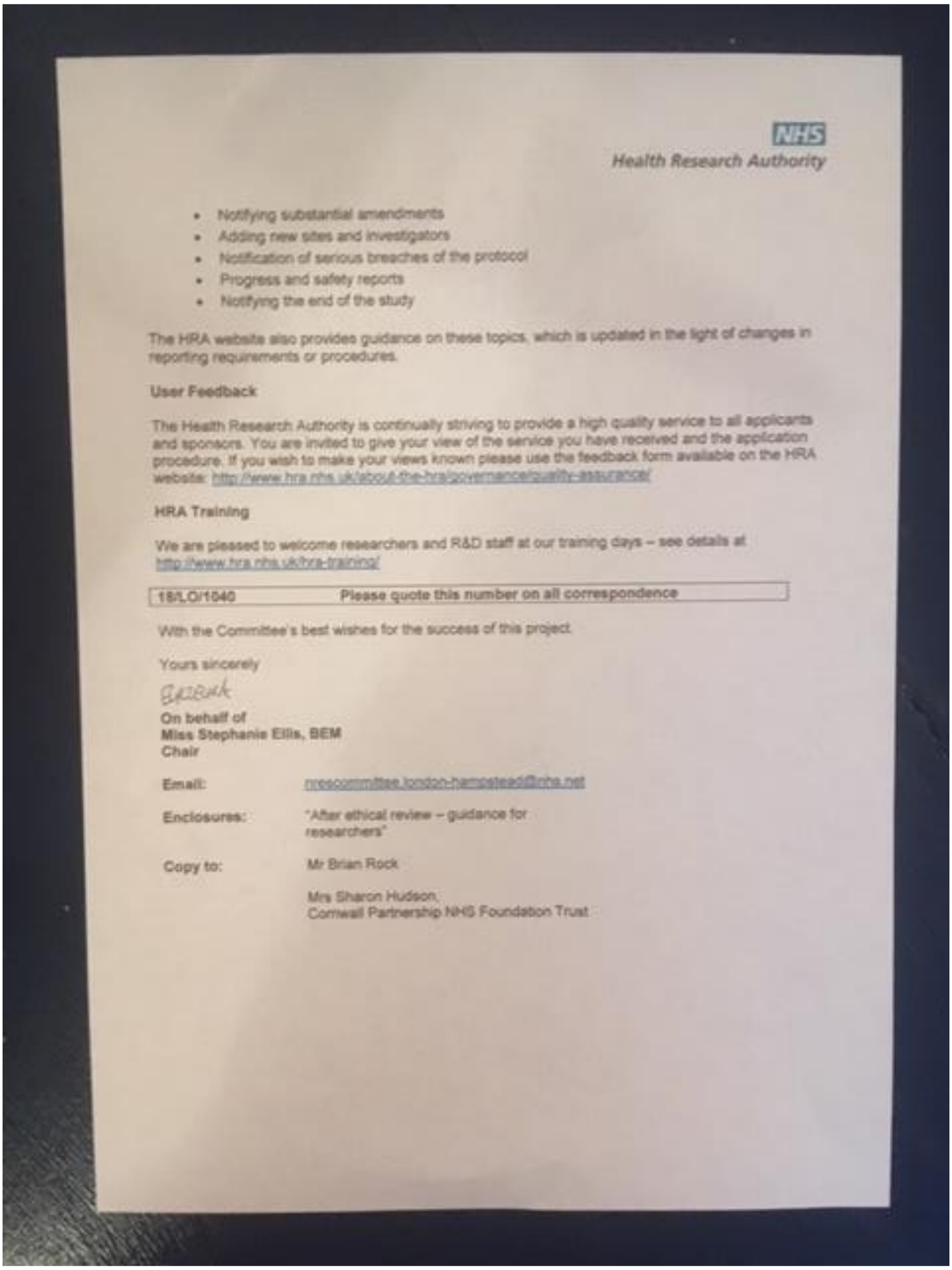
Thank you for your letter of 18 July 2018, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above



- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

18/LO/1040	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely

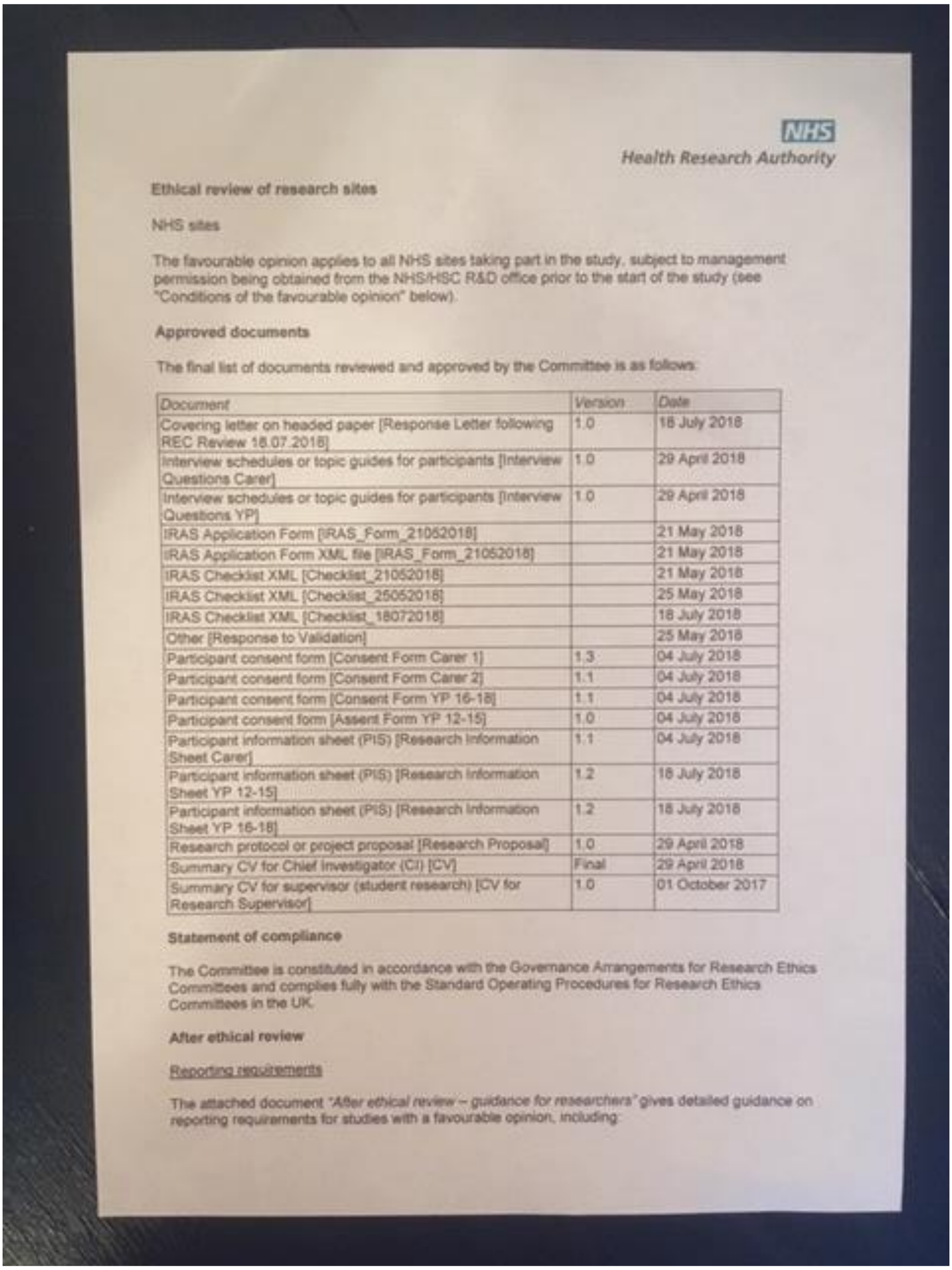
On behalf of
Miss Stephanie Ellis, BEM
Chair

Email: nrescommittee.london-hampstead@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: Mr Brian Rock

Mrs Sharon Hudson,
Cornwall Partnership NHS Foundation Trust



NHS
Health Research Authority

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Covering letter on headed paper [Response Letter following REC Review 18.07.2018]	1.0	18 July 2018
Interview schedules or topic guides for participants [Interview Questions Carer]	1.0	29 April 2018
Interview schedules or topic guides for participants [Interview Questions YP]	1.0	29 April 2018
IRAS Application Form [IRAS_Form_21052018]		21 May 2018
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Participant information sheet (PIS) [Research Information Sheet YP 16-18]	1.2	18 July 2018
Research protocol or project proposal [Research Proposal]	1.0	29 April 2018
Summary CV for Chief Investigator (CI) [CV]	Final	29 April 2018
Summary CV for supervisor (student research) [CV for Research Supervisor]	1.0	01 October 2017

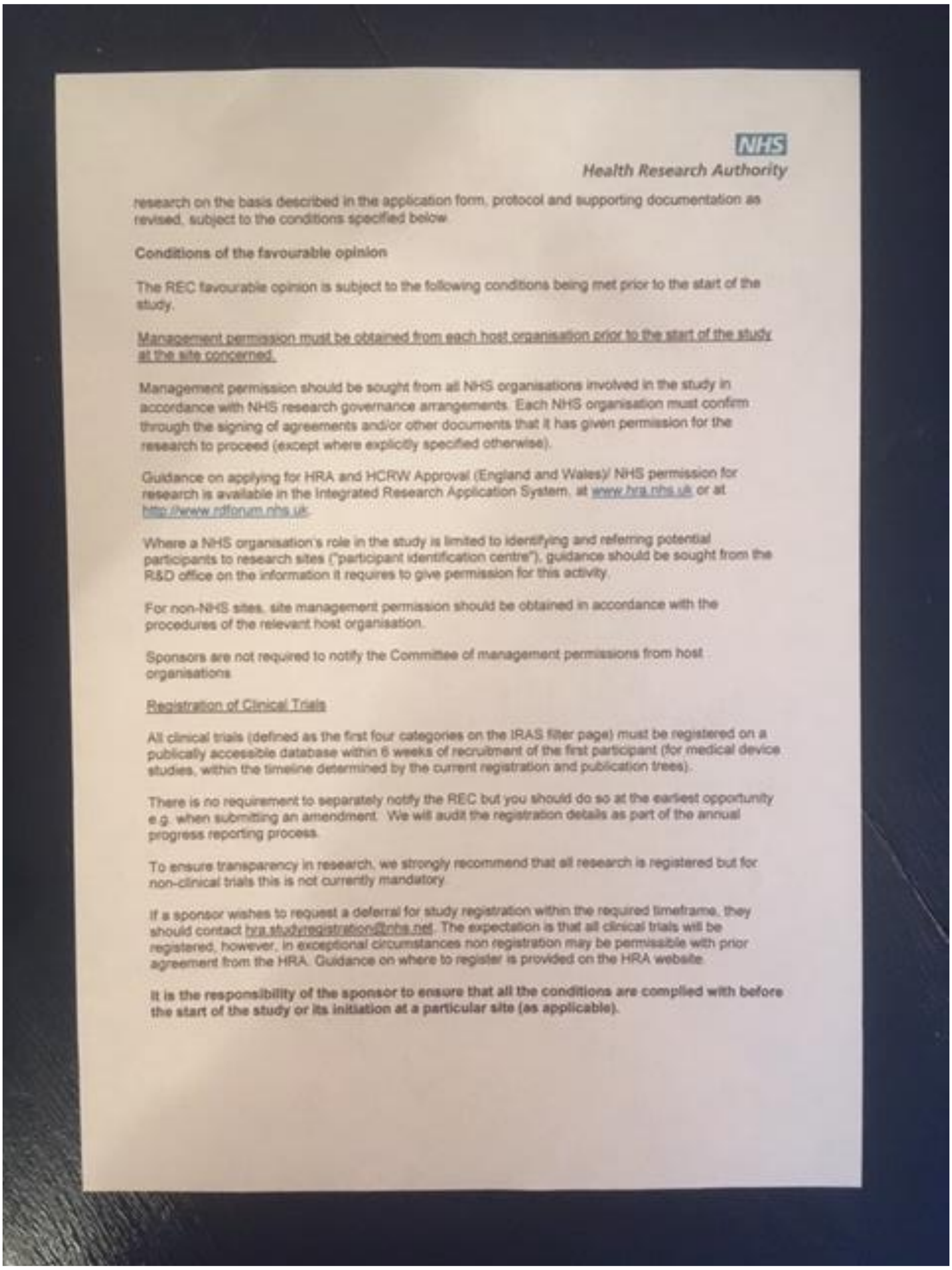
Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:



research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System, at www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations.

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

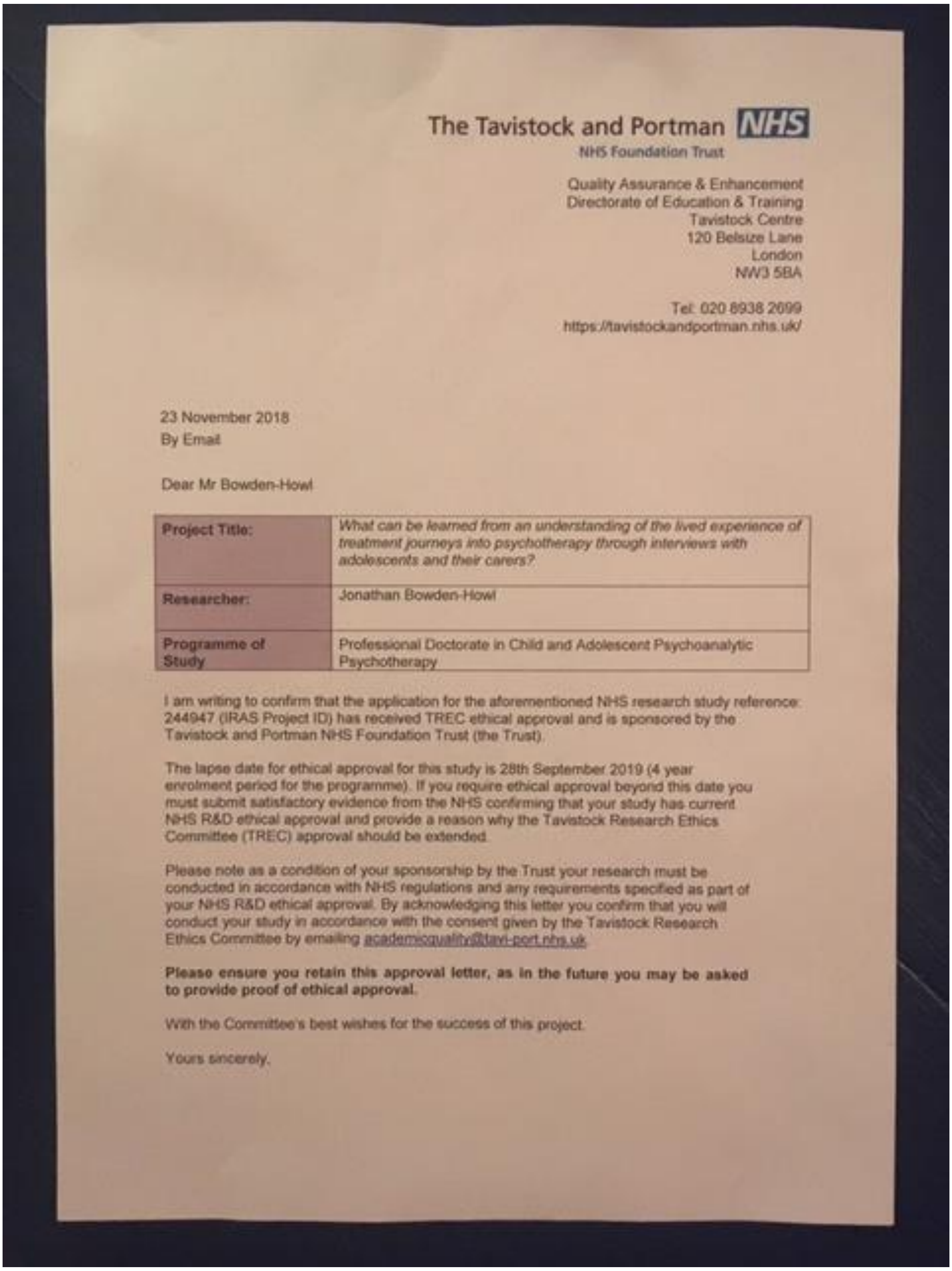
There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Letter detailing Tavistock Research Ethics Committee approval:



The Tavistock and Portman NHS
NHS Foundation Trust

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

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

23 November 2018
By Email

Dear Mr Bowden-Howl

Project Title:	*What can be learned from an understanding of the lived experience of treatment journeys into psychotherapy through interviews with adolescents and their carers?*
Researcher:	Jonathan Bowden-Howl
Programme of Study	Professional Doctorate in Child and Adolescent Psychoanalytic Psychotherapy

I am writing to confirm that the application for the aforementioned NHS research study reference: 244947 (IRAS Project ID) has received TREC ethical approval and is sponsored by the Tavistock and Portman NHS Foundation Trust (the Trust).

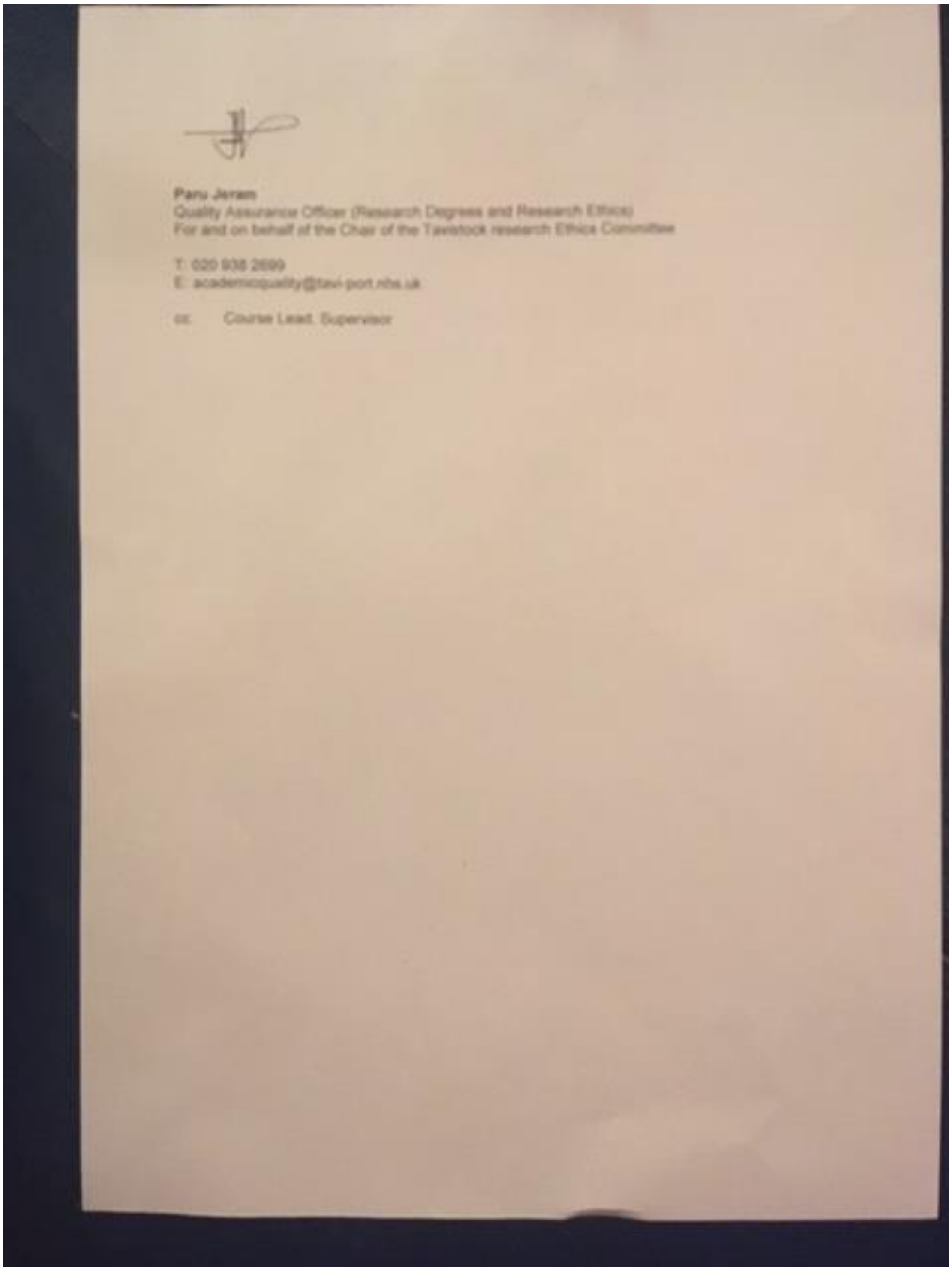
The lapse date for ethical approval for this study is 28th September 2019 (4 year enrolment period for the programme). If you require ethical approval beyond this date you must submit satisfactory evidence from the NHS confirming that your study has current NHS R&D ethical approval and provide a reason why the Tavistock Research Ethics Committee (TREC) approval should be extended.

Please note as a condition of your sponsorship by the Trust your research must be conducted in accordance with NHS regulations and any requirements specified as part of your NHS R&D ethical approval. By acknowledging this letter you confirm that you will conduct your study in accordance with the consent given by the Tavistock Research Ethics Committee by emailing academicquality@tavi-port.nhs.uk.

Please ensure you retain this approval letter, as in the future you may be asked to provide proof of ethical approval.

With the Committee's best wishes for the success of this project.

Yours sincerely,

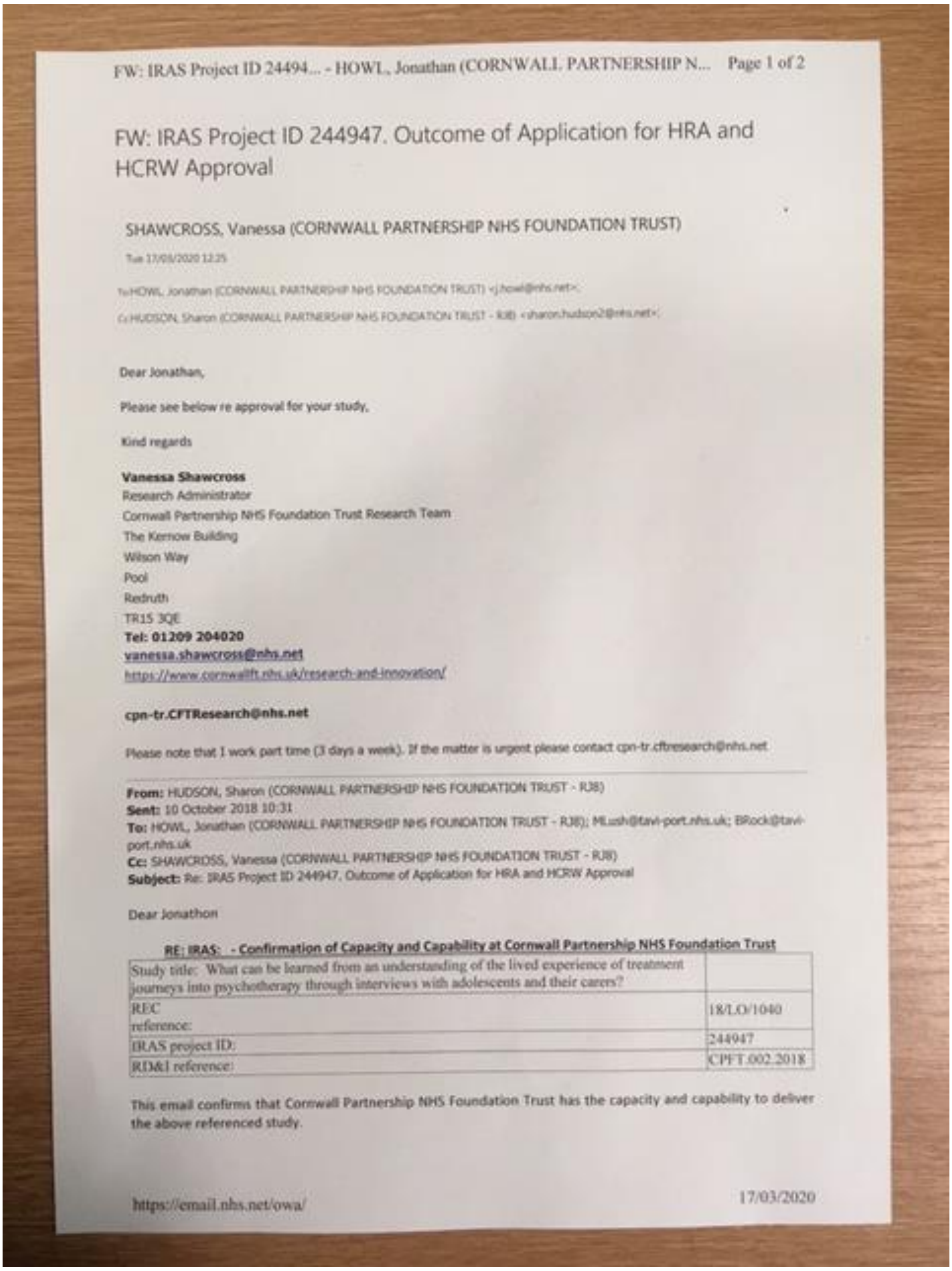


Paru Jeram
Quality Assurance Officer (Research Degrees and Research Ethics)
For and on behalf of the Chair of the Tavistock research Ethics Committee

T: 020 938 2699
E: academicquality@tavi-port.nhs.uk

cc: Course Lead, Supervisor

Letter detailing approval to proceed with the study from CFT Research Team:



FW: IRAS Project ID 24494... - HOWL, Jonathan (CORNWALL PARTNERSHIP N... Page 1 of 2

FW: IRAS Project ID 244947. Outcome of Application for HRA and HCRW Approval

SHAWCROSS, Vanessa (CORNWALL PARTNERSHIP NHS FOUNDATION TRUST)

Tue 17/03/2020 12:25

To:HOWL, Jonathan (CORNWALL PARTNERSHIP NHS FOUNDATION TRUST) <j.howl@nhs.net>;

Cc:HUDSON, Sharon (CORNWALL PARTNERSHIP NHS FOUNDATION TRUST - RJ8) <sharon.hudson2@nhs.net>;

Dear Jonathan,

Please see below re approval for your study,

Kind regards

Vanessa Shawcross
Research Administrator
Cornwall Partnership NHS Foundation Trust Research Team
The Kernow Building
Wilson Way
Pool
Redruth
TR15 3QE
Tel: 01209 204020
vanessa.shawcross@nhs.net
https://www.cornwallft.nhs.uk/research-and-innovation/

cpn-tr.CFTResearch@nhs.net

Please note that I work part time (3 days a week). If the matter is urgent please contact cpn-tr.cftresearch@nhs.net

---

From: HUDSON, Sharon (CORNWALL PARTNERSHIP NHS FOUNDATION TRUST - RJ8)
Sent: 10 October 2018 10:31
To: HOWL, Jonathan (CORNWALL PARTNERSHIP NHS FOUNDATION TRUST - RJ8); MLush@tavi-port.nhs.uk; BRock@tavi-port.nhs.uk
Cc: SHAWCROSS, Vanessa (CORNWALL PARTNERSHIP NHS FOUNDATION TRUST - RJ8)
Subject: Re: IRAS Project ID 244947. Outcome of Application for HRA and HCRW Approval

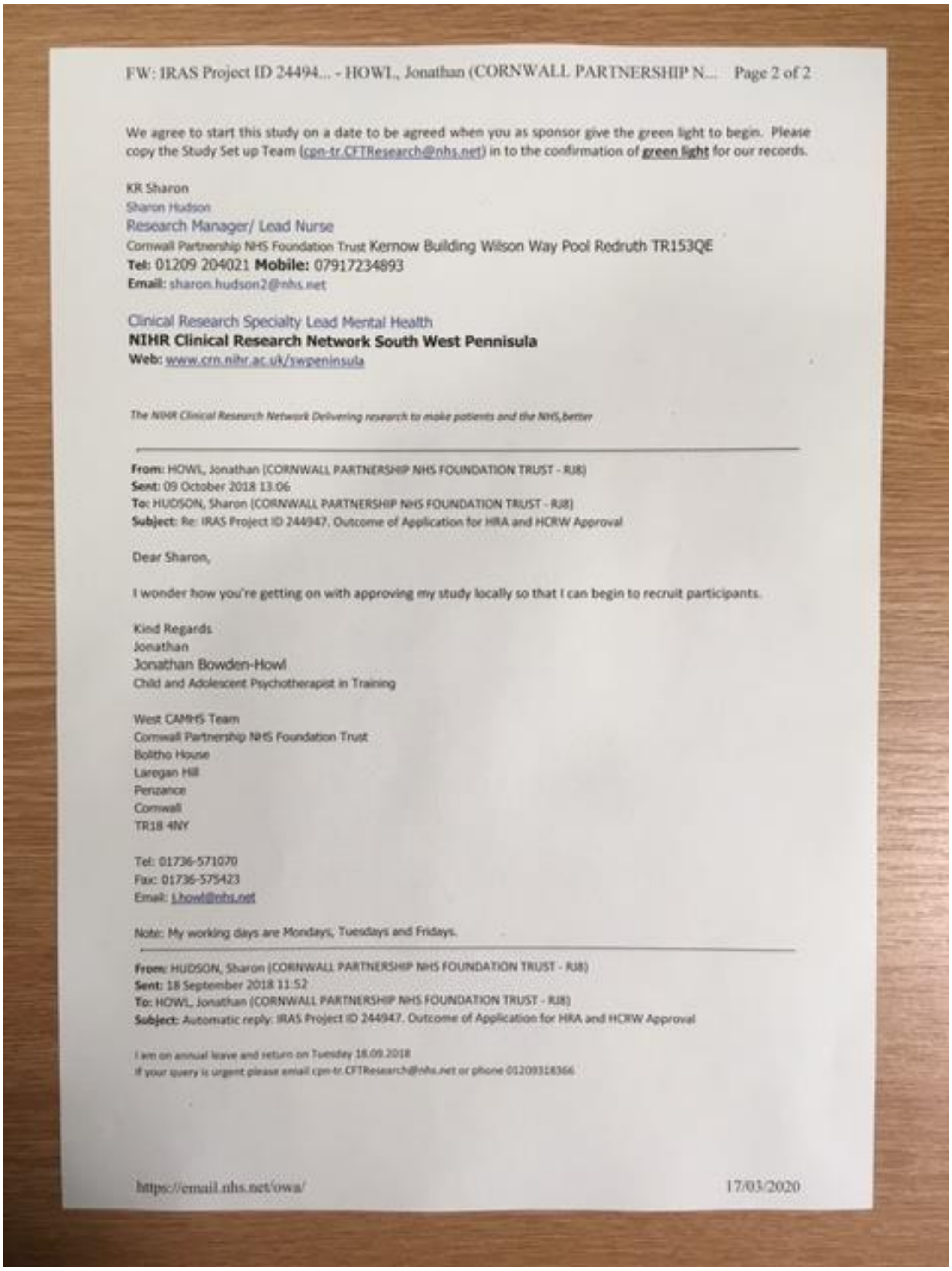
Dear Jonathon

RE: IRAS: - Confirmation of Capacity and Capability at Cornwall Partnership NHS Foundation Trust

Study title: What can be learned from an understanding of the lived experience of treatment journeys into psychotherapy through interviews with adolescents and their carers?	
REC reference:	18/LO/1040
IRAS project ID:	244947
RD&I reference:	CPFT.002.2018

This email confirms that Cornwall Partnership NHS Foundation Trust has the capacity and capability to deliver the above referenced study.

https://email.nhs.net/owa/ 17/03/2020



FW: IRAS Project ID 24494... - HOWL, Jonathan (CORNWALL PARTNERSHIP N... Page 2 of 2

We agree to start this study on a date to be agreed when you as sponsor give the green light to begin. Please copy the Study Set up Team (cpn-tr.CFTResearch@nhs.net) in to the confirmation of **green light** for our records.

KR Sharon
Sharon Hudson
Research Manager/ Lead Nurse
Cornwall Partnership NHS Foundation Trust Kernow Building Wilson Way Pool Redruth TR153QE
Tel: 01209 204021 **Mobile:** 07917234893
Email: sharon.hudson2@nhs.net

Clinical Research Specialty Lead Mental Health
NIHR Clinical Research Network South West Pennisula
Web: www.crn.nihr.ac.uk/swpeninsula

The NIHR Clinical Research Network Delivering research to make patients and the NHS,better

---

From: HOWL, Jonathan (CORNWALL PARTNERSHIP NHS FOUNDATION TRUST - RJ8)
Sent: 09 October 2018 13:06
To: HUDSON, Sharon (CORNWALL PARTNERSHIP NHS FOUNDATION TRUST - RJ8)
Subject: Re: IRAS Project ID 244947. Outcome of Application for HRA and HCRW Approval

Dear Sharon,

I wonder how you're getting on with approving my study locally so that I can begin to recruit participants.

Kind Regards
Jonathan
Jonathan Bowden-Howl
Child and Adolescent Psychotherapist in Training

West CAMHS Team
Cornwall Partnership NHS Foundation Trust
Bolitho House
Laregan Hill
Penzance
Cornwall
TR18 4NY

Tel: 01736-571070
Fax: 01736-575423
Email: J.howl@nhs.net

Note: My working days are Mondays, Tuesdays and Fridays.

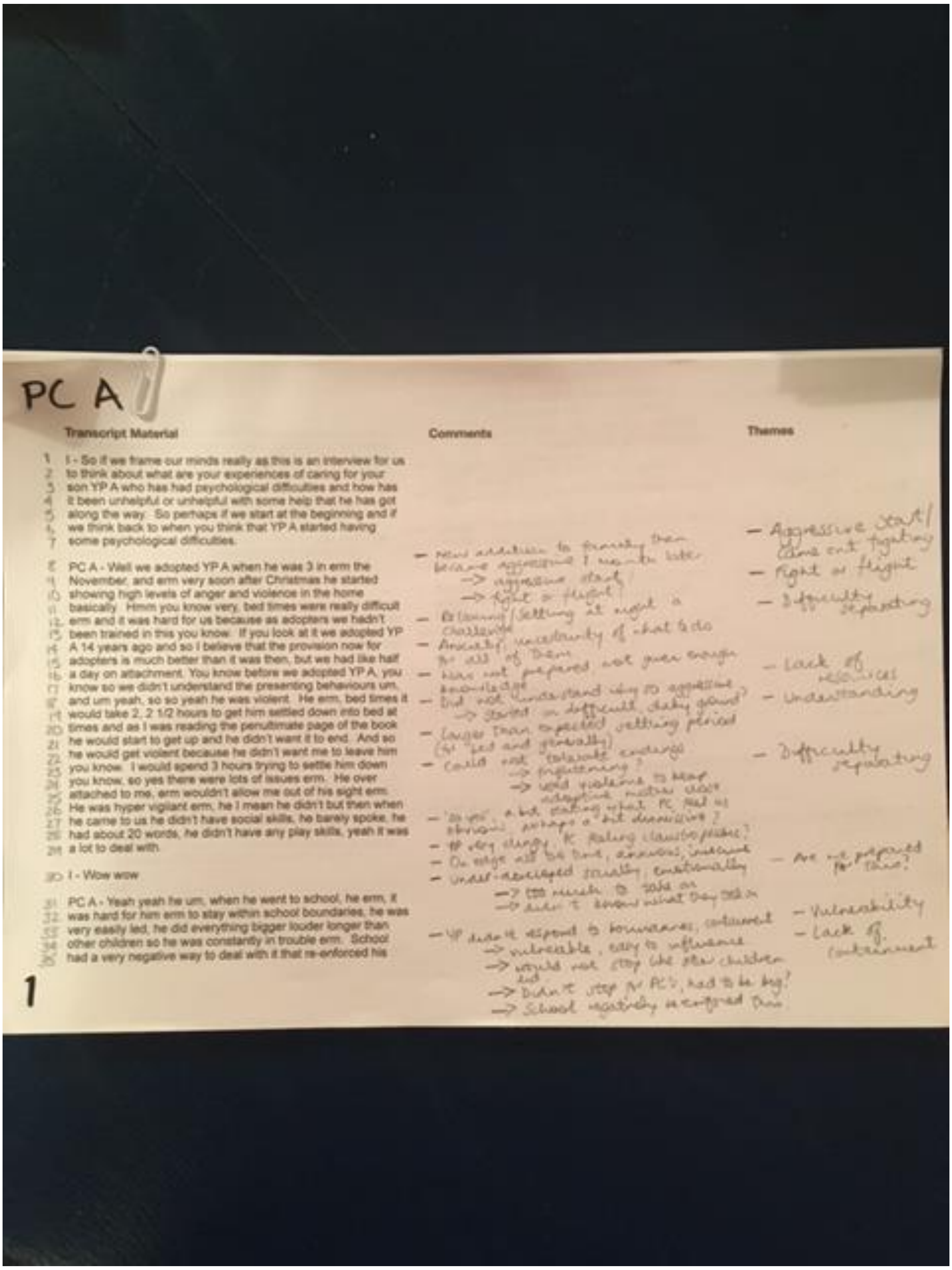
From: HUDSON, Sharon (CORNWALL PARTNERSHIP NHS FOUNDATION TRUST - RJ8)
Sent: 18 September 2018 11:52
To: HOWL, Jonathan (CORNWALL PARTNERSHIP NHS FOUNDATION TRUST - RJ8)
Subject: Automatic reply: IRAS Project ID 244947. Outcome of Application for HRA and HCRW Approval

I am on annual leave and return on Tuesday 18.09.2018
If your query is urgent please email cpn-tr.CFTResearch@nhs.net or phone 01209318366

https://email.nhs.net/owa/ 17/03/2020

Appendix 6 - Examples of the Coding Process

The first image below is the first page from the interview transcript for PC A (Anne):



PC A

Transcript Material

I - So if we frame our minds really as this is an interview for us to think about what are your experiences of caring for your son YP A who has had psychological difficulties and how has it been unhelpful or unhelpful with some help that he has got along the way. So perhaps if we start at the beginning and if we think back to when you think that YP A started having some psychological difficulties.

PC A - Well we adopted YP A when he was 3 in erm the November, and erm very soon after Christmas he started showing high levels of anger and violence in the home basically. Hmm you know very, bed times were really difficult erm and it was hard for us because as adopters we hadn't been trained in this you know. If you look at it we adopted YP A 14 years ago and so I believe that the provision now for adopters is much better than it was then, but we had like half a day on attachment. You know before we adopted YP A, you know so we didn't understand the presenting behaviours um, and um yeah, so so yeah he was violent. He erm, bed times it would take 2, 2 1/2 hours to get him settled down into bed at times and as I was reading the penultimate page of the book he would start to get up and he didn't want it to end. And so he would get violent because he didn't want me to leave him you know. I would spend 3 hours trying to settle him down you know, so yes there were lots of issues erm. He over attached to me, erm wouldn't allow me out of his sight erm. He was hyper vigilant erm, he I mean he didn't but then when he came to us he didn't have social skills, he barely spoke, he had about 20 words, he didn't have any play skills, yeah it was a lot to deal with.

I - Wow wow

PC A - Yeah yeah he um, when he went to school, he erm, it was hard for him erm to stay within school boundaries, he was very easily led, he did everything bigger louder longer than other children so he was constantly in trouble erm. School had a very negative way to deal with it that re-enforced his

1

Comments

- New addition to family then became aggressive 1 month later
  - → aggressive start
  - → fight or flight
- Calming/Settling at night is challenging
- Anxiety/uncertainty of what to do for all of them
- Was not prepared not given enough knowledge
- Did not understand why so aggressive
  - → started on difficult shaky ground?
- Longer than expected settling period (for bed and generally)
- Could not tolerate endings
  - → frightening?
  - → used violence to keep adoptive mother close
- 'so yes' a bit stating what PC feel is obvious, perhaps a bit dismissive?
- YP very clingy, PC feeling claustrophobic?
- On edge all the time, anxious, insecure
- Under-developed socially, emotionally
  - → too much to take on
  - → didn't know what they did [illegible]
- YP didn't respond to boundaries, containment
  - → vulnerable, easy to influence
  - → would not stop like other children did
  - → Didn't stop for PC's, had to be big!
  - → School negatively re-enforced this

Themes

- Aggressive start/Came out fighting
- Fight or flight
- Difficulty separating
- Lack of resources
- Understanding
- Difficulty separating
- Are we prepared for this?
- Vulnerability
- Lack of containment

This first image shows the line-by-line coding process. The page has been divided into three columns. The first of these is the transcribed interview material. The second column was used for writing initial thoughts and comments. After these initial thoughts were completed for the whole transcript, they were read again in order to consider initial themes. The initial themes were written in the third column.

An example of this process can be taken from line number 8 in the first column where PC A (Anne) mentions,

> *"Well we adopted YP A (Albie) when he was 3 in erm the November, and erm very soon after Christmas he started showing high levels of anger and violence in the home"*

The initial thoughts corresponding to this were written alongside these words in the second column. These were,

New addition to the family then became aggressive 1 month later

- *aggressive start*
- *fight or flight?*

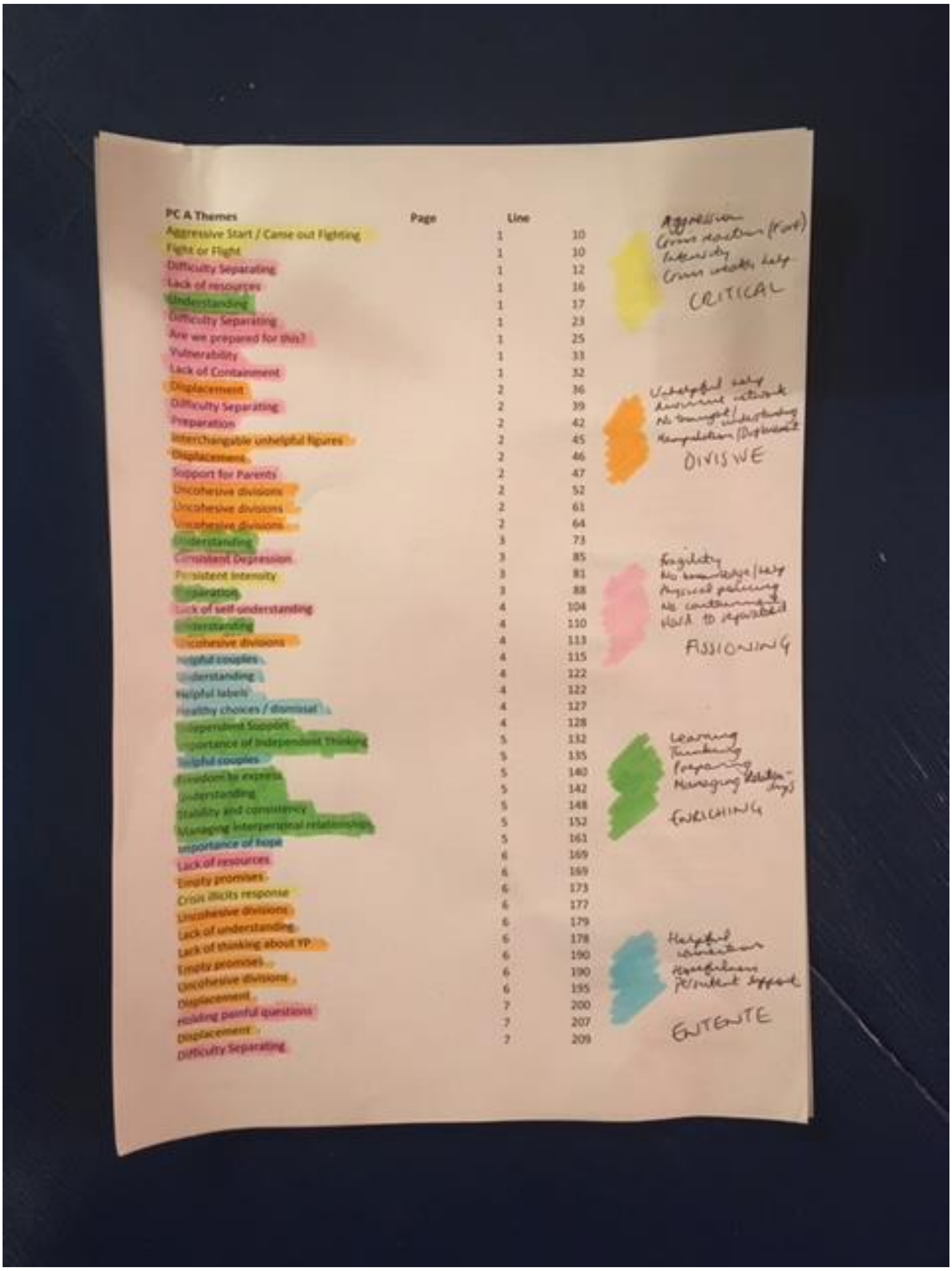
These initial thoughts were then used to consider initial themes, which were then written in the third column, again next to the above words as follows,

- *Aggressive Start / Came out Fighting*
- *Fight or Flight*

These themes were transferred to another table which can be seen in the second image on the next page.

The second image below is a further sheet gathering the codes from PC A’s (Anne’s) interview,

- The codes from the first image can be found at the top of the page.
- The codes were used to find overarching themes for PC A’s (Anne’s) interview, shown on the right side of the page.



PC A Themes	Page	Line	
Aggressive Start / Came out Fighting		1	10
Fight or Flight		1	10
Difficulty Separating		1	12
Lack of resources		1	16
Understanding		1	17
Difficulty Separating		1	23
Are we prepared for this?		1	25
Vulnerability		1	33
Lack of Containment		1	32
Displacement		2	36
Difficulty Separating		2	39
Preparation		2	42
Interchangable unhelpful figures		2	45
Displacement		2	46
Support for Parents		2	47
Uncohesive divisions		2	52
Uncohesive divisions		2	61
Uncohesive divisions		2	64
Understanding		3	73
Consistent Depression		3	85
Persistent Intensity		3	81
Preparation		3	88
Lack of self-understanding		4	104
Understanding		4	110
Uncohesive divisions		4	113
Helpful couples		4	115
Understanding		4	122
Helpful labels		4	122
Healthy choices / dismissal		4	127
Independent Support		4	128
Importance of Independent Thinking		5	132
Helpful couples		5	135
Freedom to express		5	140
Understanding		5	142
Stability and consistency		5	148
Managing interpersonal relationships		5	152
Importance of hope		5	161
Lack of resources		6	169
Empty promises		6	169
Crisis elicits response		6	173
Uncohesive divisions		6	177
Lack of understanding		6	179
Lack of thinking about YP		6	178
Empty promises		6	190
Uncohesive divisions		6	190
Displacement		6	195
Holding painful questions		7	200
Displacement		7	207
Difficulty Separating		7	209

Aggression
Crisis reaction (F or F)
Intensity
Crisis elicits help
CRITICAL

Unhelpful help
[illegible]
No thought/understanding
Manipulation / Displacement
DIVISIVE

Fragility
No knowledge/help
Physical pulling
No containment
Hard to separate
FISSIONING

Learning
Thinking
Preparing
Managing relationships
ENRICHING

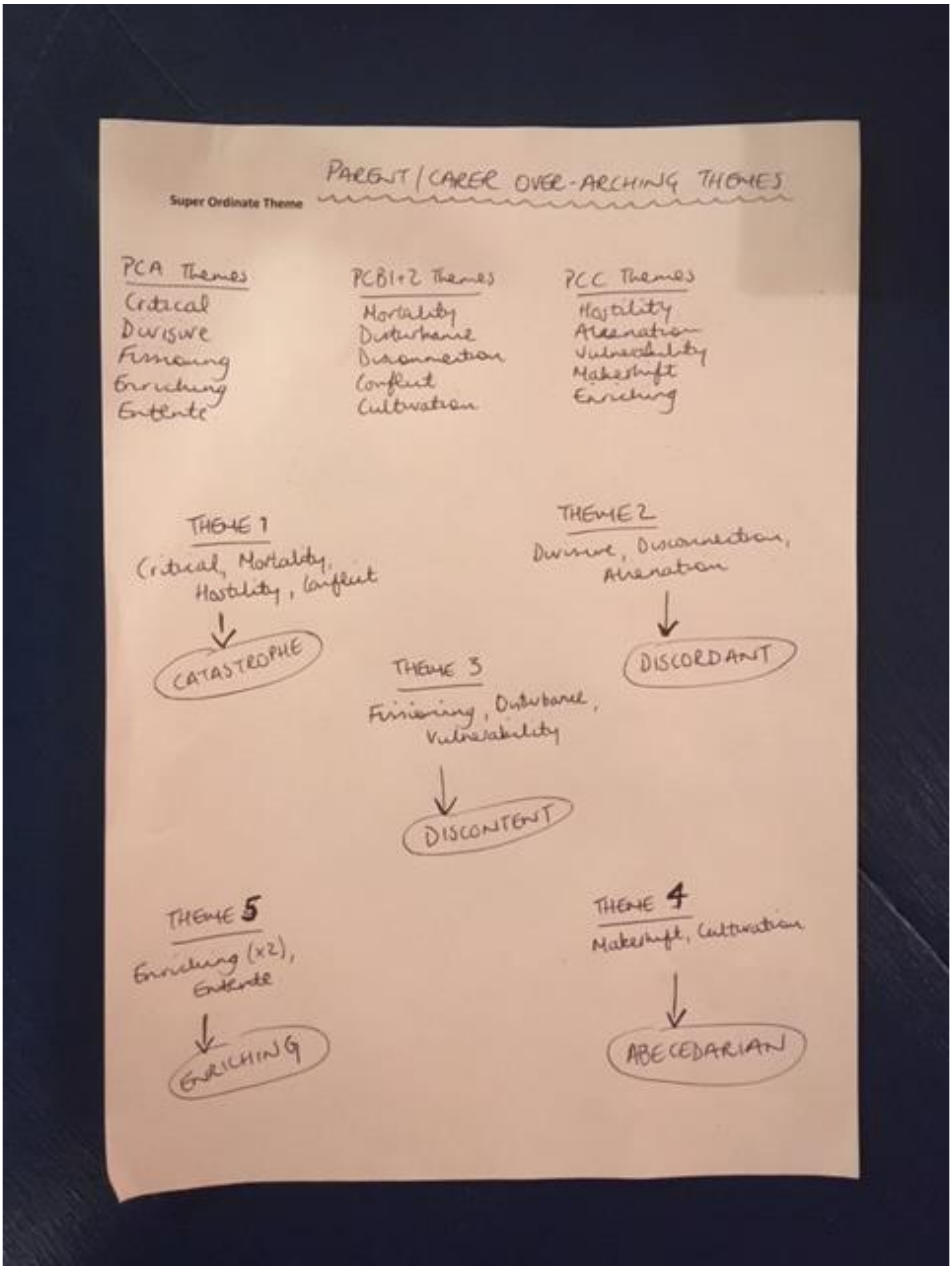
Helpful connections
Hopefulness
Persistent support
ENTENTE

To follow on the example from the first image, the two themes from the initial coding process (Aggressive Start / Came out Fighting, Fight or Flight) can be seen at the top of the page. All of the themes in this table were then re-read in order to be considered for overarching themes. Initial themes that related to one another or of a similar phenomena were then highlighted with the same colour. In the case of the example themes, yellow.

Once the initial themes had been gathered into related groups, the content of these groups were thought about in order to consider appropriate overarching themes. The most fitting thoughts around the grouping of initial themes were then written on the right of the page and highlighted in the same colour. These most fitting thoughts were further thought about in order to ascertain the appropriate overarching theme. Using the same example for PC A this was ‘critical’.

The overarching themes from each participant in their two datasets (young people, parental figures) were considered again in the next image.

The third image below details the gathering of themes from all parent/carer interviews in order to ascertain the overall super-ordinate themes (PC A = Anne, PC B1+2 = Brian and Bea, PC C = Connie):



Super Ordinate Theme PARENT / CARER OVER-ARCHING THEMES

PCA Themes	PCB1+2 Themes	PCC Themes
Critical	Mortality	Hostility
Divisive	Disturbance	Alienation
Fissioning	Disconnection	Vulnerability
Enriching	Conflict	Makeshift
Entente	Cultivation	Enriching

THEME 1
Critical, Mortality, Hostility, Conflict
↓
CATASTROPHE

THEME 2
Divisive, Disconnection, Alienation
↓
DISCORDANT

THEME 3
Fissioning, Disturbance, Vulnerability
↓
DISCONTENT

THEME 5
Enriching (x2), Entente
↓
ENRICHING

THEME 4
Makeshift, Cultivation
↓
ABECEDARIAN

This document details the overarching themes for each parental figure’s interview at the top of the page. The themes were then further thought about in order to consider how they would be appropriately grouped together to form overarching themes for the parental figures as a group, as well as the appropriate placing of the individual themes into their groups. Once the individual themes had been placed into appropriate groups, pertinent overarching themes for each grouping could be found. Again to follow the example used in this process, PC A's theme of 'critical' was grouped together with other themes under the group over arching theme of 'catastrophe'.

This coding process was outlined and discussed in supervision between the lead researcher and their research supervisor to check the coding process.

Appendix 7 - Reflective Account

Contextualising, Framing and Reflecting upon the Clinical Research Portfolio.

The clinical research portfolio has two different parts to it (in addition to this reflective piece); the clinical qualification paper and the clinical research dissertation. The clinical qualification paper is a detailed exploration and analysis of a piece of long-term intensive psychoanalytic child psychotherapy work undertaken as a trainee child psychotherapist. The aim of this work is to gather a detailed understanding of the progress of the psychotherapeutic work through an intricate exploration of the movements in the child's state of mind and why this may have occurred. Relevant psychoanalytic theories which are appropriate to the child's communications form an integral part of the exploration present in the paper . In contrast, the clinical research dissertation is the formal report of a piece of empirical research undertaken by the trainee child psychotherapist, which is then analysed using appropriate and relevant analytic methods in order to draw conclusions and implications. The discussion is informed by the introductory passages and a review of current literature in the field. Both of these components will be thought about separately before these considerations will be brought together to form final reflections on the portfolio as a whole.

Overall, the different components of the clinical research portfolio are as similar as they are different. Both have significant relevance to the training of a child psychotherapist, and for their ongoing research whatever form it may take. They are similar in that they both look to explore something in order to ascertain some meaning and understanding, however the methods utilised are different. They perhaps represent something of the differences between traditional and contemporary approaches to enhancing the skill set and knowledge base of child psychotherapy as a profession. These are important aspects to the role of the different aspects to the research portfolio, which will be discussed throughout this paper. The first component of the portfolio, the clinical qualification paper, is perhaps a more comfortable place to start as it is an embedded and well established part of training as a child psychotherapist, whereas the research dissertation is newly integrated within the training.

The clinical qualification paper is a long standing, essential part of training; a rite of passage that is imperative in facilitating the transition to formal qualification as a child psychotherapist. The undertaking of this has been a tradition in the training of child psychotherapists for many years. It is an opportunity for the trainee to demonstrate the knowledge and skills they have acquired throughout their training in both their clinical work and the application of relevant psychoanalytic theories to that case. The qualification paper is an integral part of confirming that the trainee is able to practice independently as a qualified child psychotherapist, but it does not solely serve this function and can be considered a research paper in its own right. Considering the qualification paper as a piece of clinical research, it can be appropriately described as a qualitative single case study. This specific research methodology is well established in not only the child psychotherapy tradition but the psychoanalytic tradition as a whole. The process of examining the intricate minutiae of a single piece of psychoanalytic work in order to explore specific theories of mind, both contemporary and established, remains central to the profession's knowledge base. Considering the piece of work that I conducted, it certainly felt to be an essential experience in bringing together the experiences I had with the young person that I chose to write about.

The young person I wrote about was a latency age male in local authority foster care who I saw for intensive work for a period of almost three years. This piece of work was incredibly challenging not only because of the psychological work, but also because of how physically demanding it was to contain the young person's violent projections. These came in the form of attacks on me, on the clinical space and on the play materials, which symbolised extensions of myself as his therapist. The central task was initially one of survival for both of us. Following the ability to survive and to carry on being, thought was allowed to begin to germinate between us in small moments between the ferocious omnipotent control that was exerted on me. As the work progressed these moments became more frequent and held more meaning, where we were able to think about the impact of significant events such as the emergence of a wedding ring on my finger, as well as the terrifying experience for the young person of falling victim to a natural disaster that devastated his foster home. It felt to me that this experience formed something of the backbone of my training, with the foundations and ground work to lead towards intensive work starting halfway through the first year with the intensive work itself continuing through to the end of the third year, with a gradual reduction in frequency of work ending a few months before my training post concluded. It was undoubtedly the nature of the work that provided an invaluable but tough learning experience, but this was not the only part of the learning that was highly beneficial.

The opportunity to give further thought to the work the young person and I undertook together through the writing of a paper was meaningful for a number of reasons. Before this could happen I needed to think about which period of the work to write about, as writing about almost three years of work would not be achievable in 12,000 words. This originally felt to be an inconvenience, however having such a limit required the writing to be focused and purposeful in its portrayal. Putting some further thought into which period of time to write about resulted in concentrating on the first year of therapy in depth whilst also providing ongoing context by giving a brief overview of the rest of the work. Concentrating on this period meant that focus and attention was paid to the detailed accounts of the sessions and the thoughts that these sessions generated in the supervision process. This intricate attention to detail meant that even more aspects to the work could be found and illuminated, aspects that had perhaps not been seen as significant prior to the writing of this paper. What further enabled this illumination was the consideration and application of relevant psychoanalytic theories that complimented the state of the young person's psychic reality at that moment in our relationship. In this young person's case, it was the excessive use of projection and projective identification and the core complex that provided effective theoretical templates with which to understand the young person's psychic life at the time of his first year in therapy. The combination of the attention to minute detail and the use of relevant theoretical ideas meant that significance was given to moments in therapy, such as the emergence of unexpected unconscious phenomena or quick changes in the transference relationship, that perhaps could have been overlooked. This feels something akin to Michael Rustin's idea of the therapy room acting as a psychoanalytic laboratory, whereby the tools that psychotherapists use can be tested out and explored in a multitude of ways. It is going through such a process as this that gives Rustin's words some meaning through the specific exploration of doing so myself.

What felt like the main challenge in the formal writing up of this piece of work was to do justice to the emotional experiences that this young person and I shared and evoked in one another throughout our work. In the writing there felt to be a tension between conveying the important aspects of the transference relationship and to apply psychoanalytic theories to the case without diluting the emotional content. As the paper progressed, the application of appropriate theory seemed to illuminate important moments in the transference and did not dilute them. However, this took a significant amount of contextualising and setting the scene in terms of exploring the nature of the appropriate theory, which is then further highlighted with the use of relevant clinical material from the case. The overall meaning of illuminating this was then stated afterwards. The purpose of pointing out this process is to show that it takes time and reflection, in order to convey the intricate phenomenon that occurred. and this is just for the conveyance of one part of the clinical work. The process of writing the clinical qualification paper felt imbued with meaning, learning and discovery. It was an invaluable process that not only helps in being able to write a paper for future endeavours, but also significantly conveys the voyage of discovery in each clinical encounter that can be used again and again to enrich future work. Keeping this in mind, it felt to a be a difficult task to then use clinical research in an entirely different way, when writing my dissertation, where meaning is discovered differently and with a different approach to the intricate details within. The clinical training is a long-term experience of gathering intricate details of clinical work in order to further add to psychoanalytic knowledge and understanding, where this occurs daily and feels like a naturally evolving process. The naturalistic element to this makes it a challenge to think in a different way and approach a significant piece of work in a different way, like the clinical research dissertation.

Before thinking about the specific experience of conducting and writing up clinical research, it is first important to point out the preferences I have in terms of the type of research selected. The training in child psychotherapy could also be thought of as training as a qualitative researcher who is interested in the acquisition of knowledge through exploration and interpretation, albeit through the specific lens of psychoanalysis. The enrichment I have felt through this training has already been alluded to, however this preference pointed me in a very specific research preference when considering whether to undertake a quantitative or qualitative research project. This natural preference for understanding individual experience naturally pushed me towards qualitative research. The prospect of gathering numerical data, or data to be converted into numerical values which would then be analysed using complex algorithms and formulas, filled me full of dread. This felt like something which needed to be avoided rather than welcomed, perhaps partly influenced by witnessing others' struggling with quantitative data analysis, but also by my own struggle in understanding these methods and making sense of them when reading about quantitative research. It felt like an easier and less confusing transition into conducting qualitative research rather than quantitative, but also more familiar. In the second year of the child psychotherapy training I had to complete an assignment which involved conducting qualitative analysis of a piece of clinical work. In this assignment I used interpretative phenomenological analysis (IPA) on the first page of an account of an individual psychotherapy session. I felt a great benefit from this piece of work on two fronts; the first that it helped me understand the process of IPA, and the second is that it informed my understanding of the young person from a different perspective which benefitted our work together. Referring back to this assignment helped to solidify the choice of research methodology I wished to use in my research dissertation.

The prospect of conducting clinical research and formally writing it up was a daunting and alien prospect at first. The child psychotherapy training felt very geared towards training as a child psychotherapist, rather than being trained as a formal researcher (not an implied one, as discussed about the nature of psychotherapy being like research). It felt through the training that the research teaching, although of high quality, acted as more of a bolt-on to the psychoanalytic training and not yet a well-integrated part to the overall training experience as a whole. The daunting feeling I spoke of earlier also alludes to a lack of confidence I felt as an inexperienced researcher, which may still be present in some form however prepared one is to conduct formal research for the first time. The topic to be researched within the proposed study went through several different ideas before being finalised as looking into young people's experiences of getting help and treatment prior to contact with a child psychotherapist. All of my previous research ideas seemed to centre around the exploration of individual phenomenological data, such as how a creative outlet may benefit a young person's psychological recovery.

The initial phases of the clinical research study was to formulate a research proposal which was discussed with the research module teaching staff. Once the project was agreed as one that could be realistically achievable, an application for ethical approval was made. In my case, the ethical process felt very long and arduous. Due to the study involving data acquired from direct contact with service users, the study required approval from an ethical research committee as well as approval from an individual health research authority assessor before it could proceed. This process involved several steps which were lengthy, meaning the ethical approval process took the best part of one year from initial application to final approval to proceed. Following on from this, the recruitment phase was also very elongated as it spanned one year due to unforeseen complications. This was due to several factors, including young people being reluctant to participate due to long waits and suffering significant deterioration in their mental health. These were concerning delays to experience, but the anxiety these evoked were contained through regular contact with my research supervisor. Once the data had been gathered through semi-structured interviews, I could commence the data analysis phase. Prior to this, I transcribed all interviews myself, which proved invaluable in being able to analyse the naturalistic phenomenon within through being immersed in the data by the transcription process, despite it taking a lot of time to do so. The data analysis felt to be a similar experience to being in a clinical session, in that it felt to be an interesting voyage of discovery of the intricate experiences that lay within the encounter of the research interview. This again was another phase that took time, and in my opinion it needed time and freedom to be able to uncover the individual phenomenon. If there was too tight a pressure on time then there may have been a parallel pressure to discover the themes, which may have been decided upon prematurely and inaccurately. It may have meant a further inaccuracy;

as a psychoanalytic practitioner, whenever new experiences are encountered then it becomes natural to try and understand these through the lens of psychoanalytic theories. This is not what is required to conduct IPA on new data. IPA requires a naturalistic and neutral stance in the IPA researcher that is free from desire and influence as much as possible . Putting this into practice, as a first time IPA researcher I needed to firstly be conscious of my tendency to view experience through the psychoanalytic lens, then secondly attempt to put this to one side and consider what was conveyed in a purely phenomenological way, using things such as the language the individual used and the way they conveyed it to try and comprehend their individual phenomenon. This was a challenging process to undertake due to how natural it felt to think psychoanalytically. Once the data had been analysed using IPA, psychoanalytic theories were used later to help make sense of the super-ordinate themes so that conclusions and discussion points could be found. I do not wish to presume that I achieved a good balance of neutral phenomenon, however it felt to be a reasonable start. Through the whole process of undertaking the study and the formal writing it up as the clinical research dissertation, a number of reflections emerged.

The first thought that emerged was an awareness of the tension between quantitative and qualitative methodologies, something that remains ongoing in the search for relevant clinical research that informs clinical practice. Despite my preference for qualitative data, quantitative data can include much larger sample sizes in evaluating a specific experience or intervention. However, quantitative data cannot illuminate individual voices and experiences in the same way that qualitative analysis can. There is a place for both of these methods, and that even though having a hierarchy of desired research methods (e.g. random controlled trials (RCTs) seem to be the gold standard), this should not be followed religiously (e.g. as found in NICE guidelines) but with careful thought about what kind of information is needed to be gathered from the specific study. I also reflected on the importance of understanding the context to a study in order to further understand the results that emerge and therefore the generalisability. The context of the current state of children's mental health services and how it is viewed by the public and the media goes some way to understanding why the experiences illuminated from this study mainly consist of negativity, fractiousness and struggle. Although this felt to be a disturbing set of results, considering context makes it understandable and predictable which allows for conclusions to be gathered and asserted. A final reflection on the clinical research dissertation is that it was a surprisingly enjoyable and fulfilling process to do. Despite it feeling elongated, arduous and time consuming, it also felt to be a hugely informative, enlightening piece of work to undertake. The ability to gleam significant messages within the phenomenological data to inform services' understanding of the individuals they come into contact with, felt very fulfilling. It also sowed a seed for undertaking further work in clinical research, whether it be individually or part of a research team, something which I hope to return to at some point. The ability to undertake clinical research feels like an important skill for a modern healthcare clinician to develop. With this in mind, it is pertinent to now gather up the thoughts already conveyed in this reflection in order to consider overall thoughts and reflections.

As previously pointed out, the two different components of the research portfolio, the research dissertation and the qualifying paper, are different but not as different as originally thought. Both can be thought about broadly as qualitative research, one is single case study research (qualifying paper) and the other (research dissertation) is a small-scale study utilising IPA. The methodologies are clearly different, but both are used to understand the intricate details of our experiences, albeit through different lenses. Both of them have relevance and applicability but in different ways. The clinical qualifying paper, or single case study, plays an important role in two ways. The first is the detailed exploration of clinical work by qualified psychotherapists as a method of confirming existing theories, or the discovery of new theories and ways of working. The use of these theoretical explorations are integral in the training of child psychotherapists by using them as learning and reference material, e.g. practice-based evidence. The second is also important to the training of child psychotherapists as mentioned before, as a way of demonstrating the theoretical knowledge and clinical skills that they have gathered throughout their training in readiness to become qualified practitioners in their own right. This methodology has great importance in training and education, but has limited applicability in its use as clinical research to gather understanding of a range of experiences or evaluate interventions. In contrast, formal qualitative research such as the clinical research dissertation, or small-scale IPA study, is more able to produce understanding and conclusions that can inform clinical interventions and delivery of services e.g. evidence-based practice. Clinical research is a neutral process, rather than something that is purely psychoanalytically focused, as with the single case study research. Psychoanalytic single case studies have a long and important tradition in the field of psychoanalysis, whereas the use of more contemporary research methods are relatively new in their uses in this profession.

The use of the two different components of the clinical research portfolio symbolically represent the dilemma and tension that exists within the area of research in psychoanalysis. This by no means a new dilemma, but one that has existed for a long time. The qualification paper is the familiar, older part to the portfolio, whereas the research dissertation is new in its integration as a required aspect to the child psychotherapy training. This represents the historical context; the use of single case studies can be traced back to the founders of psychoanalysis, such as Klein and Freud, whereas the use of other research methods in psychoanalysis has long been resisted. This has been due to a fear of diluting the contribution that psychoanalysis can make to psychological understanding. There is a degree of truth in this, however psychoanalysis and psychotherapy face different challenges than it has faced before. There are various papers and articles which discuss the difficult fight for survival that these professions are currently embroiled in due to briefer psychological treatments that are reinforced by highly regarded clinical research, e.g. RCTs. If the psychoanalytical professions such as child psychotherapy are to endure in the turbulent modern healthcare arena, then these more novel approaches need to be used in order to assert our place as an essential profession in not only the mental health field, but in many areas of healthcare. The integration of the two components of the clinical research portfolio is an important step to achieve this, but there is further work required in order to further integrate it into clinical training, and to assert the importance of both for the modern psychoanalytic practitioner. Skills in both of these component areas will equip child psychotherapists such as myself not only to survive in the modern healthcare construct, but also actively contribute to knowledge within this field. Psychoanalytic research and psychoanalytically informed research is a gradually growing field, one that will in my view, makes an invaluable contribution to both modern clinical work and the acquisition of further learning and thinking.