What are the advantages of offering adolescent exploratory therapy (AET) in preparing adolescents to engage in psychotherapy?

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

Tavistock and Portman NHS Foundation Trust

University of Essex 24.03.2023

Acknowledgements

I would like to thank Jocelyn Catty and Brinley Yare for their encouragement and support. Thank you to Moira Shulman for supporting me in bringing the project to completion. I am grateful to Elena Della Rosa for her thoughtful and patient supervision throughout the project. I would also like to thank all the participants for their generosity and inspiring work. A big thank you to Sarah Fielding and the staff at the Brent Centre for their support and collaboration in this study.

I would like to thank my partner Rosalind Holmes, for her indefatigable support and belief in me and for her help to bring the final thesis together. I would also like to thank my children for their unwavering patience and love. Finally, I would like to thank my analyst for her support and wisdom.

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Abstract

Objectives: This study seeks to explore the views and perspectives of Adolescent Psychotherapists offering Adolescent Exploratory Therapy (AET) and Adolescent Psychotherapy to adolescents in their in-house services at the Brent Centre for Young People (BCYP). The study aims at researching participants' understandings and views on the aspects of AET that facilitated or hindered adolescents' transition to long term Adolescent Psychotherapy.

Methods: 8 adolescent psychotherapists were interviewed, using semi-structured interviews. Interviews were transcribed verbatim and analysed using a constructionist grounded theory approach (Charmaz, 2014).

Results: Therapists discussed how they conceptualized adolescence as experiencing a loss of control and agency. They discussed a psychoanalytically informed frame that allowed them to engage adolescents and empowered them to gain insight into their difficulties, which in turn promoted the therapeutic alliance between adolescents and therapists and stimulated adolescents' commitment to seeking further help in the form of psychotherapy.

Conclusion: The findings stress how adolescents can find it difficult to seek help with adults as this threatens their individuation-separation process and agency. Conversely, some adolescents are too frightened to engage with the development process coming stuck in their development. AET is designed to take into account some of the developmental difficulties

adolescents have in engaging in psychodynamic oriented therapy. In addition, AET aims at forming a therapeutic alliance with the adolescent from the very beginning of treatment. Furthermore, AET is designed to foster the development of agency and insight into young people's psychological difficulties and need for further help in the form of psychotherapy while maximizing the young person's sense of agency. Further larger-scale research on AET from adolescent patients' perspectives is recommended.

Key words: *Adolescent Psychotherapy, Adolescent Exploratory Psychotherapy, preparatory work, psychotherapy dropout.*

Introduction

G. Stanley Hall (Hall, 1904) was the first researcher to understand adolescence "as a separate stage of life subject to enormous stresses and strains" (as cited in Savage, 2007, p. 66). Hall was one of the first researchers to identify adolescence as a "new birth" and a sensitive period in human development. Some recent empirical research has characterized adolescence as a stage in which an extensive psychological and neurobiological restructuralization takes place only comparable to the growth and maturation that occurs in the first few years of life (Sowell, Thompson, & Toga, 2007; Giedd, 2004; Blakemore & Choudhury, 2006). This has led some researchers to declare adolescence as a "second chance" (Blos, 1967) or "the promise of adolescence" (Stenberg, 2014) implying that adolescence is paradoxically a time of growth but also a time of risk which has the potential to shape developmental trajectories (Modell & Goodman, 1990; Graber & Brookes-Gunn, 1996; Steinberg, 2002; Steinberg, 2014; Greenfield, et al., 2003; Learner & Castellino, 2002).

From a psychoanalytic perspective, adolescence has also been considered as a crucial developmental crossroad in the human cycle. Some young people will undergo temporary adjustments to the turmoil brought about by adolescence whilst others will go on to experience mental health difficulties which can develop into persistent adult psychological problems (A. Freud, 1965; Moffitt, 1993; Walker, Sabuwalla, & Huot, 2004; Steinberg et al., 2006).

Psychotherapists who work with adolescents have recognized the difficulties in engaging adolescents in psychotherapy. They are also concerned with how to prevent adolescents from

prematurely dropping out of psychotherapy. Similarly, within psychoanalytic practice and theory there has been an effort to adopt psychotherapeutic methods and techniques to working with adolescents in ways that are sensitive to this age group and their individual developmental characteristics. Systematic research and randomized controlled trials (RCTs), have shown promising evidence of the efficacy of psychodynamic or psychoanalytic therapy in fostering enduring therapeutic gains in adolescents and young adults (Driessen et al., 2015; Abbass et al., 2013).

However, not all adolescent patients respond to treatment and the rates of treatment drop out (Kazdin, 2003; Fonagy et al., 2015; de Haan, et al., 2013), and poor attendance rates (Gearing, Schwalbe, & Short, 2012; Shirk, 2011) have been a cause for concern. Mental health services are facing increasing pressures to provide short term to medium term open-ended and time limited psychoanalytic psychotherapies to adolescent populations.

Similarly, within the child and adolescent psychotherapy professions, efforts have been made to dovetail therapies in order to accommodate them to the needs and particular characteristics of adolescent and young adult patients. Some researchers have called for the need to make therapies more flexible when working with adolescents (Hudson et al., 2014). This philosophy seems to respond to a need to make the service accessible to young people who are reluctant to seek treatment (Briggs, 2019).

This qualitative research uses a grounded theory methodology as developed by Charmaz (Charmaz, 2006) to investigate what aspects or ingredients of the therapeutic processes are considered to contribute to positive outcomes in clinical work with adolescents. I have chosen this methodology because unlike other qualitative methodologies it has the ability to go beyond mere exploration and description to explaining phenomena in applied settings which have not been conceptualized by theory (Birks & Mills, 2015; Miller, 1995).

Adolescent Exploratory Therapy (AET) is a form of open-ended therapy which combines assessment as well as psychotherapeutic intervention. AET was developed at the Brent Centre and it was designed to offer a period of preparation for long term psychotherapy (De Sauma, 2005). AET appears to have been designed to take into account the specific developmental characteristics of adolescents that make this age group particularly challenging to engage in long term psychotherapy. The purpose of the present study aims to explore which structural and relational factors are involved in Adolescent Exploratory Therapy which facilitates or hinders adolescents to transition to adolescent psychotherapy from the psychotherapist's point of view.

Chapter 1 Literature Review

1.1 Aims

My main aim for this chapter has been twofold. In the first part of the literature review I provide important contextual information about Adolescent Exploratory Therapy, its structure, aims and background history. In the second part of the literature review a more formal critique of the literature is presented. I have decided to use the main aims of AET as outlined by De Sauma (2005) as a starting point for the key concepts that were used in the empirical research and psychoanalytic literature.

1.2 Adolescent Exploratory Therapy in context

The Brent Centre for Young People (BCYP) began its life as a walk-in clinic in 1967. At the start, only a small number of young people were offered psychotherapy or psychoanalysis. Most were offered extended consultations, known then as 'interviewing' (Shillito, 2020). Interviewing aimed to engage adolescents in thinking about the difficulties in their lives that prompted them to approach the centre for help (Flanders et al., 1996; Novick, 1977; Joffe, 1991).

This therapeutic model was underpinned by psychoanalytic ideas of adolescent development and developmental breakdown (Bronstein & Flanders, 1998; Flanders et al., 1996; Laufer, 2012). AET is designed to function as an extended period assessment and exploration of once-weekly sessions. AET aims at giving the adolescent the opportunity to own their difficulties and transfer into psychotherapy if needed (Shillito, 2020). Those who needed further treatment were usually offered either weekly or twice weekly psychotherapy or psychoanalysis (Wilson, 1997). Interviewing was thought to have therapeutic benefits, leading to the development of Adolescent Exploratory Therapy (De Sauma, 2005; Shillito, 2020). It is important to underscore that AET also came about partly as a response to the clinical experience of premature break down of psychoanalytic based treatments offered to adolescents (Bronstein & Flanders, 1998).

1.3 AET Structure

Adolescents at the BCYP are referred via their GP which is likely to appeal to adolescents who are interested to start treatment (Baruch et al., 1998; Kazdin, Mazurick & Bass, 1993). At the end of each session, the young person can opt to come back for follow-up sessions.

This flexibility enables the adolescent to retain some degree of control and not feel trapped in a relationship of dependence (Alfillé-Cook, 2009).

The frame or structure in AET is based on psychodynamic method where the sessions are with the same therapist, at the same place and at the same time. In AET sessions are 45 minutes in length as opposed to the 50 minutes that a psychotherapy session would last for. AET serves as an assessment period (between six months to a year) of once-weekly exploratory sessions (Shillito, 2020). Those adolescents who need further help are offered Adolescent Psychotherapy at up to three sessions a week for up to three years (Brent Centre, 2022). In these cases, the adolescent is transferred to a different therapist to the one they were seeing for AET.

Adolescents are made aware the AET is time limited which puts the end in sight from the very beginning (Baruch et al., 1998; Bronstein & Flanders, 1998). As part of transfer from AET to psychotherapy there is a change of therapists which can lay the groundwork to help the adolescent choose psychotherapy instead of extending a relationship of over dependency on the AET therapist.

1.4 The aims of AET

Laufer believed that some disorders in adolescence were linked to developmental difficulties and needed psychoanalytic treatment (Perret-Catipovic & Ladame, 1998; Laufer, 1998). However, early clinical experience and research at BCYP suggested that many of the young people seeking help at the BCYP were not ready to take part in psychoanalysis or psychoanalytic psychotherapy due to their level of disturbance or lack of insight into their psychological and behavioural problems (Flanders et al., 1996).

De Sauma (2005) has suggested that offering ongoing psychotherapy to adolescents is not helpful, as the young person does not understand what psychotherapy would imply and would

not know what to expect (Alfillé-Cook, 2009; Midgley et al., 2014). They would not understand the reason he or she is being offered something he/she has not experienced before and would drop out. Alternatively, they would submissively accept only to leave treatment prematurely.

The literature on work with adolescents in community services such as at the Brent Centre describes the framework necessary to facilitate engagement and to prevent premature dropout (Bloch, 1995; Laufer & Laufer, 1987; Wilson, 1991). This includes, but is not limited to, accessibility by allowing self-referral as well as the "setting out of procedures and ground rules and processes (the style, orientation and perceived attitudes of the therapist)" (Wilson, 1991, p. 451).

From an AET approach, Bronstein & Flanders (1998) have argued that adolescent patients might experience paranoid anxieties triggered by the prospect of seeking help with an adult. They describe several clinical cases whereby the adolescent patient appears to have reacted to the start of treatment by exhibiting paranoid fears of being taken over (Bronstein & Flanders 1998). They attribute the adolescent's fear of being taken over to pubertal changes occurring in their bodies. They argue that the adolescent's anxiety about entering treatment is a "fear of being passively overwhelmed due to the threatened loss of an omnipotent defence which had been established to cope with adolescent change" (Bronstein & Flanders, 1998, p. 34).

De Sauma argues that it is important to provide the adolescent with an understanding of the underlying anxieties as opposed to a "magic solution to the adolescent's problems" (p. 8). Adolescents who seek help at the centre might not understand that their emotional and behavioural problems are indicative of something else related to their own psychological world. Enabling the adolescents to own their need for help by developing some understanding

that their emotional and behavioural problems are symptomatic of something else specific to each of them is key (Hurry, 1986).

According to De Sauma (2005), the aims of AET can be summarized as follows:

1) Establishing a therapeutic space where clinician and patient could create an alliance based on trust and respect.

2) Exploring with the adolescent the real reasons that brought him/her to the Centre and helping him/her to understand them.

3) Helping the adolescent to own his/her own difficulties instead of attributing them to other people like teachers and parents or to institutions and society in general.

4) Helping the adolescent to feel the need for further help in the form of intensive psychotherapy, other psychological therapies, or psychiatric intervention.

5) In addition, interpreting the transference in AET is not the central aim as it might be in psychotherapy or psychoanalysis, instead the development of the transference is followed very closely which enables the therapist to understand the young person's difficulties and needs (Bronstein & Flanders, 1998).

1.5 Systematic Literature Review

In order to investigate the literature available around my research question I used a conceptual framework based on the aims of AET to further develop my search concepts and keywords. I then created synonyms for each of my keyword concepts as shown in the table in appendix 1 (see Appendix 1).

I gathered the literature via my EBSCOhost account. In addition, I sourced several studies and relevant literature using different search browsers (Google Scholar), online journals (Journal of Child Psychotherapy) and other research databases (PsycInfo, PsyArticles and PepArchive). I used texts obtained from the Tavistock and Portman NHS Trust Foundation library. I used Boolean operators 'AND' and 'OR' in conjunction with other techniques such as double quotes in the search engine or * when searching for plurals to find relevant papers for the literature review.

Relevant material such as journals, books and articles were obtained from online libraries. I also emailed the Brent Centre for relevant unpublished papers that they might hold in their archives related to AET. The literature review is organised in topics that address different aspects of the research question.

1.6 Evidence regarding the mental health needs of adolescents

The literature highlights that many adolescents and young people face multiple developmental challenges and stresses that affect all aspects of their life (Arnett, 2015; Roisman et al., 2004). According to Kessler and colleagues (Kessler et al., 2005) mental health disorders will present before the age of 14, and 75% by the age of 24. Young people between the ages of 12 to 30 years face developmental demands and challenges that pervade all aspects of their life making adolescence and early adulthood a crucial phase for the development of mental health difficulties (McGorry, 2018). The transition from adolescence into adulthood is a sensitive stage of development. Mental health difficulties during this phase of life can affect a whole host of developmental milestones, including financial independence, educational and employment attainment, identity and relationship formation, and attending autonomy (Moffitt & Caspi, 2019). In England, data from the 2017 MHCYP

study found that 15.3% of young people aged 11–19 had at least one mental health disorder. In addition, 6.3% of young people were thought to have two or more mental health disorders (NHS Digital, 2020).

1.7 Shortage of provision for adolescents and young people

Although adolescents and young adults have the highest level of need, they also have great potential to benefit from mental health care. This age group have poor access to well-timed mental health services (McGorry et al., 2022). The average waiting time to start psychological therapies was 18 weeks (Crenna-Jennings & Hutchinson, 2020). Long waiting lists to access psychological therapies have meant that a vast number of young people have disengaged from treatment due to waiting times between sessions (Frith, 2017). About 26% of young people and children referred to CAMHS services were not accepted in 2018-2019 (Whitney et al., 2018). Evidence suggests that young people who reported their mental health got worse while they were waiting for support (Edbrooke-Childs, 2020).

The research literature suggests that young people and young adults do not have timely access to the support they require when they need it (CQC, 2018). In addition, an upper age limit of 18 years has been institutionalised in mental health services which can be experienced as an abrupt and disrupting change from child to adult services which can lead young people to deteriorate or even disengage from services (Youth Select Committee, 2015). Broad and colleagues (Broad et al., 2017) suggested that young people can experience the timing of transition to adult services as random and out of step with their developmental needs and priorities. Several authors have argued that a child-adult template for mental health services is not only developmentally misaligned but can lead to a disruption of service at a time when it is needed most (McGorry et al., 2022). They argue that new models of

integrated mental health services aimed at the 12–25 year age group are needed to end the damaging transition point at 18 years. Services like the Brent Centre offer such integrated mental health services to young people in the 11-24 year age group whom the NHS do not have the capacity to treat.

1.8 Psychoanalytic theories of adolescent development

Most psychoanalytic and psychological schools have conceptualized development as a chronological emergence of a new hierarchical organization of the body and mind which includes stages (Freud, 1905), positions (Klein, 1935) or developmental lines (A, Freud, 1965). More recently, Waddell conceptualized development as "process" (Waddell, 1998) occurring through the life course in which regressing or developing might occur in an uneven process (Bion, 1962; A. Freud, 1965; Meltzer, 1986).

In the psychoanalytic literature there is no marker of the beginning and the end of adolescence, although most thinkers believe it to start around 11/12 years of age and end around 25 years of age. However, there is a significant corpus of knowledge that conceptualizes adolescence as a long transition into adulthood (Arnett, 2012) that extends into the third decade. This transition into adulthood can take place in a piecemeal or in uneven ways (Briggs, 2019; Jones, 2006) and is influenced not only by biological aspects but also by sociocultural ones and requires specific psychological qualities (Furlong & Cartmel, 2007).

Bodily changes during adolescence give rise to new sexual and aggressive feelings which can threaten the adolescent with overwhelming anxiety. During adolescence there is an increase in depressive anxieties linked to the task of individuation and separation (Waddell, 2018;

Bronstein, 2020). Others have argued that adolescence involves a period of identity crisis (Erikson, 1968; Blos, 1967; Briggs, 2019).

Laufer (1997) wrote about the importance of integrating the new sexually maturing body into a new sense of a mature identity. Laufer and Laufer (1984) have emphasised that a central task of adolescent development is to change the relationship to the body. They suggest that a sense of self is dependent on the successful integration of sexual bodily changes into a sexual identity.

Waddell (2018), building of the work of Melanie Klein (1946) has argued that adolescence involves a "normal regression" to infantile states of mind, which is characterized by paranoid-schizoid position (i.e., by extremities of splitting, projection, and denial). Adolescence entails a revisiting and reworking of old infantile oedipal conflicts in the face of heightened sexual and aggressive impulses that will test the early emotional growth of the depressive position, in spite of intensified paranoid-schizoid splitting.

Bion (1969), suggested that early success or failures to establish an internal container determines the ability to think about new experiences. In the face of intensified anxiety, the young person must find ways to master it, avoid it or to deny it. Waddell argued that the ability to "think about and suffer emotional experiences feeds the mind and promotes growth", arguing that this capacity is "constantly opposed by the intolerance to frustration and emotional pain" (Waddell, 1999, p. 217). Waddell (1999) argues that growth and development is predicated in the capacity of the adolescent to develop a capacity to think symbolically as opposed to act out their feelings.

Building on the Laufers' work, Ladame has suggested that adolescence is a process of becoming-a-subject that requires the adolescent to take part "in an internal struggle and a social process, which confers meaning to intrapsychic and intersubjective experiences of

change" (Ladame 2008, p. 77). There is growing consensus among psychoanalytic writers that the process of identity formation not only extends beyond adolescence but adopts the characteristic of a life-long enterprise (Bohleber, 2010).

1.9 The challenges of psychoanalytic psychotherapy with adolescents

For Anna Freud, an increase of drive energy during adolescence disturbs the pre-existent balance between ego and id leading to a debilitated ego (Perret-Catipovic & Ladame, 1998). Other changes during adolescence such as rigidity of defences, poor frustration tolerance or tendency to avoid emotional pain by action were regarded as incompatible with psychoanalytic work with adolescents.

Blos (Blos, 1962) underlined the problem of the resurgence of infantile instincts and Oedipal anxiety during adolescence. These emotions, experienced as dangerous and shameful, typically make it difficult for adolescents to undertake therapy. Adolescent patients often experience the setting as intrusive and threatening and can easily feel afraid of regressing and experience the transference relationship as overwhelming and incestuous (Meltzer, 1978).

Blos (1980) finds that the adolescent is busy with this internal destructuralisation and that this process can be misunderstood by analysts as "resistance": "The dynamics of this intrinsically adolescent paradox had led—mistakenly—to a widespread pessimism about the feasibility or effectiveness of psychoanalysis during the adolescent period" (p. 148). He looks at adolescence as a second individuation process during which the young person is both regressing and striving to find a new independence and identity, separate from his/her parents.

1.10 Development breakdown, developmental impasse and trauma

The literature highlights the problem of distinguishing between "normal developmental turbulence" during adolescence and those that are more symptomatic of pathological illness that can become "life-course persistent" (Moffitt, 1993; Waddell, 2006; Flynn and Skogstad, 2006).

For Bateman (1996), developmental breakdown is linked to the solidification of early difficulties and its accompanying defences to the detriment of a possible reworking of these early conflicts and difficulties. Deadlock or foreclosure of development comes about when the young person feels the developmental process is too dangerous to engage in (Perret-Catipovic & Ladame, 1998).

Disturbed adolescents for the Laufers (Laufer & Laufer, 1989) tend to have a passive relationship to their body which can bring about feelings and phantasies which are experienced through their body as being forced upon them. The body presents itself on the mind of the young person in a powerful way which can cause the young person to behave in ways which are out of his/her control. They argue that breakdown can have untoward consequences for mental health, more importantly this could establish the belief that attacking and eventually destroying the physically mature body will be the solution to the young person's psychological problems. Therefore during adolescence the body can be perceived as the spring of these disturbing feelings and receptacle of the adolescent's hostility (Laufer, 1982). This often leads to behaviour aimed at manipulating, distorting, attacking and changing the body (Lemma, 2015)

Those adolescents who have been exposed to early experiences during infancy and childhood of physical or sexual trauma, neglect or unstable homes can predispose them to increased risk of depression and suicide attempts, among other health risks (Felitti et al., 2019). These

adverse experiences can be seen as potentially hampering what Waddell (2002) refers to as the 'psychic agenda' or 'the negotiation of the relationship between adult and infantile structures'. In this sense, aspects of infantile structures can reappear and can take over in a concrete and compulsive way in those adolescents experiencing breakdown. Treating adolescents who are experiencing a breakdown is a difficult task as violence; suicidality and propensity to act out are re-experienced in the transference relationship (Campbell, 2006).

1.11 Intensive psychotherapy and alternative psychoanalytic models

Several empirical studies have found evidence for the efficacy of long-term psychodynamic psychotherapy in the treatment of adults with enduring mental health difficulties (Fonagy, et al., 2015; Leichsenring & Rabung, 2008). Hauber et al., (2017) more recently carried out a study with adolescents with personality disorders in a hospital setting. As part of their study they offered intensive psychotherapy (5 times a week). In their pilot study they found that personality disorders in adolescents can diminish during intensive psychotherapy. A similar study was conducted by Feenstra et al., (2014) in a hospital setting for adolescents with personality disorder in which intensive psychotherapy was provided over a period of 12 months. These studies provide some support for the use of psychodynamic psychotherapy in the treatment of personality disorders in adolescents. Moran et al. (1991), conducted a number of high quality studies investigating the use of intensive psychoanalytic psychotherapy (3–5 sessions per week) to help adolescents with poorly controlled diabetes. Young people in the treatment group (receiving intensive psychoanalytic psychotherapy) experienced a significant improvement in diabetic control compared to the control group.

An early study at the Anna Freud Centre suggested that children with major depression showed reliable improvement and no depressive symptoms at the end of treatment, and those who had more intensive (4-5 times per week) treatment had better outcomes than those who attended once weekly therapy. Interestingly adolescents receiving intensive psychotherapy did not improve their outcomes when their difficulties were less severe (Fonagy & Target, 1994). Similar outcomes were found in the Horn et al. (2005) study. Midgley et al., (2006, 2017) in a qualitative study interviewed 27 adults who had been seen in intensive psychoanalytic treatment as adolescents. He found that for some adolescents receiving intensive psychotherapy contributed to their sense of stigma.

A community-based study of psychodynamic treatment for adolescents and young adults presenting with multiple difficulties by Baruch (1995) showed overall improvement in all domains of functioning during therapy. However, "externalizing" problems were more difficult to treat than "internalizing" problems. Moreover, young people with externalizing problems did better if they also presented with emotional problems or if the youth was receiving more intensive treatment and were older (Baruch et al., 1998; Baruch and Fearon, 2002; Baruch and Vrouva, 2010). Overall, there seem to be some evidence that intensive psychoanalytic based treatments are effective in treating mental health difficulties in adolescences. Midgley et al., (2021) in a recent narrative synthesises review of the evidence for psychodynamic psychotherapy suggests that there is some support for intensive psychodynamic psychotherapy especially for internalizing disorders such as depression, anxiety and emerging personality disorders. However, they acknowledge that there is a range of methodological limitations (small sample sizes, lack of RCTs). They suggest that further high-quality research is needed in order to better understand the effectiveness of psychodynamic psychotherapy for young people.

In the psychoanalytic literature, Wilson (1987) describes the Brent Centre approach to twice weekly psychotherapy or psychoanalysis. He argues that intensive psychotherapy can support the young person in negotiating his adolescence more adequately and finding a pathway towards a more confident sense of himself as an adult. He argues that intensive psychotherapy is the most thorough and intensive effort to reach back to past experience and to provide the opportunity to re-experience it, understand it and find alternative solutions and adaptations to the painful and conflictual feelings the patient may struggle with. For Blos (1967): "intensive therapy makes resistance (defenses) and transference the object of systematic investigation or interpretation. In a broader sense we might say that intensive therapy restores a lost or disrupted continuity in ego experience. Such a restorative achievement has far-reaching consequences: It promotes the process of individuation, it establishes firm ego boundaries, it stabilizes the distinction between self and object, and it enhances the faculty or reality testing" (p. 902).

Conversely, adolescence is a period of life when the idea of entering into a relationship of dependence is in conflict with the young person's developmental task of separation and individuation. Wilson (Wilson and Smith, 1997) writes about the conflict between the adolescent developmentally striving for autonomy and independence vis-à-vis letting themselves achieve the degree of closeness and dependency necessary for treatment. Laufer (1997) emphasises that psychotherapy can be challenging for adolescents who can feel compelled to regress, deviate and change their minds. Encouraging a young person to develop a relationship which elicits feelings of regression and dependency might need a committed endeavour by the youth as well as the therapist, since adolescence involves a process of moving against regression (Briggs, 2019).

Other researchers have argued that shorter-term therapies are better suited to the developmental needs of adolescents given that this age group is defined by a fear of regression and dependency and a striving for autonomy (Golombek & Kozenblum, 1995; Shefler, 2000). For example, the Improving Mood with Psychoanalytic and Cognitive Therapies (IMPACT) study (Goodyer et al., 2011), was a RCT that sought to compare treatment outcomes of depressed adolescents receiving CBT, a brief psychosocial intervention or STPP (Short-Term Psychoanalytic Psychotherapy) across different CAMHS settings in the UK. STPP was manualised into a treatment modality that was incorporated into the IMPACT study (Goodyer et al., 2017).

Short-term psychotherapy appears in the literature as an umbrella term to describe different ways of working with adolescent patients within a time limited or short-term frame. Presently, there are more than 250 randomised controlled trials published vouching for the efficacy of STPP with different mental health difficulties in adolescent populations (Lilliengren, 2020). Short-Term Psychoanalytic Psychotherapy has become an alternative to long term, intensive and sometimes expensive psychoanalytic treatments in services that face increasing economic pressures (Lemma et al., 2011; Malda Castillo et al., 2020).

The literature describes several types of time-limited psychoanalytic oriented psychotherapy with adolescents. Of particular interest is Briggs and colleagues' (Briggs et al,. 2015) 'Time-limited Adolescent Psychodynamic Psychotherapy' (TAPP). This is a 20-session manualised psychoanalytical model which aims at understanding adolescents' difficulty and focuses on developmental issues hindering the developmental processes. Briggs highlights that this intervention needs an approach that supports and promotes the developmental process with adolescents (Midgley et al., 2013). Briggs argues that this type of short term-psychotherapy

aims at facilitating the emotional and psychological separation from parental figures, including taking ownership of the adult sexual body, thoughts, wishes and desires (Briggs, 2008; Laufer, 1984). Briggs (2010, 2019) suggests that the time-limited aim of TAPP can help adolescents who are able to use this structure without feeling overwhelmed by an open-ended commitment.

While the time-limited nature of short-term psychotherapies with adolescents can help the young person who is able to use this structure, not all adolescents are able to engage with short-term psychotherapies let alone more intensive forms of psychotherapy or psychoanalysis (Briggs 2010, 2019; Baruch 2001). As I will discuss later, high dropout rates in short term psychotherapy with this age group is worrying and a significant challenge for mental health services (Kazdin, 1996; O'Keeffe et al., 2020).

Several psychoanalytic thinkers and practitioners have contended that a preparatory phase in adolescent treatment is indicated to minimize dropout (Blanck & Blanck, 1974; Sklansky, 1972; Midgley, 2013; Freud, 1927; Bronstein & Flanders, 1998; Baruch, et al., 1998; Slavin, 1996). Blos (1962) suggested that a preparatory phase is needed to put "the therapeutic work on firm ground" (p. 902). For Blos, offering more intensive treatment "can evoke a negative reaction" (Ibid) in the young person. This phase aims at cementing a therapeutic alliance, siding with the part of the adolescent's ego who wants help and introducing the adolescent situation (technique and roles). For Blos (1962), a psychotherapy preparatory period addresses the adolescent's most disruptive and troubling fears and fantasies, as well as expectations and hopes with which the adolescent approaches therapy.

The literature reflects some common themes in the anxieties that adolescents present at the start of therapy. These anxieties are linked to the nature of both the clinic setting and therapeutic process (Bloch, 1995; Laufer, 1987; Wilson, 1991). Whereas some can

experience the beginning of treatment as entrapping, for others, any hint of ending can be experienced as rejection or an injury to the maturing adult ego in the young person (Briggs, 2019; Cregeen et al., 2017).

Therapists are all too aware that adolescents are reticent to embark on long-term therapy, which can give rise to intensified anxiety at a point in their life in which the young person must navigate conflict associated with the separation and individuation process typical of this age. Conversely, a short time commitment can appear as an attractive treatment choice to those adolescents who are intensely anxious about establishing bonds of dependence. In cases such as these, a time limited treatment, or even a comprehensive consultation, can aid the young person to become aware of their difficulties. Short term interventions can support ongoing development as opposed to asking the adolescent to make a long-term commitment that can trigger fears of regression and entrapment in the young person (Aliprandi, Pelanda, & Senise, 1990; Ladame, 1991). Several authors argued that an extended consultation is not only a diagnostic instrument, but ought to be understood as a space with therapeutic potential for helping the adolescent think and individuate (Novelletto, 1991; Bronstein & Flanders, 1998; Joffie, 1991). Adolescents who are capable of engaging in psychotherapy often benefit from a pre-therapy phase before being able to commit to it (Ruggiero, 2006).

1.12 Adolescent psychotherapy dropout

In the literature there is a shared concern that adolescent populations show high rates of premature dropout from psychological treatments. The literature suggests that between 28% and 75% of young people dropout of treatment prematurely (de Haan et al., 2013; Swift & Greenberg, 2012; Warnick et al., 2012). In the IMPACT trial, when dropout was defined as ending treatment without the agreement of the therapist, 37% of adolescents were classified

as having dropped out of treatment, and a further 11% did not take up the treatment on offer (O'Keeffe et al., 2020).

Within the literature, researchers have studied the different predictors of premature dropout in adolescent populations. Kazdin's "risk factor model" (1996) considers the factors that could amplify the probability of dropout, for example symptom severity or socio-economic disadvantage. This model suggests that it is those adolescents with the more severe symptoms and socio-economic disadvantage whose risk is higher for dropout. Other factors, such as barriers experienced when attending treatment or not perceiving the treatment as relevant can increase the likelihood of dropout (O'Keeffe et al., 2019; Pellerin et al., 2010).

The literature suggests that adolescents find it difficult to own their problems, and seeking help through psychotherapy is at odds with an adolescent's need for autonomy, which can interfere with the adolescent's commitment to therapy (Oetzel & Scherer, 2003). Another important predictor is treatment expectations among adolescents prior to the start of psychotherapy treatment. Before treatment, adolescents tend to see the therapist as playing a big role in the therapy, while they see their own role as not requiring as much effort, which could result in premature dropout (Weitkamp et al., 2017; Midgley et al., 2016).

Related to expectation of therapy is the concept of locus of control (Rotter, 1966; Levenson, 1973). Internal locus of control describes a conviction in an adolescent that the outcome of the therapy depends on one's own effort. External locus of control refers to the conviction that change is affected by external factors such as a view of the therapist as a powerful other (Rotter, 1966; Levenson, 1973). Philips et al. (2007), reported that adolescents who drop out of therapy prematurely tended to deny and avoid taking personal responsibility for their

problems (External locus of control), whereas those who took ownership of their problems (Internal locus of control) tended to stay in treatment. This is consistent with Gergov and colleagues (Gergov et al., 2021) who found that helping adolescents own agency during the assessment could reinforce their commitment thus benefiting them more through further treatment.

Other researchers have proposed that being referred by adult figures as opposed to being self-referred might also contribute to premature dropout (Baruch et al., 1998; de Haan et al., 2013; Bird 1986, 1989). Finally, missed sessions early in treatment were also found to be predictive of dropout, with each missed session within the first four raising the risk of dropout threefold (O'Keeffe et al., 2017).

1.13 The therapeutic alliance in adolescent psychotherapy

Of particular relevance in the literature of studies with adolescent patients is the construct of the therapeutic alliance. Freud was the first to recognise that in order to increase the chances of a positive result in the psychoanalytic treatment we must "make the patient into a collaborator" (Breuer and Freud 1893-1895, p. 282). Other thinkers have since then expanded and built on the concept of the therapeutic alliance (Sterba, 1940; Zetzel, 1956). Of particular importance is the work of Greenson (1971) who conceptualised the notion of the therapeutic relationship as the collaboration between patient and therapist comprised of three distinctive constituent parts: a) the working alliance (the part of the relationship devoted to the "work" of treatment) b) the transference and countertransference (the distortions and defensive projections of both patient and analyst) and c) the real relationship (the real and transference-free reactions between patient and analyst) (Greenson, 1971).

Bordin (1979) proposed what has come to be regarded as the canonical definition of the alliance thus far. Bordin suggests that alliance is formed of three integrated dimensions: agreement on goals, the assignment of tasks, and the development of bonds (1979). In the literature, particular attention has been given to the emotional and relational dimensions of the alliance with adolescent patients. Given that their motivation to enter treatment is different to adults, adolescents tend to be referred by others and might have limited insight into their difficulties and therefore might not agree to or understand the need for therapy (DiGiuseppe et al., 1996). Others have disagreed with the emphasis on the bond dimension of the alliance and have argued that whereas for younger children the bond might be the main component of the alliance for adolescents there might be more of a wish for them to develop an awareness of their problems and wish to resolve them. Similarly as adolescents develop cognitively the emphases needs to shift towards the agreement on therapy goals and tasks for a robust therapeutic alliance (DiGiuseppe et al., 1996).

A robust sense of alliance in the first session is linked with positive therapeutic outcomes (van Benthem et al., 2020). However, the developmental task of separation and individuation from adult figures, and their fear of regression, makes it harder to find an agreement on therapy goals and tasks (Meeks, 1971; A. Shirk et al., 2010, 2011; Bailey, 2006; Shirk & Karver, 2003). Furthermore, the alliance with adolescent's parents or caregivers needs to take into account the parents' goals for the therapy as this might differ from the young person. Exciting research shows that parental and social support can be helpful to engage young people in therapy (Cirasola et al., 2022).

Similar to the adult literature, youth alliance research in the alliance with both adults and adolescents has consistently demonstrated a solid correlation between strong alliance and good outcomes. However, the picture of what characteristics in the adolescent contribute to the alliance-outcome link varies. For example, the link alliance–outcome was found to be

stronger for adolescents who were younger and female (McLeod, 2011; Shirk et al., 2011) but not in others (Cirasola et al., 2021; Karver et al., 2018). Similarly, having externalizing difficulties rather than internalizing ones was linked to a stronger alliance-outcome association in some studies but not in others (Shirk & Karver, 2003; Karver, et al., 2018; McLeod, 2011; Shirk et al, 2011). On the other hand, another study found that characteristics of age, gender, severity of difficulties, and behavioural problems did not have a statistically significant effect on the alliance–outcome association (Cirasola et al., 2021). This seems to suggest that establishing a robust early alliance is more important with some young clients than others, due to the variation of their characteristics.

The literature also highlights variation in the relationship between alliance and treatment type. For instance, Cirasola et al., (2021) highlights the lack of agreement on the conceptualization and how the alliance is operationalized in studies has resulted in definitions and measures of the alliance that might be more suitable for some types of therapy than others. Furthermore, Cirasola et al. (2021) in their meta-analysis on the alliance-outcome association have highlighted that the alliance in psychotherapy with young people plays an important role in outcomes. However, its impact on outcomes has been overstated. They suggest that the alliance–outcome relationship is not monolithic and it may be influenced by the young person and the therapist's characteristics, as well as therapy types.

1.14 Alliance ruptures in work with adolescents

The literature reflects a growing interest in the last 20 years in studying therapy alliance as an ongoing process involving a dynamic cycle of ruptures and resolutions in the alliance. Of particular importance has been the work of Safran and Muran (2000), who building on the work of Bordin (1979, 1994) reformulated the idea of the alliance as the ongoing, dynamic

quality of the therapeutic alliance over the process of change punctuated by moments of deterioration or ruptures and moments in which such tensions are resolved. These authors propose that the alliance undergoes withdrawal rupture moments whereby either clients or therapists move away from the other and/or the therapeutic process. It can also involve confrontation rupture moments where the patient or the therapist move against the therapeutic process or the other person involved.

Unresolved alliance ruptures tend to predict bad outcomes and dropouts. Successful resolution of ruptures have been found to lead to a stronger alliance and better outcomes (Daly et al., 2010; Gersh et al., 2017; Schenk et al., 2019; Cirasola et al., 2022). A particular difficulty that has been investigated is the so called pseudo-alliance, which refers to the adolescent's tendency to withdraw over confrontation ruptures to hide their disagreement or even pretend to agree with the therapist given the power imbalance between the adolescent patient and therapist which can hamper the adolescent's ability to disagree with their therapists openly (Cirasola, Martin, et al., 2022; O'Keeffe et al., 2020). New research emerging seems to suggest an overall prevalence of withdrawal over confrontation ruptures in adolescent psychotherapy (Cirasola, Midgley, et al., 2022; Gersh et al., 2017; O'Keeffe et al., 2020; Schenk et al., 2019). By contrast, behaviours on the part of the therapist such as 1) the therapist's failure to acknowledge the young person's emotional experience, 2) therapists being passive, unresponsive, or silent for long periods of time, 3) therapists persisting with a therapeutic activity which the young person had rejected or are not engaging in, and 4) therapists focusing on risk issues and a need to break confidentiality can also contribute to alliance ruptures (Morán et al., 2019; O'Keeffe et al., 2020).

1.15 Transference work in psychotherapy and AET with adolescents

In the literature several authors have written about the problems which can arise in the transference and counter-transference when working with adolescents. Most notable was Anna Freud (1958), who held a pessimistic view about whether a transference relationship with adolescents could develop. She believed that therapists should not pay so much attention to interpreting the transference, but instead the main focus should be directed at helping the youth to work through the defences obstructing the developmental process.

By contrast, Klein (Holder, 1999) highlighted the centrality of the role of phantasy in the transference which she believed developed from the start of treatment. According to her, the interpretation of the young person's innermost anxieties in relation to the analyst was a key component in therapy treatment from the outset. Klein thought that interpreting the patient's negative projections would facilitate the expression of anxiety and decrease the effect of negative feelings in the therapeutic relationship and the introjection of a more benign internal object (Hinshelwood, 1989).

One of the main differences in AET and adolescent psychotherapy is the use of transference interpretations. In AET, the therapist monitors the transference and countertransference closely, unlike in more intensive psychotherapy, where the focus of the session is on transference work. Bronstein & Flanders (1998) argued interpreting the transference is not the main goal in AET as it is in psychotherapy or psychoanalysis. The same authors suggest monitoring the transference and countertransference can provide a source of insight into the adolescent's difficulties and anxieties (Bronstein & Flanders, 1998; Alfillé-Cook, 2009; Joffe, 1991).

Bronstein and Flanders (1998) suggest that encouraging the unfolding of the transference would be detrimental in AET, given that the therapists doing AET will be referring the

adolescent to a different therapist for psychotherapy. Bronstein & Flanders (1998) make the distinction between understanding what is being transferred to the therapist from how that knowledge can be understood and communicated back to the adolescent in AET.

In addition, several authors have suggested that it is necessary to modify therapeutic technique in work with adolescents to take into account their developmental needs (Catty 2016; Alvarez, 2012). Edgcumbe (1993) suggested it is important to bear in mind the level of development of the young person when using transference. She distinguished between transferential issues stemming from active conflicts reproduced in the transference (which can be dealt with through interpretation of conflict and defence) and those interfering with mental processes earlier in development.

Psychoanalyst Warner Bohleber (Bohleber, 1996 as cited in Holder, 1999) echoing Blos's ideas (Blos, 1967) suggests that transference interpretations should only be used with adolescent patients if transference inhibits development. Bohleber suggests that the therapist must be careful with the newly gained identifications of the adolescent. If these new identifications are linked back to infantile experiences and identificatory processes by means of transference interpretations and genetic interpretations, and are not distinguished, this may provoke intense resistance on the part of the adolescent. This is because he must defend the process of becoming autonomous and might be struggling with issues of consolidation of his personality (Bohleber, 1996 as cited in Holder, 1999).

1.16 Studies focusing on transference work in psychotherapy and AET with adolescents

Since the 1970s, there has been growing interest in investigating the effects of transference interpretations (TI) in psychodynamic psychotherapies process and outcome research. One view has suggested that adopting an interpretative stance produces less favourable outcomes

and weakened therapeutic alliance across different forms of analytic therapies, including ones with high-level personality organization patients (Crits-Christoph & Gibbons, 2021; Luyten et al., 2012).

An interpretative stance with adolescents can bring too much attention to the therapeutic relationship and it can make some adolescent patients more anxious including ones with high-level personality organization. Early studies (Piper et al., 1991, 1999) suggested that in dynamically oriented therapy in which therapists used an interpretative stance there were higher drop-out rates compared to dynamically oriented therapies in which the therapists offered a supportive and exploratory stance.

More recently, there has been some evidence that adolescent patients might respond equally well to therapy with transference interpretations than without transference interpretations. Of particular importance is the First Experimental Study of Transference Interpretations (FEST) which investigated the effects of TIs on outcome variables by comparing adolescents who received TIs to patients whose therapists held the transference and countertransference in mind but did not make any explicit interpretations of it (Ulberg et al., 2021). The main results of the FEST revealed both treatments to have similar effects on the outcome.

Høglend and colleagues found that transference interpretations seemed to have helpful effects on long-term functioning in young people with personality difficulties and long-standing problems in creating meaningful and durable relationships (Høglend, et al., 2006, 2008; Piper, et al., 1991; Hersoug et al., 2014). Furthermore, the FEST study linked the use of transference interpretation to gains in insight and a subsequent improvement in interpersonal and global functioning, therapeutic alliance with the therapist and better outcomes (Johansson et al., 2010; Høglend, 2014).

Nevertheless, patients with higher object relation capacity appear to profit from moderate to low dosages of transference interpretations, but they have difficulty with high levels of it (Piper, et al., 1991; Piper, et al., 1993). This would suggest that with adolescent patients with poor object relations and mentalizing, the therapist might need to provide supportive interventions and containment to establish a safer ground before using interpretative interventions (Kernberg & Chazan, 1991; Baruch, 2001; Town et al., 2012). Another relevant aspect to take into account in the use of TIs is that of age and development, a young person aged 22 years is cognitively better prepared to use interpretative interventions than an adolescent aged 13 or 14 years (Kazdin, 1993).

1.17 Studies focusing on insight during adolescent psychotherapy

In the literature, there is an agreement that some adolescents are not aware of their difficulties and tend to disown their mental distress, projecting and putting responsibility elsewhere (Wilson, 1987). Flanders and colleagues (Flanders et al., 1996) conducted a qualitative study at the BCYP, they analysed the recorded psychotherapy sessions of 5 adolescent patients with the aim to study the role that Repetitive Compelling Behaviour (RCB) and Repetitive Compelling Thoughts (RCT) played in AET and subsequent psychotherapy treatment. They found that both RCB and RCT were associated with the young person's way of managing their anxiety. In their study they were able to establish that RCB and RCT played a role in those cases of adolescents seen in AET that dropped out of subsequent psychotherapy prematurely. This would suggest that AET could help adolescents develop a capacity to reflect and be thoughtful rather than being compelled to act out, thus increasing the chances of successfully engaging in psychotherapy.

Baruch et al., (1998) in a community-base study suggest that some of the difficulties in engaging these young people in treatment stem from a poorly developed capacity to reflect on their own and others' mental states due to developmental disturbances. The development of these capacities is crucial for engaging in the therapeutic process. Bronstein & Flanders (1998) suggest that AET functions as "a preparation for psychotherapy in that its aim is the development of some capacity to bear mental pain, to think about themselves, to own the need for help" (p. 15). The same authors agree with De Sauma (2005) in the importance of AET as a space for the development in the adolescent of self-understanding and self-reflection as key to the young person's transferring to psychotherapy.

This is borne out by different studies which suggest that increase in self-understanding or self-reflection may be associated with positive treatment outcomes in psychodynamic psychotherapy (Høglend et al., 1994; Kivlighan et al., 2000; Grande et al., 2003; Johansson et al., 2010; Crits-Christoph, Gibbons, & Mukherjee, 2013; Cropp et al., 2019; Bachrach & Leaff, 1978).

There is some evidence that supports the idea that psychodynamic psychotherapy helps adolescent patients gain greater insight compared to other therapies (Connolly-Gibbons et al., 2009; Jennissen et al., 2018). These studies evidence the theoretical hypothesis that insight could play an important role in the process of change in dynamic psychotherapy with adolescents and is associated with greater motivation to engage in therapy and fewer dropouts and better outcomes. Furthermore, Gatta and colleagues in their pilot study looked at the link between insight and working alliance in psychotherapy with adolescents. They noted that the adolescent's insight into their own difficulties was the greatest predictor of the adolescent motivation to accept further treatment when suggested (Gatta et al., 2010).

1.18 Qualitative studies focusing on therapists' views and experiences of offering psychotherapy

Binder and colleagues (Binder et al., 2008) in their qualitative study explored the perspectives of nine psychotherapists and the challenges they encountered connecting and forming a bond in adolescent psychotherapy. The therapists were part of CAMHS in Norway and in their study, they identified five themes: understanding the problem, so that collaborative work could be established; finding the therapist role; motivating the adolescent; engaging: developing a frame to co-create meaning making; and dealing with the adolescent's ambivalence. In their study they drew attention to the importance of the psychotherapist's subjective experience of therapeutic dilemmas (Binder et al., 2008).

Although common dilemmas amongst participants were identified, they had different solutions, but agreed that the creation of a therapeutic bond was difficult especially when the adolescent felt ambivalent. The researchers highlighted the importance of flexibility when providing therapy needs for young people which was at loggerheads with public mental health treatment and demands (Binder et al., 2008).

Qualitative studies involving interviews with clinicians have increasingly played an important part within the wider therapy research literature. This particular area has developed from a need to share applied knowledge and represents an alternative perspective to other types of research, such or qualitative studies of client experiences or RCTs (Binder et al., 2016). In their qualitative study, Råbu and Mcleod (2018) draw attention to the value of professional knowledge in areas of therapeutic knowing in contextualized settings. They argue that it is important to investigate the dilemmas associated with theory and practice experienced by therapists.

1.19 Conclusion

Both the psychoanalytic and empirical literature highlights that engaging and keeping adolescents in psychotherapeutic based treatments tends to be challenging, due to several developmental factors. Many young people seeking help my feel put off and frightened by the prospect of open-ended, long-term psychotherapy. The themes in the literature have highlighted some of the main themes that are important contributors to outcome in psychotherapy with young people. It has been suggested that engaging adolescents needs an adaptation of traditional psychoanalytic methodology to accommodate developmental tasks and disturbances within the context of the process of adolescence.

AET was designed to offer a period of preparation for long term psychotherapy. There is little literature available on what aspects and elements of AET can be helpful or unhelpful in preparing those adolescents who need it to transfer from AET to long term psychotherapy or psychoanalysis. Understanding psychotherapist views and perspectives of different modalities and aspects of the therapeutic process and therapeutic structures has been recognized as essential to clinical research. This study aims to explore from the therapist's point of view the techniques typically used by therapists both working in AET and psychotherapy with the view to understand how offering AET to adolescent patients can be helpful in preparing adolescents for formal psychotherapy.

Chapter 2 Method

2.1 Psychotherapy and Grounded Theory

Knowledge in psychoanalysis has tended to mainly come from clinical experience instead of formal research (Anderson, 2006). Despite this apparent mismatch between psychodynamic approaches with academic research, some efforts have been made to provide a dialogue between the two. Midgley (2009) draws attention to the current debates about the place and meaning of research within child psychotherapy. Applied clinical research has begun to investigate the efficacy of child psychotherapy, while process research has started to explore the mechanisms for change in psychotherapy. Midgley (2009), has noted that child psychotherapy has started to draw on qualitative methodologies from social sciences. This doctorate therefore seeks to wed both psychotherapy and research. Midgley (2004), stresses the importance of identifying research that can be credibly carried out and selecting suitable methodologies for its completion. Grounded Theory, he argues, is "considered highly complementary to traditional methods of psychoanalytic research" (Midgley, 2006, p 75).

2.2. Research aims and purposes

This study aims at exploring what makes AET a helpful model of therapy from the perspective of those who deliver it. It attempts to establish and explore what aspects of AET facilitate or hinder the process of preparing young people to move from AET to psychotherapy. It also explores the challenges and predicaments that those working both in

AET and more traditional forms of psychotherapy might encounter when working with adolescent populations.

2.3 Ontology and epistemology: Constructivist Grounded Theory (CGT)

This study employs a qualitative methodology to examine the views of adolescent psychotherapists using semi-structured interviews. The data was analysed using Constructivist Grounded Theory (CGT) (Charmaz, 2014). The study is underpinned by a constructivist epistemology and ontology position. Constructivism views reality as existing in relation to historical, cultural, and social dynamics and contexts (Bryman, 2016). Epistemologically, constructivism draws attention to the subjective nature of the relationship between the researcher and participant, and the construction of meaning (Pidgeon & Henwood, 1997; Hayes & Oppenheim, 1997). Epistemologically, constructivism argues that knowledge is co-created. Constructivist grounded theory advocates for a position where the researcher is an active co-constructor of knowledge generated in the research process, in contrast to the idea that researcher knowledge is unbiased (Charmaz, 2014).

I thought it would be appropriate to adopt a social constructivist approach to the study given that social constructivism regards the creation of knowledge and truth situated within a social context and relationships. I thought this would be relevant given the overlap of CGT and psychoanalytic thinking and the epistemological position that meaning and truth in psychotherapy is co-constructed between therapist and young person. I hoped that by studying the factors and processes within a situated clinical setting, I could further understand how offering AET to adolescents might facilitate their transition to more traditional forms of psychoanalytic psychotherapy.

2.4 Selecting A Grounded Theory (GT) approach

Before settling for Grounded theory as my method for approaching the data, I also considered using other methods of analysis such as Thematic Analysis (Braun & Clarke, 2006) and Interpretative Phenomenological Analysis (Smith et al., 2009). Although both approaches mentioned are flexible in the way they gather data and offer a comprehensive understanding of participant's experiences, I decided to use CGT as my method because it is also a good fit when exploring under-investigated areas of study. Furthermore, I wanted to pursue a method that could explain how and why AET is a helpful therapeutic model in helping young people transition to more traditional forms of psychotherapy. In addition, given the dearth of research or theory on AET, GT also felt like a well-suited approach to the study of the matter at hand in a way that is inductive and is data lead. I thought CGT was a good fit for my project as its openness and flexibility can help to generate ideas and potential theories in a particular context, which can help explore new ideas about the clinical usefulness of AET in working with adolescents.

Michel Rustin has argued that grounded theory is better suited to the development of theories in a specific context "rather than attempting to test out their scope or incidence of application and empirical incidence" (Rustin, 2019, p.14). Anderson (2006) has suggested that grounded theory can generate theory that is rooted in the data and hence, it can produce explanations and results that are applicable to clinical settings. Likewise, because of its constant comparative element, this methodology lends itself well to comparing and contrasting child psychotherapist experiences and views of AET and more formal forms of psychotherapy, and how they might differ in their clinical helpfulness. To summarise, I decided to use this methodology because:

- It is inductive lead
- It uses a meticulous and comparative method of analysis
- It has as its aim the development of theoretical analysis
- GT has the advantage of being able to inform policy and practice (Charmaz, 2014, p. 14)

The GT approach I decided to employ consisted in different stages of the analytic process, as suggested by Charmaz (2014):

- Initial coding: the first step in the process which consists in "naming each word, line or segment" to "define what is happening in the data and begin to grapple with what it means" (Charmaz, 2014, p. 113).
- Focused coding: "a focused, selective phase that uses the most significant or frequent initial codes to sort, synthesize, integrate, and organize large amounts of data" (Charmaz, 2014, p. 113).
- "Memo-ing" or memo writing: "informal analytic notes" written during the initial stages of analysis and coding which "chart, record and detail a major analytic phase of the research journey" and record a "path of theory construction" (Charmaz, 2014, p. 162-4). This step in the process is of particular importance in beginning to build theoretical categories in CGT, since it allows the investigator to "stop and analyse your ideas about the codes in any – and every – way that occurs to you during the moment" (Charmaz, 2014, p. 162). This helps the contrasting and comparing process between the data, and it helps to make analytic links from the beginning of the process.

- Theoretical categories: Using “memo-ing” to organize and elevate focused codes into theoretical categories that start to shape the “conceptual elements in a theory” (Glasser & Strauss, 1967, p. 37). This step involves ascertaining “which codes best represent what you see happening in [the] data” and through “memo-ing” “rais[ing] them to conceptual categories for your developing analytic framework” (Charmaz, 2014, p. 189). The resulting conceptual frame helps to explain the links between the data, and forms the bases for the building of a main CGT.

- Grounded Theory: an overall conceptual framework which aims at answering the research question, by supplying an analytic and abstract theoretical explanation of the process reflected in the data. Charmaz (2014) emphasises that the CGT approach is the product of the coding, interpretation, analysis and construction of the data by the researcher, crafted through an iterative and comparative process that oscillates between codes, memos and categories.

2.5 Research strategy and study design

2.5.1 Sampling strategy and recruitment

I used selective sampling as my sampling strategy and I decided to contact the BCYP and recruit child and adolescent psychotherapists from their team. Selection criteria depended on the adolescent psychotherapist having had ample experience of both adolescent exploratory therapy (AET) and adolescent psychotherapy or offering psychoanalysis to adolescents. I had hoped to interview those psychotherapists from the senior team at the BCYP, whom I thought would be best suited to speak about both AET and adolescent psychotherapy or psychoanalysis.

The BCYP also employs psychodynamic counsellors who had experience of offering AET and psychotherapy. I had to decide quite early on whether to widen my sampling criteria to recruit. The first participant to volunteer was a psychodynamic counsellor with experience of AET and intensive psychotherapy. I also had to think about whether to recruit from former therapists who had worked at the Centre in the past. The research lead invited me for an informal talk to learn more about my research. Following this meeting, I was invited to a research meeting where I could talk about my project and the need for participants who worked at the BCYP. In this meeting, they showed interest in my project and I was then invited to email and circulate my recruitment and advertisement materials in order to start recruiting (Appendix 2 & 3).

I did not intend to set a limit to the number of participants as there was a danger that setting a limit could potentially hamper the discovery of new categories. Initially, there was interest in the research; however, the recruitment process took quite a long time due to the fact that therapists working at the BCYP were extremely busy. Initially, I thought that my recruitment criteria were mainly aimed at enlisting therapists that had experience of delivering both AET and Adolescent psychotherapy through their in-house services. However, this further complicated the recruitment process because the pool of such clinicians working in-house services was reduced.

2.5.2 Participants

Initially, I emailed the research department at the BCYP in the hope of recruiting participants into my study (see Appendix 2). Quite early on I released that there was a difference in the theoretical orientation amongst the participants, who came from different training

backgrounds. Some had a Kleinian background whereas others came from the independent school. There was a participant who had Kleinian training but considered himself now as a Freudian. I was under the impression that the focus of the study would be on the experiences and views that participants held, and not so much on their theoretical leanings. I thought it would be interesting to explore if there were any similarities in their views of the advantages of offering AET to young people in helping them to transition to more traditional models of intensive/once a week psychotherapy. Five participants were female, and three were male, which may have reflected the fact that the profession is female dominated.

Interview	Participants[1]	Role
1.	Laura	Psychodynamic Counsellor & Psychotherapist
2.	Sarah	Consultant child and adolescent psychotherapist and Psychoanalyst
3.	Martha	Consultant child and adolescent psychotherapist
4.	William	Child and Adolescent Psychotherapist and Psychoanalyst
5.	Jane	Consultant child and adolescent psychotherapist
6.	Stephanie	Consultant Child and Adolescent Psychotherapist and Psychoanalyst
7.	Steve	Consultant child and adolescent psychotherapist
8.	Jonathan	Consultant Child and Adolescent Psychotherapist and Psychoanalyst

2.5.3 Ethics

Ethical approval for this project was granted through the Tavistock's Research Ethics Committee (TREC) on 14th April 2021 (see Appendix 7). To safeguard the anonymity of the participants all audio files of the interviews were stored in a password protected folder and

[1] All the names used in this table are pseudonyms to protect anonymity

were destroyed following their transcription. All copies of the transcripts of the interviews were kept safe in a locked drawer which only I had access to. I give each of the participant's a pseudonym so that I was able to identify them. During the transcription process I made sure that any identifying features were either changed or erased. I was the only person to read the interviews.

Following the completion of the study the hardcopies of transcripts will be kept in a locked drawer for up to 2 years before being destroyed. Participants were made aware of this procedure via the consent forms and participant information sheets. Participants were informed of the very small risk of some identifying features being discoverable, however, every effort was taken to ensure confidentiality. This risk was included in the participant information sheet for the participants benefit (see Appendix 3). Once they had read and understood this, they needed to give informed consent before proceeding (see Appendix 4). Participants were informed that they could withdraw from the study at any time up to three weeks after the completion of the interview (see Appendix 4).

Finally, following each interview, participants were emailed with the opportunity for a debriefing meeting with me should they need it. The email also included contact details for my supervisor and the head of Academic Governance and Quality Assurance at the Tavistock in case participants needed to raise any concerns with them (see Appendix 3).

Before the start of the interviews, participants were reminded of the necessity to safeguard anonymity when speaking about patients. Similarly, participants were made aware that during the transcription of the data I would endeavour to remove or change any details that could compromise the confidentiality of their patients. In addition, I have intentionally omitted vignettes from the final thesis in order to protect the anonymity of patients being discussed by participants.

2.5.4 Research strategy and data collection

The start of the study took place remotely due to the Covid Pandemic and the interviews were conducted via zoom and lasted between 50 minutes and 110 minutes. The outbreak of Covid-19 impacted gaining ethical approval and recruitment. I therefore made the decision to conduct all interviews online using Zoom. I also conducted one interview via telephone.

Semi-structured interviews were chosen for this study as it was understood that interviews would yield rich, detailed data. Interviews also permitted an iterative process by which areas of interest could be further explored and theoretical sampling followed as indicated by Grounded theory.

I entertained alternative methods to collect the data for the study. For example, while I was collecting the data, I was invited to clinical team meetings at the BCYP. For a while I considered using some for the notes I made during this meeting in the study.

Nevertheless, Grounded Theory offers the option to use theoretical sampling, which I felt was bettered suited for study using semi-structured interviews. Similarly, an interview-based study would be a better fit for this methodology and would stimulate spontaneous ideas generated during the discussion with participants. I met with the interviewees via zoom as this was the most convenient for them. This included meeting them from their home or place of work.

All participants were emailed information about the research project as well as an indicative interview schedule before meeting them for the actual interview. They were asked to sign two consent forms; one of which I kept for my records and the other they kept for theirs. The initial interviews were semi-structured (see appendix 5) with interviewees asked general

questions about their work at the BCYP in order to find out what they understood as important issues when delivering Adolescent Exploratory Therapy.

The length of the interviews depended on how much each participant had to say about the topic but also depended on the time they could spare for the interviews due to the fact that some interviews took place during their working hours.

2.5.5 Conduct of the interviews

I initially faced the dilemma of whether to recruit the first participant who was a Child and Adolescent Psychodynamic Counsellor. As part of my exclusion criteria, I had originally thought to exclusively interview child psychotherapists who worked delivering AET from the BCYP. However, I thought it best to widen my inclusion criteria and I decided to include a Child and Adolescent Psychodynamic Counsellor. I thought it would be important to include a Psychodynamic Counsellor as there are a number of them working at the Centre and I thought that by doing so the data would be representative of the therapists working there.

I explained that I was aware that AET was used in different ways and also that it was used both as a preparatory therapy but also as a standalone intervention. However, I wanted to investigate if there were any benefits and disadvantages to offering AET and what aspects of offering AET were conducive to helping young people to engage in more traditional forms of psychoanalytic psychotherapy.

I started by asking a general question about her views of delivering AET. She raised interesting issues concerning the referral process and how young people are referred to the BCYP. She spoke about issues of technique linked to the referral process. Similarly, she also raised interesting links between development in adolescence and issues of dependency and separation and technical difficulties with this patient group.

Another of my intended questions concerned the changes that the therapist noted in the relationship with the patient that alerted her to her patient being ready to make use of adolescent psychotherapy. The participant had already highlighted the problem of how young people are referred to the centre and how this might affect technique and the use of transference interpretations. She also raised the issue of how most young people were seen in AET rather than in psychotherapy due to the number of referrals and she explained that it would not be possible to see all young people in psychotherapy. She also pointed out that she felt that not all young people needed intensive psychotherapy and expressed her view that some young people need help with a particular issue within their development.

I was struck when she spoke about the issue of how AET might be more flexible and how its structure and method was designed to allow you to hand over some control to the young person when committing to therapy. The idea of commitment and power imbalance in the relationship towards grown-ups and institutions in adolescence was also something that she brought up in our interview and went on to inform the directions of areas of interest in subsequent interviews.

A different dilemma I faced arose at the end of the theoretical saturation process (see section 2.6.6 Theoretical Saturation). As part of this phase I had intended to conduct an 8th interview to help refine my theoretical categories. However, the participant was unable to meet and he agreed to provide written answers to my interview questions. We had planned to arrange a follow up interview meeting to discuss the answers he'd provided beforehand to my written interview questions. Unfortunately, we were unable to arrange a meeting due to the participant's work commitments. However, I was not sure whether to include his answers as part of the data due to the fact that Grounded Theory prefers semi-structured interviews as a way of gathering rich data. However, I thought that his responses to my questions were interesting and relevant to the research question.

2.5.6 Intensive interviewing

I selected semi-structured interviews as my method to gather data as it would provide rich and detailed material. I conducted intensive interviews as suggested by Charmaz (2014). The interviews were designed to explore the views and experiences from the participant perspective of the advantages of offering AET to young people and how this might help to prepare young people for later engagement in more intensive forms of psychotherapy. To assist me with the interviewing process, I created an indicative interview schedule with six main themes and some prompts to use in case they were needed. I sent an interview schedule to each participant prior to the interview for their information (Appendix 5). However, in keeping with CGT, the main idea was to be led by the participant's views and experiences and prompts were only used when necessary. I aimed to get close to the issues which were raised as important by the participants without being led too much. I began my questions with a very general question about adolescent psychotherapists' experience of working at the BCYP and offering AET. Pidgeon (1996) cautions against the researcher excessively directing the interview for there is a danger of missing important data. The iterative nature of the interview schedule also meant that I could investigate further areas I found of interest and undertake theoretical sampling as recommended by CGT. I recorded the interviews using a digital recorder which was password protected and once the interviews had been transcribed the recording was erased.

2.6 Data analysis

The data analysis of the process was directed by one of the main principles in Grounded Theory (GT) in which the analysis of the data begins early on in the process. Starting the data analysis at the beginning enabled me to follow up questions and emergent areas of interest and to further explore these in subsequent interviews. I interviewed one participant to begin

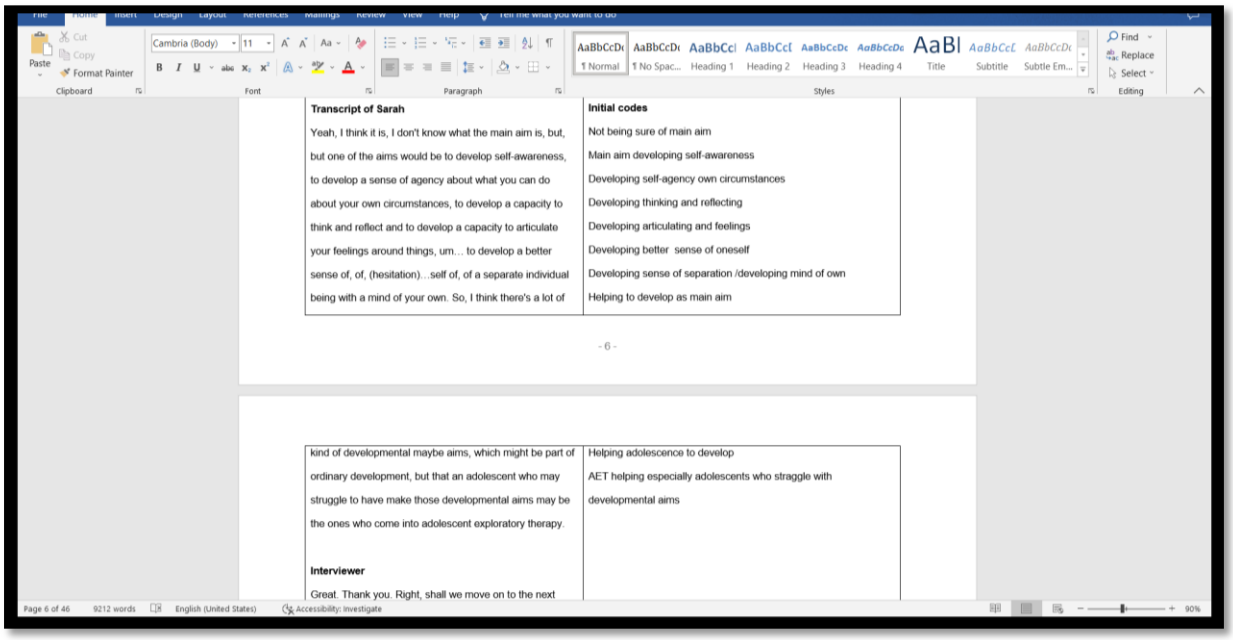
with and I then began with the analysis of the interviews straight away before I carried out further interviews.

In keeping with GT, I read and reread the transcript before I decided to commence the coding process. I then proceeded to the first stage of coding and I started line by line coding. For instance, I thought a question needed to be added about technique in relation to the role and stance of the therapist in AET and in what way participants found that it helped when engaging adolescents in AET.

2.6.1 Open coding

I began to code my interviews line by line trying to move quickly through the data. However, I found it helpful to be flexible with this aspect and sometimes I coded longer sentences or even paragraphs and at other times I coded short phrases. While developing my codes I aimed at interrogating the data and my initial codes were both aimed at summarizing and analysing the data. I tried as much as possible to use gerunds in order to preserve action and stave off the formation of premature concepts. In fact, Charmaz (Charmaz, 2014, 2015), argues that it is helpful for the coding process to be "done with gerunds," which can facilitate the development of explanations and conceptual designs that reflect on actions and social processes.

Figure 1



Transcript of Sarah	Initial codes
Yeah, I think it is, I don't know what the main aim is, but,	Not being sure of main aim
but one of the aims would be to develop self-awareness,	Main aim developing self-awareness
to develop a sense of agency about what you can do	Developing self-agency own circumstances
about your own circumstances, to develop a capacity to	Developing thinking and reflecting
think and reflect and to develop a capacity to articulate	Developing articulating and feelings
your feelings around things, um… to develop a better	Developing better sense of oneself
sense of, of, (hesitation)…self of, of a separate individual	Developing sense of separation /developing mind of own
being with a mind of your own. So, I think there's a lot of	Helping to develop as main aim

- 6 -

kind of developmental maybe aims, which might be part of	Helping adolescence to develop
ordinary development, but that an adolescent who may	AET helping especially adolescents who straggle with
struggle to have make those developmental aims may be	developmental aims
the ones who come into adolescent exploratory therapy.	
Interviewer	
Great. Thank you. Right, shall we move on to the next	

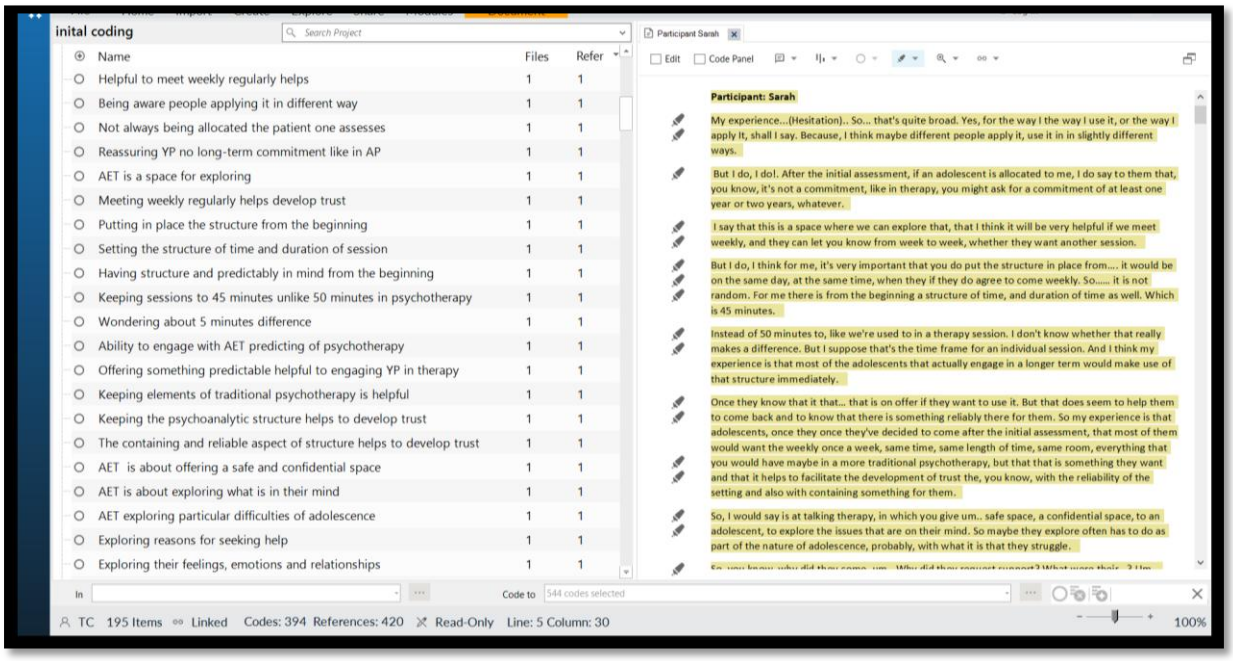
Initial coding stages on a word document.

Once I had interviewed four participants and transcribed and coded all interviews, I found that I was left with a vast number of codes. I tried to move on to the next stage of comparing and contrasting my initial codes across the four interviews, however this proved a cumbersome step as I was having difficulty visualizing all my codes on a single table. At this stage in the process, I decided to use NVivo software to help me with the comparative aspect of the process. I had no previous experience of using NVivo, however I was able to talk to other students who were able to point me in the direction of some online resources. I watched a series of free video tutorials online that offered a step-by-step approach to using NVivo for the uninitiated.

2.6.2 Choosing NVivo 10 for qualitative data analysis

Fairly early on I realized that I could not input my initial codes directly into NVivo. I decided to re-code all of the four transcripts which took some extra time but I felt that it was worthwhile as this process helped me have a deeper understanding of my data. Using NVivo to re-code my transcripts was very helpful. I found the coding process became more transparent as I was able to represent how I arrived at constructing GT (Bringer et al., 2004).

Figure 2



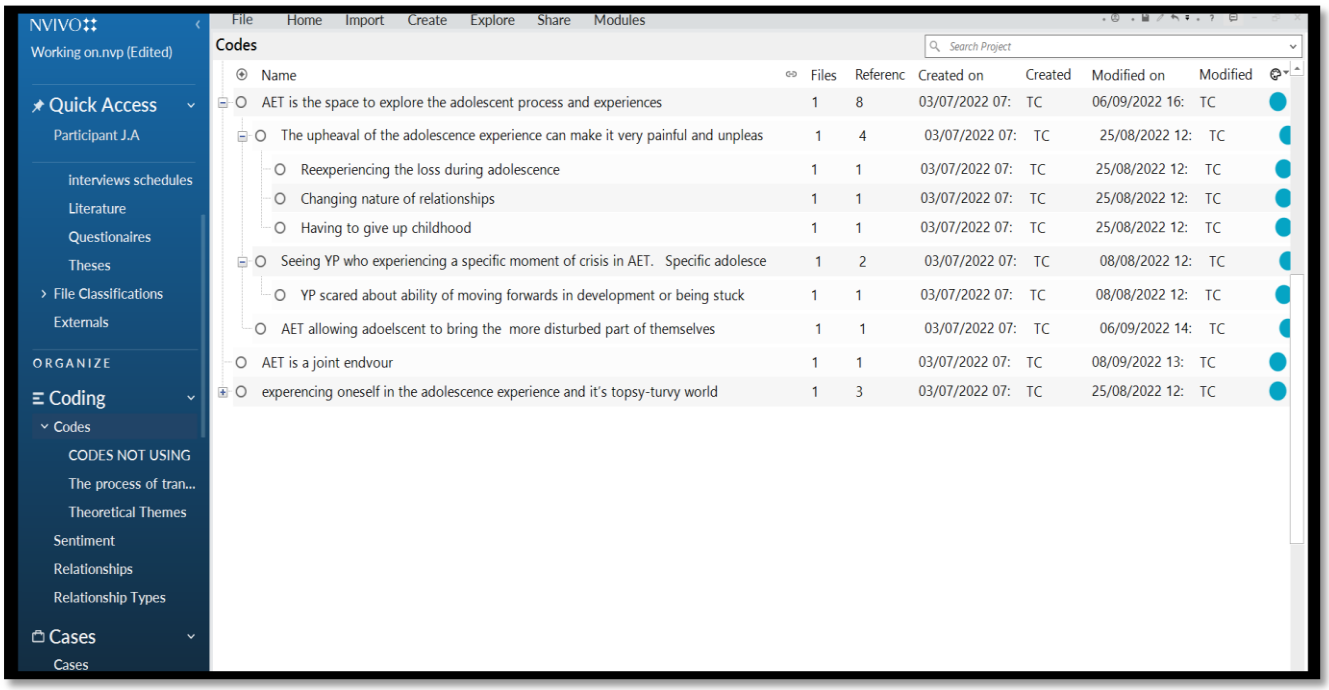
Early stages of re-coding in NVivo alongside transcript.

2.6.3 Focused coding

After having come up with some tentative focused codes for my first three interviews I realised that I had a large number of codes and that it would be difficult to compare and contrast. I tried to use a word document to organize my focused codes into columns but I came to understand that it was difficult to compare the codes across the entire data set. As Charmaz suggested “Researchers can then take those codes demonstrating analytic strength

and raise them to tentative categories to develop. When the researcher's initial codes are concrete, the researcher can code them by asking what analytic story these codes indicate, and thus arrive at a set of focused codes" (2014, p. 343).

Figure 3



Focused coding in development.

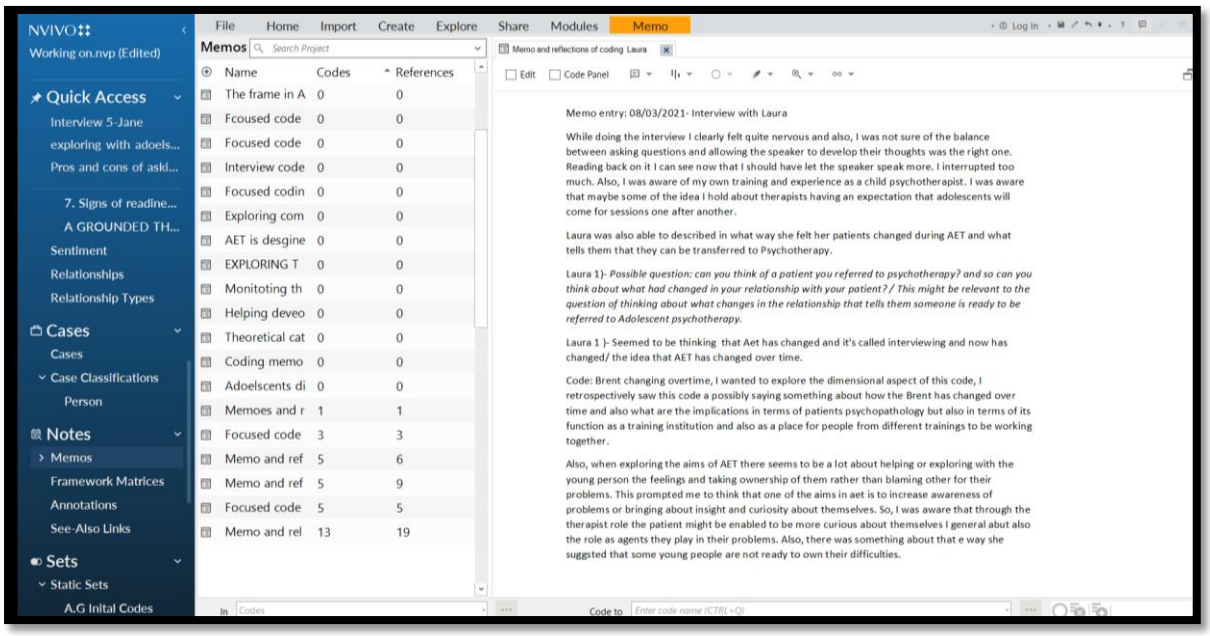
As Child and Adolescent Psychotherapists mentioned new areas, I changed the interview schedule between interviews to show the iterative focus of some of the questions. This constituted the bases of an important step in theoretical sampling whereby "interview questions were refocused to gain specific information regarding an emerging concept" (Draucker et al., 2007).

2.6.4 Memo-ing and Research diary

Early in the process I pursued "memo-ing" and my diary to write down early leads and intuitions about the data. Early ideas were then applied in generating theoretical thoughts. I

used the note taking function on NVivo in order to connect what I had coded up to this point and areas for further exploration and reflection.

Figure 4



Example of "memo-ing" in Nvivo.

I conducted an initial interview and coded it and then I conducted another four interviews. Following this I conducted 2 further full interviews. This form of interviewing allowed me to move through the process of GT in an iterative way, and to examine gaps in the data, check leads and hunches and gather further detail to consider early theoretical ideas. For example, I was able to interrogate and expand on promising areas, such us important themes around commitment to AET in adolescent patients. After having open-coded and formed focused codes in the initial five interviews, I felt that my initial categories were not descriptive enough and I struggled to move my focused codes into the next stage of GT. I decided to go back to recruiting and I conducted two more interviews in order to add more descriptive depth to the story that was beginning to emerge from my initial focused codes and theoretical categories.

2.6.5 Theoretical categories, sampling and sorting

Fairly early in the process I record in a diary my initial thoughts and theoretical leads and their connections to the emerging data. While writing and recording my ideas I was aware of my previous professional experience of working with adolescents and what had been said in the literature review in an attempt to understand if anything that I was coding was not reflected in the data itself. The process of aggregating memos into the seven main categories helped me to both identify more precisely the theoretical connections between categories and add to the depth of my analysis. I was able to move back and forth cyclically between codes and my diary to verify that the codes were emerging from the data.

After my initial analysis of interview 6, I reread the early memos and reflections about the data I had made so far in order to compare these reflections and ideas against the data. This exercise was helpful in enabling me to develop my theoretical ideas about how AET can help adolescents to transition into more traditional forms of psychotherapy. I discussed this with my supervisor and contrasted and compared it against codes substantiated in the data. After I had developed my theoretical categories, I carried out Theoretical sorting (Charmaz, 2014). I created a mind map in NVivo which included the focused codes within them. I began to rearrange these in an attempt to make possible connections between the focused codes and theoretical categories. This process was helpful for me to verify if my theoretical ideas explained the data. Playing around with my focused codes and theoretical categories I started to create arrows in order to explore the possible influences between them. In an iterative process, I examined the focused code multiple times to identify if they corresponded with ideas in the theoretical framework I was developing. At this point, I carried out the last two interviews using as reference the emerging theoretical ideas that I had created. I coded this

interview and compared the new resulting codes with the existing codes, checking for any difference in the theoretical ideas I had formed.

During this process I took a reflective and reflexive stance when approaching the data and constructing Theory. Using memos and my research diary I recorded any ideas that were associated with the theories I had been entertaining, making sure to make a note about any prior knowledge or preconceived ideas that came to my mind. This process helped me to look back at the evolution of the theory from the start of the research. This ensured that I was as transparent as possible when reassessing the theoretical categories, focused codes, open codes and the data from interviews. In this way I could track what was in the data and what I might be bringing into it. This safeguarded that my theoretical framework was data led and emerged from the data and reflected the CPT's reflections and constructions of how AET can help adolescents to engage in more traditional forms of psychotherapy or psychoanalysis.

As previously stated, I made sure that the process of GT was iterative by following up new ideas and theoretical leads collected in previous interviews. Nevertheless, there was one theme that was part of theoretical sampling. Namely, an idea relating to how AET has changed over time and whether it's prime focus was to feed into psychotherapy. In interview 6 the idea of the frame and the setting in AET in relation to adolescents was discussed in depth, subsequently this helped me to redefine some of the theoretical categories. Similarly, interview 7 also helped to construct and corroborate what I had found in previous interviews which added to the definition and depth of my theoretical categories.

2.6.6 Theoretical Saturation

After having created an overarching theoretical framework, I decided to conduct two further interviews: interviews 7 and 8. This step was helpful in comparing and contrasting the new

codes from the interview against the existing ones from previous interviews to explore if there were any similarities or differences while remaining open to new ideas. This step in theoretical sampling was helpful in fleshing out the "conceptual and theoretical development of your analysis" (Charmaz, 2014, p. 197).

I kept in mind the theory I had created while I analysed interviews 7 and 8 which helped double-check that the ideas I had developed resonated with the interview data. This process resulted in more than 180 new codes some of which were then incorporated in the final theoretical categories. However, each of these new open codes were easily sorted into focused codes and theoretical categories, with no new theoretical categories created. This process helped me acknowledge that I had reached a sufficient level of theoretical saturation relating to my theory.

When I engaged in the stage of theoretical saturation, I tried to bear in mind the following questions as suggested by Charmaz (2014):

1. Which comparisons do you make between data within and between categories?
2. What sense do you make of these comparisons?
3. Where do they lead you?
4. How do your comparisons illuminate your theoretical categories?
5. In what other directions, if any, do they take you?
6. What new conceptual relationships, if any, might you see? (p. 214)

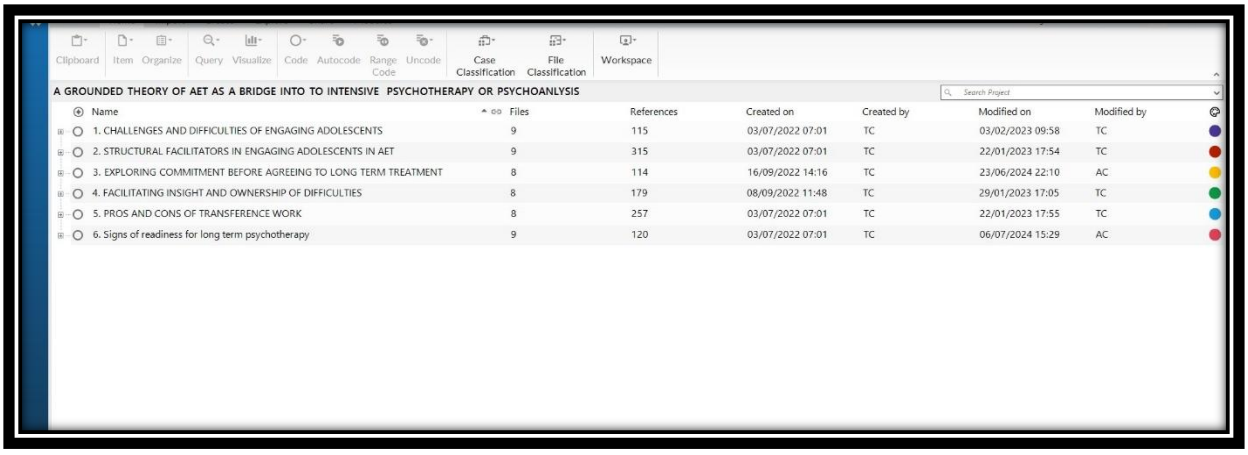
Examples of the comparisons made, and how they formed the overarching GT will now be introduced in chapter 3 and discussed in more detail in chapter 4.

Chapter 3 Findings

In this chapter I will present the Grounded Theory that I identified which represents AET as a form of therapy that is designed to empower adolescents to develop and explore the possibility of engaging in psychotherapy. However, it is important to state that theoretical category 1 did not arise in direct response to the research question. My rationale to include it in the findings and in the discussion sections was determined by the fact that it provides important contextual information about the research question and is relevant to working with adolescents. The relevance of each category in relation to this study's research question will be analysed in depth in the discussion section.

The GT was formed of seven categories; each category is represented by a colour in the diagram provided below. Categories are also colour coded in line with the original colour they were assigned in NVivo during the analysis process. I have included a screenshot of the final categories which are colour coded.

Figure 5



Screenshot of final categories on NVivo.

I have also decided to include a diagram with lines and arrows to represent the different categories and the interaction between them. All seven categories were found to be interconnected. I have decided to use capital letters to represent their importance in the diagram below. Findings from each category will now be outlined as per their numbers attributed in the diagram. Further discussion relating to all categories, the GT and the wider literature will be made in chapter 4.

Figure 6

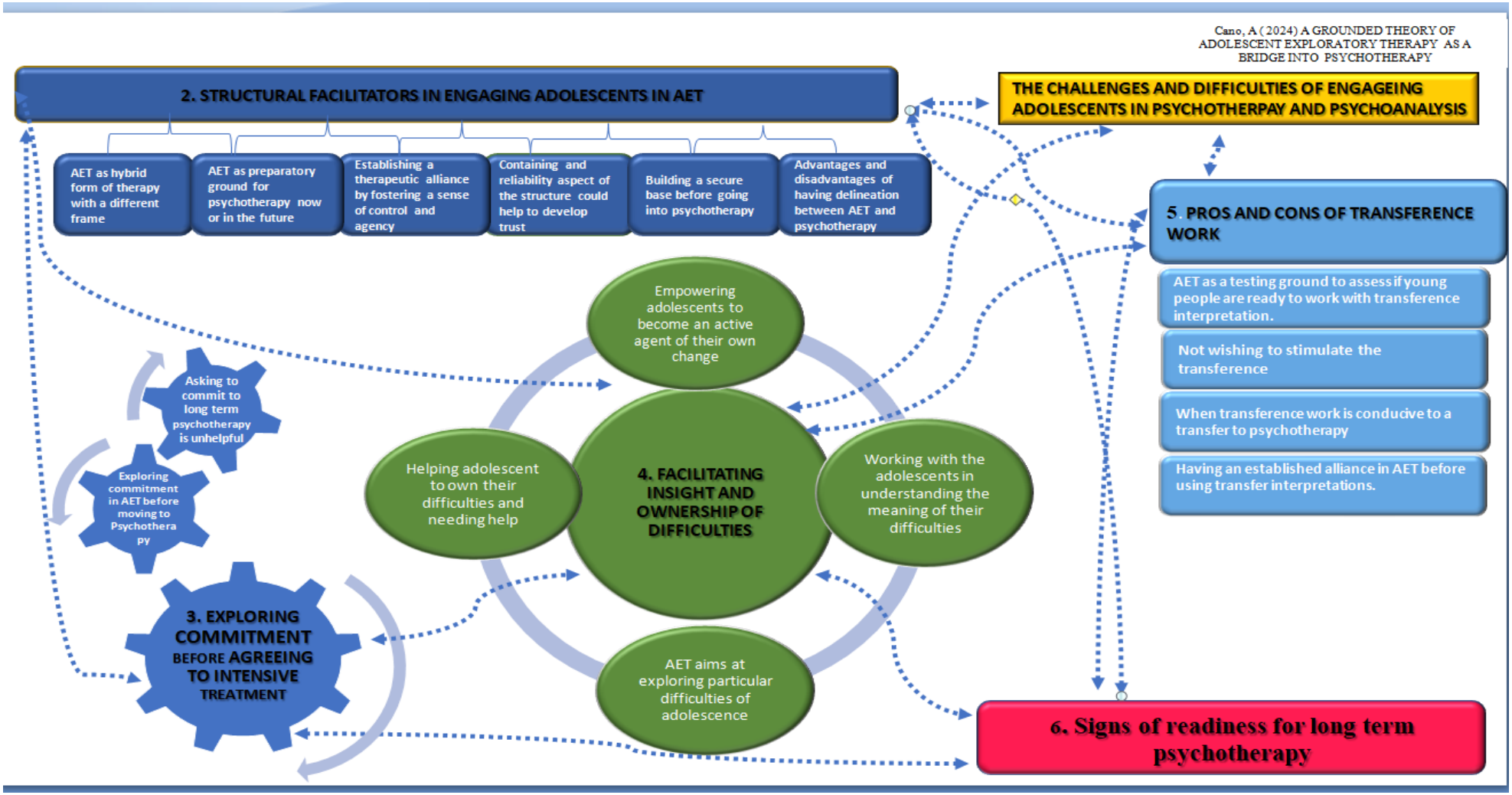
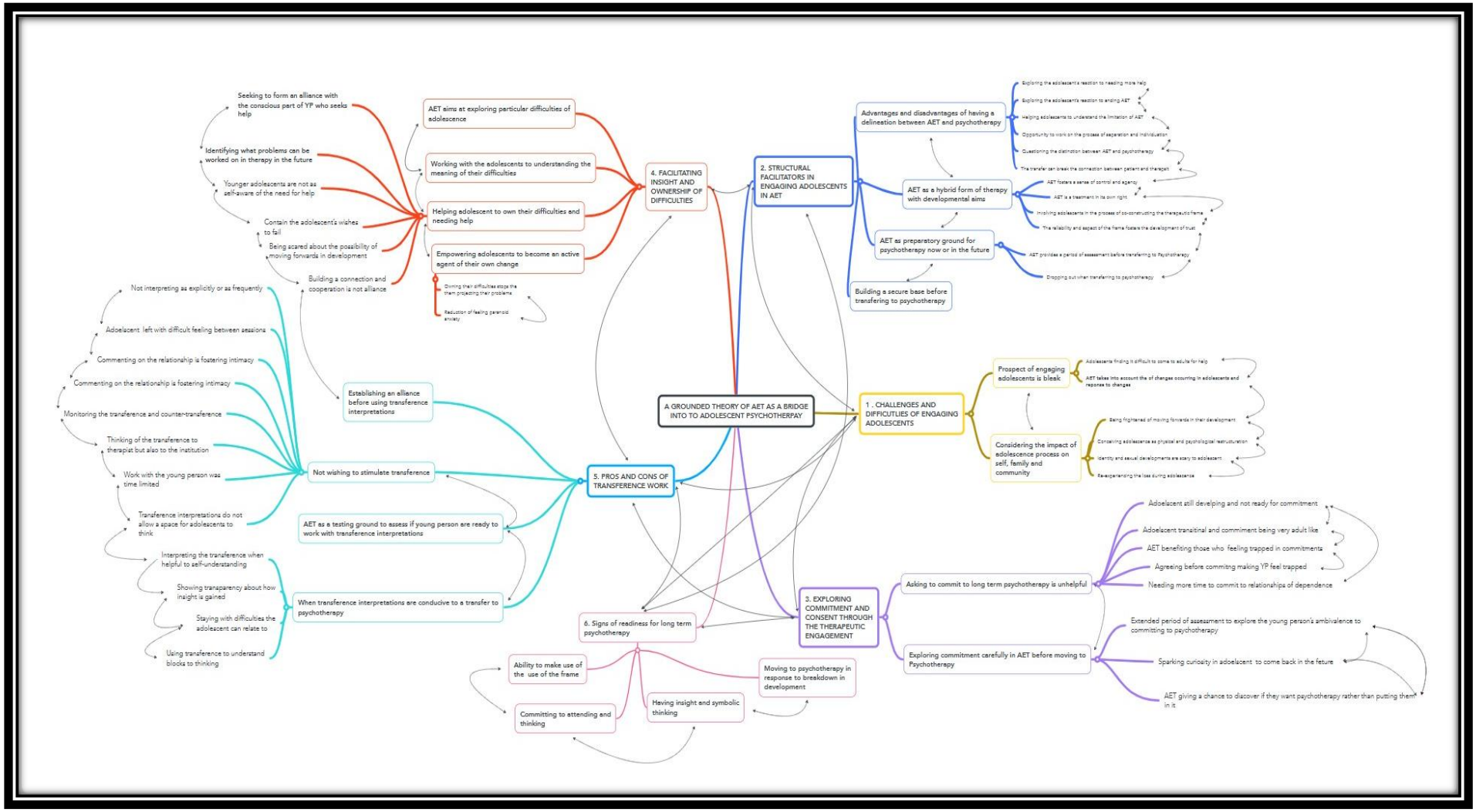


Diagram of theoretical categories and their relationship

Figure 7



Flow diagram of overarching theory showing interconnections

Theoretical Category 1. The challenges and difficulties of engaging adolescents in psychotherapy and psychoanalysis.

Figure 8

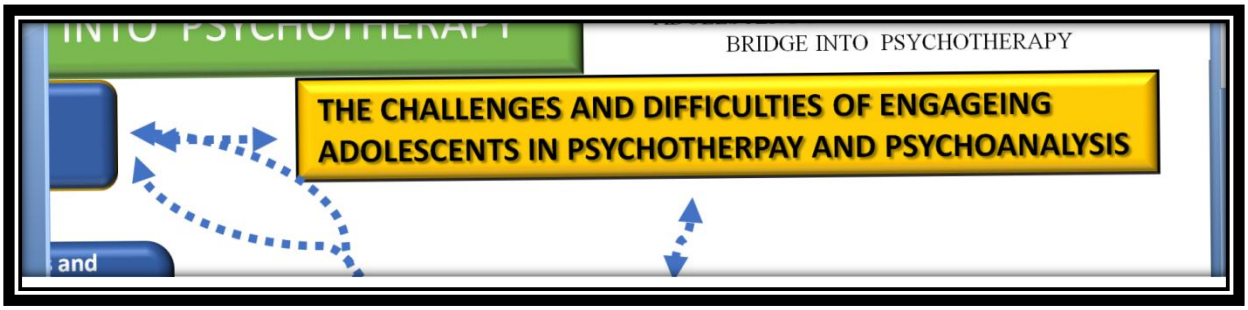
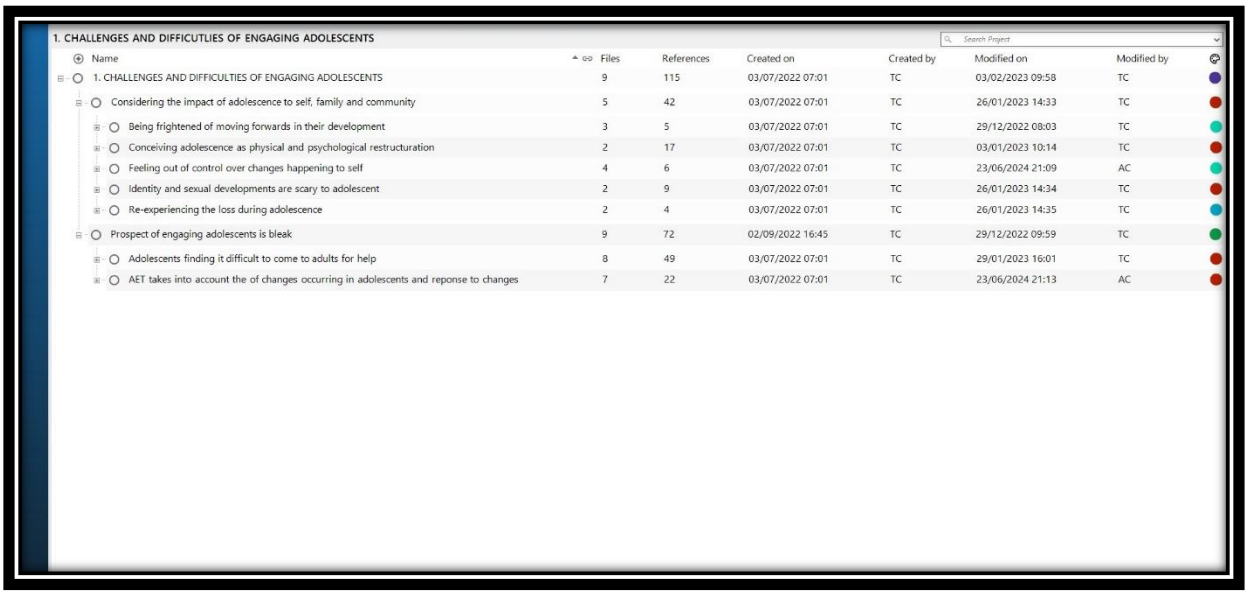


Diagram of Theoretical Category 1.

This category highlights participants' understanding of how the changes young people undergo during the process of adolescence can impact their ability to access and engage in traditional forms of psychotherapy or psychoanalytic therapy. They considered that AET had been designed to accommodate some of the difficulties that adolescents have in engaging in therapy.

Figure 9



Focused codes from theoretical category 1 and occurrence across interviews

1.2 Considering the impact of the adolescence process on self, family and community

Participants explicitly reflected on **conceiving adolescence as physical and psychological restructuration** (6, 132-136) with deep ramifications for the adolescent but also for their family and society. Stephanie[2] in interview 6 highlighted this in the following ways:

> *"That is, if you like, restructuring and a drastic change, that is connected both to the physical aspects linked to the body, obviously, pubertal changes. It has to do with a relationship the adolescent has with himself or herself, with the parents and the peer group and society"* (6, 132-136).

This period of re-structurization as highlighted by Stephanie was seen as necessary for **identity and sexual developments** (6, 137)[3] during adolescence. However, these changes can be experienced by the young person as conflictual and anxiety provoking. For some participants, the task of separating from parental figures and finding an identity for oneself

[2] Refers to interview pseudonym name and paragraph number.
[3] I have written in bold the most salient codes within each focused code that forms the category.

could trigger feelings of claustrophobia or agoraphobia (6, 170-173). This was suggested by Stephanie: "*The second thing is that adolescents feel very quickly, they need to separate from the parents and to establish a sense of identity, which is not just a merge or identification, or in projective identification with a pair of parental views. In that movement, in that separation, issues about separateness about claustrophobia and agoraphobia, become highly prominent*" (6, 170-173).

The process of separation and individuation could lead to **re-experiencing previous losses** (3, 386-388) during this developmental phase. The changes brought about by the adolescent process were thought to make the youth **feel out of control** (5,156-158) over the changes happening to their bodies: *"there is something about adolescents themselves, that, um... for example, one of the things with adolescents is that they feel everything is so out of control, because of the lack of control of their body, you know, their body develops, and they have no say"* (5, 156-158).

As a result of these changes, some adolescents were described as **being frightened of moving forwards in their development** (6, 40-41). For example Stephanie discussed a case of a young man who; *"couldn't leave home, needed to be with the mother all the time, and was brought by the mother to the centre and was completely regressed to being a child"* (6, 538-340).

1.3 Prospect of engaging adolescents is bleak

Several participants mentioned that adolescents **find it difficult to come to adults for help** (6, 173-178). Seeking help with an adult could be seen as threatening to the adolescent autonomy and entrapping. Stephanie put it in the following way: *"So the idea of an adolescent who is having difficulties and needs to turn for help to an adult, is very*

threatening to the adolescent. They prefer peer groups, they prefer to talk to, you know, their own friends, if they have friends, and if not feel very much alone. So, to come to an adult for help it doesn't feel right; they want to move away, they don't want to get enclosed with another parental figure." (6, 173-178).

The changes brought about by the adolescent process and concomitant anxieties were thought to **hinder adolescents engaging in psychotherapy or psychoanalysis** (7, 182-184). This was discussed by Steve in his interview: "*I don't think adolescents necessarily respond particularly appropriately to the psychoanalytic approach. You have to modify your psychoanalytic understanding to fit the adolescents"* (7, 182-184)

Linked to this point, participants highlighted the need for professionals to engage with adolescents in a **different form of therapy that takes into account the adolescents' changes and reactions to the process of adolescence** (6, 130-132). This was discussed by Stephanie in her interview:

> "*AET had developed on ideas of changes occurring in adolescents, it was developed based on a number of, I think, very important issues linked to psychopathology, and it was based on the idea of the changes that happened at puberty"* (6, 130-132).

Jane also made this point in her interview*:*

> *"So, I think there are lots of reasons why it might be particularly difficult for an adolescent to engage, these you know, have been all thought about, and in some ways, encapsulated in this idea of AET. Because while you get the two sides of them, which of the two sides of adolescence, one is that they're being thrown out. So if you sort of say, oh, you can only just, you know, we offer 10 sessions, that can feel too little. But if you say, oh, it's completely ongoing, then they can feel like you're drawing them*

into, you know, another sort of parental type. So, it's about trying to balance where they are developmentally and what's going on for them developmentally" (5, 23-32).

Judging from participant's responses, participants convey their views that the changes brought about by the adolescent process made it particularly difficult to engage adolescent patients in more traditional forms of psychotherapy or psychoanalysis. They underscored that a different type of approach was needed to work with this age group that takes into account adolescents' feelings about seeking help with adults and the Janus-faced nature of adolescents who can fluctuate between feeling trapped in long term commitments and/or abandoned by short terms interventions.

2. Theoretical category 2: Structural facilitators in engaging adolescents in AET

Figure 10

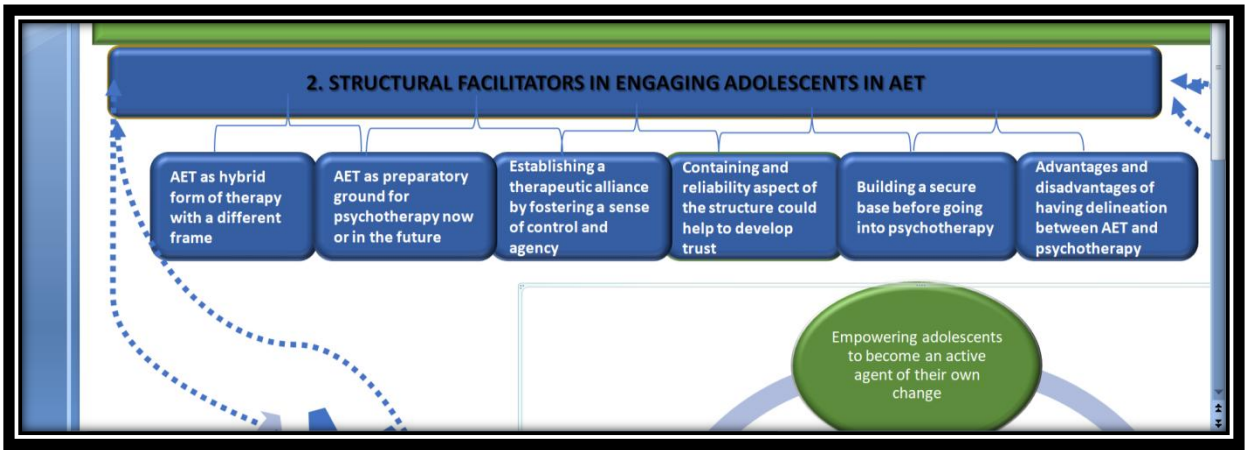
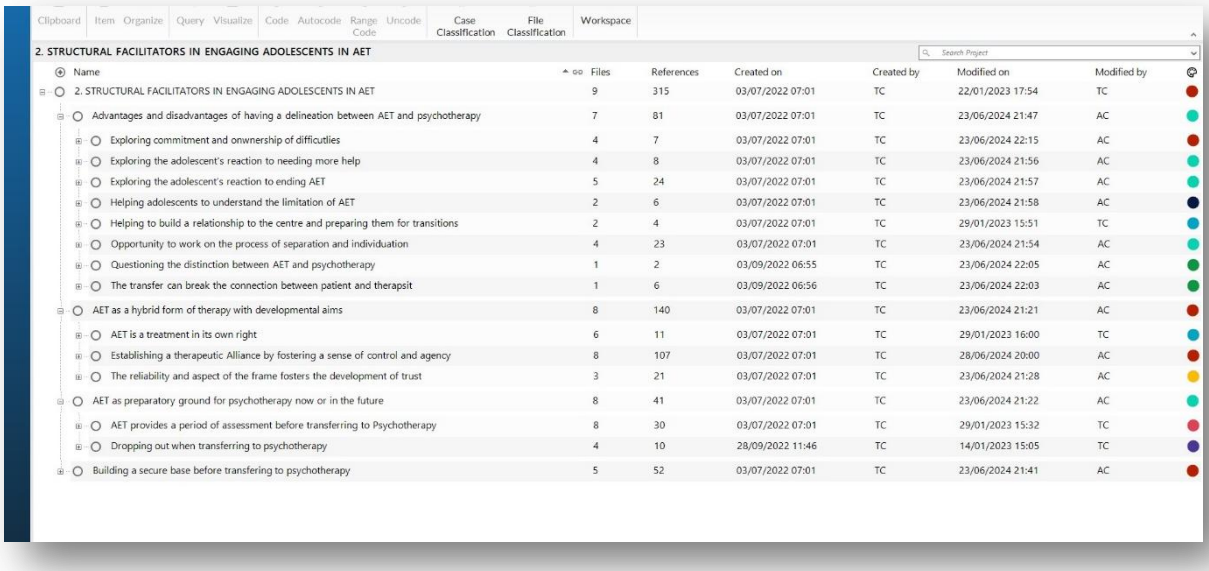


Diagram of Theoretical Category 2.

Next, I will present the findings that correspond to what aspects of the structure in AET were perceived to be helpful or unhelpful when engaging adolescents in AET in general and those particular factors that seemed to be advantageous or disadvantageous when transitioning to

long term psychotherapy. This was the biggest category and the focused codes are shown in the screenshot below.

Figure 11



Name	Files	References	Created on	Created by	Modified on	Modified by
2. STRUCTURAL FACILITATORS IN ENGAGING ADOLESCENTS IN AET	9	315	03/07/2022 07:01	TC	22/01/2023 17:54	TC
Advantages and disadvantages of having a delineation between AET and psychotherapy	7	81	03/07/2022 07:01	TC	23/06/2024 21:47	AC
Exploring commitment and onwnership of difficutlies	4	7	03/07/2022 07:01	TC	23/06/2024 22:15	AC
Exploring the adolescent's reaction to needing more help	4	8	03/07/2022 07:01	TC	23/06/2024 21:56	AC
Exploring the adolescent's reaction to ending AET	5	24	03/07/2022 07:01	TC	23/06/2024 21:57	AC
Helping adolescents to understand the limitation of AET	2	6	03/07/2022 07:01	TC	23/06/2024 21:58	AC
Helping to build a relationship to the centre and preparing them for transitions	2	4	03/07/2022 07:01	TC	29/01/2023 15:51	TC
Opportunity to work on the process of separation and individuation	4	23	03/07/2022 07:01	TC	23/06/2024 21:54	AC
Questioning the distinction between AET and psychotherapy	1	2	03/09/2022 06:55	TC	23/06/2024 22:05	AC
The transfer can break the connection between patient and therapsit	1	6	03/09/2022 06:56	TC	23/06/2024 22:03	AC
AET as a hybrid form of therapy with developmental aims	8	140	03/07/2022 07:01	TC	23/06/2024 21:21	AC
AET is a treatment in its own right	6	11	03/07/2022 07:01	TC	29/01/2023 16:00	TC
Establishing a therapeutic Alliance by fostering a sense of control and agency	8	107	03/07/2022 07:01	TC	28/06/2024 20:00	AC
The reliability and aspect of the frame fosters the development of trust	3	21	03/07/2022 07:01	TC	23/06/2024 21:28	AC
AET as preparatory ground for psychotherapy now or in the future	8	41	03/07/2022 07:01	TC	23/06/2024 21:22	AC
AET provides a period of assessment before transferring to Psychotherapy	8	30	03/07/2022 07:01	TC	29/01/2023 15:32	TC
Dropping out when transferring to psychotherapy	4	10	28/09/2022 11:46	TC	14/01/2023 15:05	TC
Building a secure base before transfering to psychotherapy	5	52	03/07/2022 07:01	TC	23/06/2024 21:41	AC

Focused codes from theoretical category 2 and incidence across interviews.

2.1 AET as hybrid form of therapy with a different frame

Participants talked about AET as being a **type of short-term psychotherapy** (3, 328-329) which lasted from three sessions to one year as described by Martha**:**

> *"I would say the shortest, was probably three sessions and the longest, I saw a young person for a year"* (3, 328-329).

AET was described as based on psychoanalytic theory (2, 113) of as described by Sarah:

> "*AET is still based on psychoanalytic theory, that there is still an understanding in the therapist, about the unconscious and about internal object relations, and about anxiety and defences. One of the aims would be to develop self-awareness, to develop a sense of agency about what you can do about your own circumstances. Also, to*

develop a capacity to think and reflect and have a better sense of, being a separate individual with a mind of your own. So, I think there's a lot of kind of developmental aims, which might be part of ordinary development, but that an adolescent who may struggle to make those developmental aims may be the ones who come into adolescent exploratory therapy" (2, 55-61).

From the extract above AET was described as a form of psychoanalytic based psychotherapy with developmental aims including to develop a sense of agency, to develop a capacity to think/reflect and to become more separate from parental figures.

One of the rationales for offering AET was the lack of resources that prevented therapists from offering psychotherapy to all adolescents seen at the Centre. They also touched on the fact that not all adolescents need psychotherapy or psychoanalysis and they were better helped in AET. They described that young people who went into long-term psychotherapy tended to be adolescents **who had long standing developmental histories** whose difficulties needed to be worked on in the transference (5, 352-254).

In addition, AET could also be used as a period **of extended assessment** *(*2,117-120) as described by Sarah: "*And so, adolescent exploratory therapy, could be used as a kind of an extended assessment, to see if an adolescent would be able to make use of once-a-week therapy or more intensive psychotherapy*" (2,117-120).

However, because of the time limited duration of AET, there were some limitations in the sense that AET **did not lend itself to work through deep-seated difficulties** (2, 244-245). This was suggested by Sarah: *"but in AET, the method in terms of how to address anxieties and difference differs slightly in that, in that it doesn't create the setting nor the method to go*

in to those more deeper, more primitive levels of the unconscious functioning of the patient" (2, 244-245).

2.2 AET as preparatory ground for psychotherapy now or in the future

My hypothesis had been that AET could be used to help prepare adolescents to transition into psychotherapy/psychoanalysis. This was confirmed and participants talked about AET being used as **preparatory ground for psychotherapy now or in the future** (3, 78-80). This was discussed by Martha who suggested that:

> "*AET in itself is a treatment, but it has, it's a, it's almost a kind of preparatory ground*" (3, 78-80) and Jane also reinforced this point: "*In some ways, the AET is a preparation for possible psychotherapy, either now or in the future. You know, so there's always that thought that they might get a taste of something that helps them sometime in the future. They managed to hold on to or keep something good when they're at a younger age, and later then realize that actually, this sort of helps*" (5, 236-249).

From the extract above, one can see that AET in part aims at preparing adolescents now or in the future for once-a-week therapy or more intensive psychotherapy suggesting that younger adolescents might need a longer time to be able to engage in more intensive forms of psychotherapy. One of the rationales offered about the need to prepare adolescents in AET before transferring them to psychotherapy was linked to the amount of **dropouts when transferring adolescents to psychotherapy** (6, 183-184). This was discussed by Stephanie in her interview:

> *"(...) one of the things it was observed was that with interviewing (AET), there were fewer adolescents that would end up leaving the psychotherapy. In my experience at*

X, we offered psychotherapy to adolescents, three meetings and then psychotherapy. And very often, adolescents came to two sessions and then disappeared, or two months, and then they disappeared and you thought; what's going on? Well, that they can do in interviewing, because interviewing was organised in such a way that in each session, each meeting, we asked the adolescent would they want to come back. You know, it was up to them. Okay, many came back after a month or two months. Or you would say; you know, what about coming in two weeks' time?, if you felt they were too pressurised or you don't want to come this week, do you want to come in two weeks' time? Okay. So there was a lot of, that room for manoeuvre in interviewing" (6, 183-194).

2.3 Establishing a therapeutic alliance by fostering a sense of control and agency

AET had an intake system where the young person had **to be referred by their GP** (5, 34-35). It seemed important to **understand whether the referral is coming from the young person or adults around them** (5, 38-45).This issue was highlighted by Jane;

"I think that they have to, even if they're ambivalent about it, they have to want to know that actually, the space is there for them […] rather than because the school thinks it's their behaviour or mum thinks that they're not doing well, or they have no motivation. So for example, I've got somebody who's coming to me, who a social worker wants them to come but this person is over 18. And I said, quite frankly, to begin with, at least I want to try and engage her by herself rather than thinking that it's, it's part of um...you know, part of the adult world. That it's something for her to opt into or not" (5, 38-45).

In this sense, it seemed important to **involve the young person in the decision making to give them control over the process** from the moment of the referral to foster a sense of control and agency, as well as an understanding of the young person's motivation to get help from the start of the process. Participants were aware of the need to **avoid pulling adolescents into something too child-like or adult like** (5, 28-32) given that adolescents struggle with issues of autonomy. From this point of view, there was a sense that it was important to respect adolescents as their own group and developmentally distinctive from adults or children. Having a centre for adolescents was thought to be contributing to assuaging young people's anxieties about **being perceived as being mad or different** (5, 265-274) to their peers and the stigma associated in seeking help at the centre. This was encapsulated in Jane's interview:

"Because there's a lot of...stigma anyway to, mental health, we always try and look for where they think, Oh, I shouldn't be here. Or if I am here ...it is because I have no control over my life and I must be mad, or, um... I must be the only one. And if there's an opportunity, I might say, well, you might feel worried about coming to a place like this. Um ... but isn't it interesting that there's a whole centre? So I expect you're not the only one, you know, so there's sort of things like that where I think we can sort of understand where they're coming from, because we're focusing on a particular age and developmental stage I think, that's part of it is as you really get into the mindset of where they are" (5, 265-274).

Linked to the previous code of how seeking help can elicit feelings in the young person of being different to their peers, and having no control, participants talked about how some adolescents might experience the psychoanalytic frame as an imposition from adults adding to the sense of lack of agency and control when they came to the Centre. On the other hand, they described how AET does not make adolescents feel there is a fixed frame and they are

more **involved in the process of co-constructing the therapeutic frame** (6, 194-203) as stressed by Stephanie in interview:

> *"Well, the setting in a therapy is the frame is quite fixed. You have normally once a week, 50 minutes etc. You have to come twice a week, etc, here is the contract! In interviewing you never make the adolescents feel like that. So from the point of view of the frame, one could say the setting that we're trying to establish is one that accommodates a bit more in the sense that we're not imposing something that the adolescent doesn't know why they have to accept. So this is kind of following the adolescent defensive organisation a bit. So there is a manoeuvring around a different frame where that room for manoeuvre was not interpreted as resistance or difficulties."* (6, 194-203)

As part of establishing a therapeutic alliance by helping young people to control and foster their agency, it was important to involve adolescents in the process of co-constructing the therapeutic frame. Stephanie discussed how during AET the therapist asked the young person if they wish to come back. Asking adolescents if they wanted to come back was underpinned by the idea of **involving adolescents in decision making and giving them control** (5, 277-288). This was discussed by Jane in her interview:

> "*So, would you like a session next week, just to come and think about that, and, you know, maybe that you have decided to finish. You know, so that's where we try and involve them and give them a bit of control, really"* (5, 277-288).

Asking adolescents if they wanted to come back was also linked to the idea of **helping them to own their problems and need for help** (6, 356-357) as suggested by Stephanie: "*But it was always a question of making the adolescent feel they had a say whether they wanted to*

come back or not. That they could own their own problems and need for help at that level" (6, 356-357).

All these different elements help to provide the adolescent with a sense of control over the initial stages of the therapeutic process as well as fostering a sense of control and agency over the therapeutic process in AET that could lead to the **establishment of a therapeutic alliance (**5, 424-430**)**. This was highlighted by Jane in her interview:

> *"So I think you know, and just the way we talk to them and respect them and it's all done in sort of, not an adult way, but not a childish way. And that's why I think it's great to have this adolescent centre because everything is set up not to trigger off the sense of, either I'm mad, or I have no control over my life, um... life is like my body, or I have no agency. And all those things together, I think that's something to do with sort of making this alliance with them"* (5, 424-430).

2.5 Containing and reliability aspect of the structure could help to develop trust

Participants discussed the importance for adolescents to feel that there is a frame they come back to once they have decided to commit to long term psychotherapy. It seemed important for the young person to feel that they can commit to know that the space and structure is there for them. This was discussed by Sarah:

> "*So, my experience is that adolescents, once they've decided to commit after the initial assessment, most of them would want the weekly once a week, same time, same length of time, same room, everything that you would have maybe in a more traditional psychotherapy, but that that is something they want and that it helps to facilitate the development of trust , you know… with the reliability of the setting*" (2, 16-18).

2. 6 Building a secure base before going into psychotherapy

Across the interviews I coded examples of participants reflecting on the importance of having a structure that helps to **build a secure base before going into psychotherapy** (3, 162-165). Martha talked about how the therapist might have to do a lot of work in the network to develop an understanding of the frame in the network prior to an adolescent moving to psychotherapy: " *I think that's the difference, you know, that probably a therapist may well have done an awful lot of, I don't know, kind of building the frame and supporting the acting out, understanding that, working in the network, all of that before, in the time of AET before going to psychotherapy, I think. It's almost that you're building a very kind of secure base before to prepare them to go on to see someone"* (3, 162-165).

Similarly, it seemed important to **consider the degree that an adolescent might be trapped in a family system** (3, 562-563) that could hinder the adolescent ability to gain a degree of separation from their family needed to access psychotherapy. In this sense, this could prevent the adolescent developing a sense of independence and agency that could make it difficult for adolescents to go into psychotherapy. This was highlighted by Martha in her discussion of a patient: "*But she came here, and I think the psychotherapy represented something about having independence and agency. But in her family network, she was not permitted to have any independence at all. I think, it can feel, you know, if a young person can't leave, can't have actual independence, I think psychotherapy can be difficult"* (3, 567-569).

2.7Advantages and disadvantages of having delineation between AET and psychotherapy

An important aspect of the treatment of those adolescents who have had AET and are ready for psychotherapy is that sometimes the adolescent patient will be transferred to a new

psychotherapist or psychoanalyst. Jane talked about: "*how when we were a much smaller service, we would definitely sort of have a big delineation between AET, and therapy, and there would always be a change in therapists"* (2, 338-340).

This transfer from one therapy to another was beneficial to the extent that it presents the opportunity for the young person to work on the **process of separation and individuation** (6, 320-330). This point of transition between AET and psychotherapy also presented the opportunity to explore if the adolescent is able to give up AET. Stephanie put this point in the following way:

> *"It was felt that it was helpful to the adolescent to be able to separate to make the move, to tolerate giving up AET and moving to something else, that this is part of the process of adolescence. And that it is always about giving something up, you know, in every process in life, we always have to give up, the child has to give up the breast, the adolescent has to give up being the child. Some adolescents cannot give up their sense of childhood, because it was fantasised as free from conflict. Let's say they feel troubled by their sexuality, troubled by peer relationships, and they regress to wanting to be looked after. Those adolescents could stay in interviewing for years, three years or five years. So it's not the right thing"* (6, 320-330).

Participants talked about the importance of **exploring the adolescent's reaction to needing more help** (5, 345-349) during AET before transferring to the new therapist. In particular, it seemed important to explore the adolescent's anxieties about being put forward for more help in the form of psychotherapy. In her interview Jane talked about how:

> "*With AET, we do always sort of spend quite a lot of time thinking on the ending, thinking about what it means for them to be going forwards. You know, does it mean*

that we think, you know, if we're sort of putting them forward for something more, does it mean, we think they are really, really bad, you know, that they're really mad, they're really, um... you know, they need so much more help" (5, 345-349).

Similarly, the end of AET and the change of therapists could be used to as an opportunity to **explore the adolescent's reaction to ending** (6, 466-472) AET and the relationship to the AET therapist and the start of a new relationship with a new therapist. This was described by Stephanie:

"*And also the acceptance that they have to move on that, yes, we have done a piece of work. How would you feel about seeing somebody else? And young people would say; no, I hate it, or I like it. Then there will be a different process, explaining the setting of the psychotherapy in interviewing. Okay. Now, you know, you will have to come regularly, it's a commitment. This is what is going to happen, there will be breaks. And all that brings is quite different. So when the adolescent moves and what we used to do is introduce a therapist to the adolescent and then say goodbye" (6, 466-472).*

Participants talked about **Helping adolescents understand the limitations of AET** (6, 326-331), which referred to the view that adolescents were informed from the start of AET that it was time limited. It also suggests the idea that the ending of AET is a short term intervention and that if the adolescent still needs help they would be able to have more intensive work. In this sense AET seemed to have a clear and distinctive aim as discussed by Stephanie in the following excerpt:

"*The aim is to help the adolescent own that they have a problem and own that they need help. So it's not just a kind of open exploratory going anywhere in everywhere because yes, they need to know why we are not offering them psychotherapy. And*

once we work out what is that you feel, we both feel you need, we will discuss it, and then we will help you get it. You know whether it's therapy or more intensive work. So from the beginning, that adolescent will know that that process is moving towards an ending" (6, 326-331).

More importantly, this period of ending and transition between therapies could be used to **assess the adolescent's ability to own their problems and wish to change** (7, 243-254). This was encapsulated by Steve in his interview when he discussed the change of therapist and how the ending of AET could be used to explore the adolescent's ability to own their difficulty, explore the limitations of AET and assess their wish to change and work on their problems in psychoanalysis:

"I think if you really care about this, if you really are serious, rather than just come and see me every so often, you really do need to sit down, really take on your problem that you've got. If you are serious about this, if you really want to change, I think you need more time. I think you need somebody who can probably help you better than I can. I can only help you so far and there's more to go. And much to my amazement, after a bit of resistance, she said, all right, then, I'll give it a try. And I think she did give it a try, and I think it worked. And I think she stayed for a couple more years of analysis" (7, 243-254).

2.8 The transfer can break the connection between patient and therapists

Steve suggested that a change of therapist and the decision to move the patient to someone else could result in the connection between AET therapist and patient being broken. This could lead to the young person breaking away from AET:

"*I think on very many occasions it led to the contact being broken because the kid had made a connection with somebody. I have the impression that this is my memory that some did not transfer very well. They couldn't understand why they couldn't see me anymore*" (7, 215-217).

From this extract, there is a sense that the decision to transfer a patent came with some benefits and some risks. It seemed as if for some young people it was difficult to understand why they could not continue to work with the AET therapist with whom they have formed a connection. Perhaps, for some adolescents the loss of the AET therapist might too much to bear which might result in the connection between young person and AET therapists being broken.

2.9 Questioning the distinction between AET and psychotherapy

This code was surprising and challenging to the premise of this study that assumed to some extent that there is a clear distinction between AET and psychotherapy/psychoanalysis. In interview 7, Steve openly questioned the distinction between AET and psychotherapy or psychoanalysis: *"(...) it came about because there was a view that, well, this person made a good connection. Now is this the time for us now to really seriously consider psychoanalysis? And that we necessarily must make a transfer from the person with whom the adolescent is connected (in AET) to a psychotherapist or to a psychoanalyst, and therefore after there will be proper psychoanalysis or proper psychotherapy? I never, ever saw that distinction. But that was not the prevailing view*" (7, 110-119).

The debate about the distinction between AET and psychotherapy seemed sometimes unclear to participants when it came down to how therapists were using it in their practice. This was raised by Laura: "*Because I've had the experience, and I think other people have to have, you*

might be presenting an AET case, and an older member of staff will say that you were doing psychotherapy with this person. And so there is this sort of question of where's the boundary between the two? And I think my viewpoint on that would be that rather than it being a formal decision, it often depends on the patient and what stage they're at. And someone I might be, you know, on paper doing AET with but I am actually doing psychotherapy within the room because they're able to think more, more about things than the next person, and so it can develop, just because they have that capacity to do psychotherapy"(1, 169-178).

From the above extract, one can see that sometimes the delineation between AET and psychotherapy can be problematic in terms of its delineation to participants themselves. This seemed to suggest that the distinction between AET and psychotherapy and the decision making process can lag behind the developments taking place in the AET space. We can see that the transfer from AET to psychotherapy had its pros and cons, in some cases the transfer was thought to be advantageous whereas in other cases, it was thought to be more helpful for the AET therapist to continue to see the adolescent rather than transfer them to other therapists to do the psychotherapy.

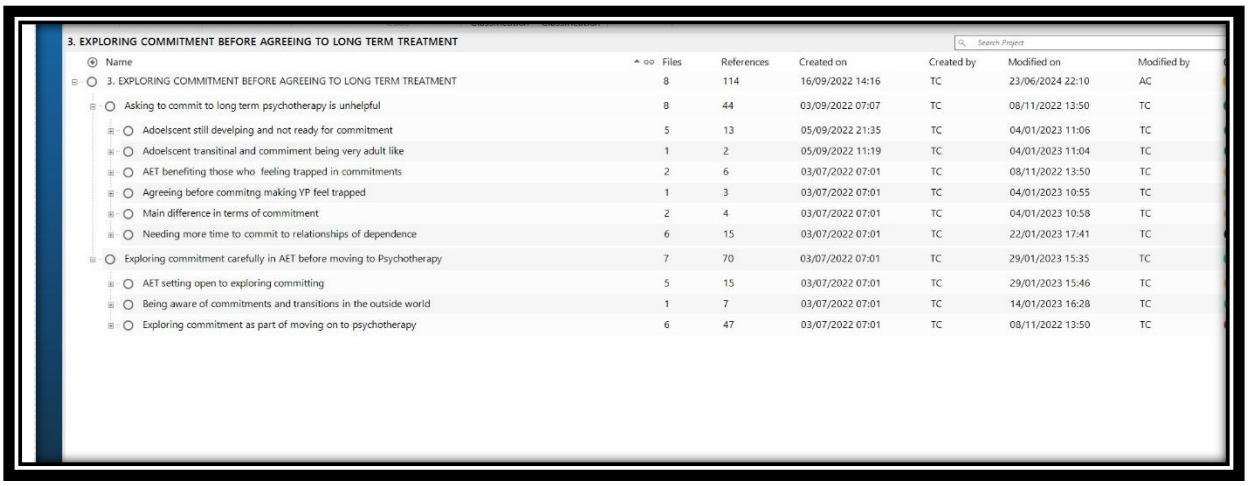
3. Theoretical Category 3: Exploring commitment before agreeing to treatment

Figure 12

Diagram of Theoretical Category 4.

As described in the previous section asking adolescents to make a long term commitment to psychotherapy without being able to explore their readiness to commit to it could result in some adolescents prematurely dropping out of AET.

Figure 13



3. EXPLORING COMMITMENT BEFORE AGREEING TO LONG TERM TREATMENT

Name	Files	References	Created on	Created by	Modified on	Modified by
3. EXPLORING COMMITMENT BEFORE AGREEING TO LONG TERM TREATMENT	8	114	16/09/2022 14:16	TC	23/06/2024 22:10	AC
Asking to commit to long term psychotherapy is unhelpful	8	44	03/09/2022 07:07	TC	08/11/2022 13:50	TC
Adoelscent still develping and not ready for commitment	5	13	05/09/2022 21:35	TC	04/01/2023 11:06	TC
Adoelscent transitinal and commiment being very adult like	1	2	05/09/2022 11:19	TC	04/01/2023 11:04	TC
AET benefiting those who feeling trapped in commitments	2	6	03/07/2022 07:01	TC	08/11/2022 13:50	TC
Agreeing before commitng making YP feel trapped	1	3	03/07/2022 07:01	TC	04/01/2023 10:55	TC
Main difference in terms of commitment	2	4	03/07/2022 07:01	TC	04/01/2023 10:58	TC
Needing more time to commit to relationships of dependence	6	15	03/07/2022 07:01	TC	22/01/2023 17:41	TC
Exploring commitment carefully in AET before moving to Psychotherapy	7	70	03/07/2022 07:01	TC	29/01/2023 15:35	TC
AET setting open to exploring committing	5	15	03/07/2022 07:01	TC	29/01/2023 15:46	TC
Being aware of commitments and transitions in the outside world	1	7	03/07/2022 07:01	TC	14/01/2023 16:28	TC
Exploring commitment as part of moving on to psychotherapy	6	47	03/07/2022 07:01	TC	08/11/2022 13:50	TC

Focused codes from theoretical category 3 and incidence across interviews.

3.1 Asking to commit to long term psychotherapy is unhelpful

As already outlined in the previous sections one of the main differences between AET and longer-term psychotherapy was discussed in terms of its commitment. Participants saw some adolescents as **still developing and not ready for commitment** (4, 27-28). In interview 7, Steve stated this point: "*I'm just aware that the adolescent is still developing and not ready for commitment. But that's what you hope for, they come in and get a bit of it and they've had enough and maybe they'll try it later on but there is something transitional about it-they don't want the commitment, the commitment is more adult like really "* (7, 547-500).

Participants seemed to find that adolescents tended to be fearful of commitment to relationships and some adolescents might feel trapped in a long term commitment such as that posed by psychotherapy or psychoanalysis. Another important factor that participants discussed in the interviews was that adolescents needed **longer for young people to agree to enter into a relationship of dependency** (4, 65-66) and were concerned that offering

ongoing psychotherapy might make adolescents feel they are being pulled into parental relationships at a time when they are struggling with their individuation. From this point of view, AET seemed to **benefit those who feel trapped in commitments** (2, 207-209) as suggested by Sarah: "*I think the benefit would be for someone who says, who says explicitly, I don't want to commit for a year, I'm scared of therapy. In a sense, a three-session assessment is not giving me enough of a chance to experience what it is. So, I think it, I think, in that sense, it may be there, that, you know, a lot of adolescents aren't very reliable, and may feel trapped if they have to commit to a year of therapy*." (2, 207-209).

3.2 Exploring commitment in AET before moving to Psychotherapy

It seemed particularly helpful to have a period in AET where the therapist could **assess the adolescent's level of commitment to AET** (2, 337-338) and this could be used to inform whether the young person might be ready to commit to something that requires a longer term commitment such as psychotherapy. Sarah in her interview commented: "*So you can see that there is a commitment that could be part of the assessment that there is that commitment, they can bring themselves that would be one thing. And so adolescent exploratory therapy, could be used as a kind of an extended assessment, to see if an adolescent would be able to make use of once-a-week therapy or more intensive psychotherapy, where…, where you can see that there is that commitment"* (2, 337-338).

Linked to the previous point, this period of AET could help the AET therapist assess how much the young person is **able to commit to a relationship of dependency** (4, 127-132) which psychoanalysis or psychotherapy requires. William suggested this in the following way: "*What you're always doing all the time, that maybe it is different in psychotherapy, is*

that you're assessing how much the adolescent is able to or the young person is able to enter into a relationship of dependency" (4, 127-130).

This focused code linked to the idea that AET is geared to exploring before committing to something the adolescents haven't experienced and it seemed important to give them the chance to explore if they wish to be in psychotherapy rather than putting them in it. **Agreeing to move into psychotherapy before the young person is ready to commit** (2, 112-114) might elicit feelings of being trapped in the young person. This was discussed by Sarah: "*But if you expect them to make the commitment at the beginning, I mean, once they're in it, they may not feel trapped, but they may feel that they will get trapped into something that they don't want to or are not ready to commit to"* (2, 112-114).

In this regard, AET could be used as an **extended period of assessment to explore the young person's ambivalence to committing to psychotherapy**. This was discussed by Sarah:

> "*So, I think an adolescent who themselves seem to be someone who needs a bit of time to explore and not feel that they are expected to commit to something that they don't know what it is, and, are a bit ambivalent about it or hesitant about it. But… at the same time, do want help and is willing to, to give it a go"* (2, 180-186).

This point was also emphasised by Martha who discussed the importance **of exploring commitment as part of AET rather** (3, 413-416) than taking it for granted: "*So, they're having assessment, but really, you're expecting they're going to keep coming every week and kind of long term. […] And I'm not sure whether it's a bit of a mistake to expect that, because I think the reality is that the exploratory bit is keeping things open."* (3, 413-416).

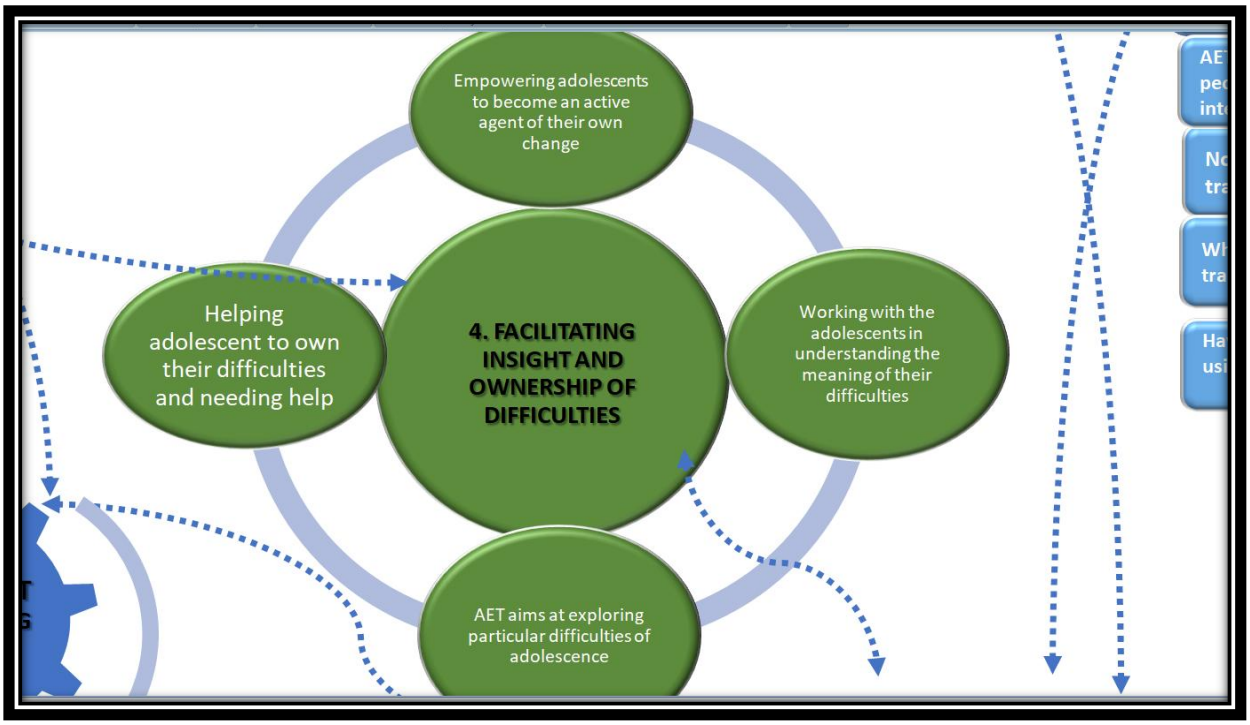
Participants also reflected that when considering a possible transition from AET to psychotherapy, it was important to be aware of the **adolescent's commitments and transitions in the outside world** (5, 145-148). In interview 5, Jane reflected on this aspect in the following way:

> *"I think that what we need to keep in mind is what is possible at this point in their lives. And you know, we've had to become, I feel that we've had to become much more thoughtful about exams and stuff because there's so much pressure put on adolescents with exams that they can sometimes feel that this extra appointment can be just too much for them, you know, rather than being helpful, they feel it can be unhelpful"* (5, 145-148).

This theoretical category is important and helps to address the research question. It links with theoretical category 1, that is to say in terms of adolescents' ambivalence and feelings about entering into relationships of dependence with adults which can evoke feelings of entrapment in long term commitments and/or abandonment by short terms interventions. Committing to something that the young person might be scared to commit themselves to before they are ready could make adolescents frightened of becoming trapped or abandoned which could lead to the adolescent disengaging from a possible transfer to more intensive psychotherapy.

4. Theoretical Category 4: Facilitating insight and ownership of difficulties

Figure 14



Theoretical Category 4

Across all interviews it was quite clear that one of the main aims in AET is for the adolescent to become aware of their difficulties and to take ownership of them. This aspect of AET was significant in three particular ways: 1) It could help the young person to understand that their difficulties are symptomatic of a psychological nature. 2) Through the young person and therapist exploring and identifying the difficulties the young person is experiencing, the adolescent and therapist can form a therapeutic alliance based on this understanding. 3) This could lead to the young person wishing to work on their difficulties in a more intensive psychotherapy or psychoanalysis setting.

Figure 15

4. FACILITATING INSIGHT AND ONWERSHIP OF DIFFICULTIES

Name	Files	References	Created on	Created by	Modified on	Modified by
4. FACILITATING INSIGHT AND OWNERSHIP OF DIFFICULTIES	8	179	08/09/2022 11:48	TC	29/01/2023 17:05	TC
AET aims at exploring particular difficulties of adolescence	6	45	03/07/2022 07:01	TC	22/01/2023 17:44	TC
Empowered to take responsibility and control	6	30	03/07/2022 07:01	TC	04/01/2023 17:19	TC
Empowering adolescents to become an active agent of their own change	5	9	03/07/2022 07:01	TC	06/07/2024 15:50	AC
Own their difficulties stops them projecting their problems	3	3	03/07/2022 07:01	TC	06/07/2024 15:51	AC
Owning their difficulties stops the them projecting their problems	3	7	03/07/2022 07:01	TC	04/01/2023 17:11	TC
Reduction of feeling paranoid anxiety	4	10	03/07/2022 07:01	TC	06/07/2024 15:52	AC
Helping adolescent to own their difficulties and needing help	7	64	03/07/2022 07:01	TC	14/01/2023 16:40	TC
Working with the adolescents to understanding the meaning of their difficulties	7	40	03/07/2022 07:01	TC	23/06/2024 22:15	AC

Focused Codes from category 4 and its incidence across interviews

4.1 AET aims at exploring particular difficulties of adolescence

Participants described AET as an exploratory approach **aimed at exploring particular difficulties of adolescence** (3, 379-382). Sarah talked about AET in terms of its aim in the following way:

> *"I would say that AET is a talking therapy, to explore the issues that are on their mind. So the exploration often has to do as part of the nature of adolescence. So I would say that it's really um… a talking therapy, where things are with what the adolescent brings in a conscious way as these issues um…to give us space to explore how they feel about it, what they think about it, where and when do they come up against difficulties. So I think it is about exploration of issues, exploration of identity, and exploration of how much they wish to reflect on themselves"* (2, 44.51).

Exploration also played an important role in AET in that it was described as facilitating the **development of awareness and insight into difficulties** (4, 54-57). In interview 4, William made this point:

> *"So, it's more about identifying the difficulties and... it is about working with the conscious part of the ego of the patient to help them observe their own "selves", to observe your own mind and say, "Look, these are the things that are really difficult at the moment"* (4, 54-57)

4.2 Helping adolescents to own their difficulties and needing help

Developing an awareness of difficulties through an exploratory process was linked to the adolescent's ability to own their difficulties and need for help. Once the adolescent has become aware of their difficulties, the next stage in the process seemed to be about "helping adolescents take ownership of their difficulties and need for help" (5, 178-179). Participants reflected on the importance of exploring the adolescent's **commitment and ownership of difficulties** (7, 246-248) and its role in moving into psychotherapy. In interview 6, Stephanie spoke about these issues and said:

> *"The aim is to help the adolescent own that they have a problem and own that they need help. You know, you're trying to help the adolescent move to saying, Gosh, you know, really, I do have a problem. I think the more they feel, you want to help them understand themselves, and that they have a problem, the more they can accept they need help"* (6, 256-259).

Once the young person is aware of their difficulties and can take ownership of their problems the therapist and the adolescent can begin to identify what problems can be worked on in psychotherapy. During this time the therapist aimed at **identifying what problems can be worked on in therapy in the future** (6, 254-256). In interview 4, the participant discussed this very point:

> *"So, at the end, you can have an idea of the different aspects of, of your life you're struggling with, and how that can be worked through in therapy, but you will not necessarily go into it when doing interviewing. We're there to engage with the conscious part of the ego, that we'll be able to observe that it would be beneficial to work on these issues in therapy. Now, it's a preparation really. So you're preparing the person for their work you know"* (4, 121-126).

This collaboration in identifying the problems that the adolescent can take into further therapy can also pave the way for the creation of an alliance with the young person. **Seeking to form an alliance with the conscious part of YP who seeks help** (4, 223-227) was seen as a crucial aspect that could help the adolescent move into psychotherapy. This was discussed by William in his interview:

"*I think that you're working with the conscious and logical part of the mind when you speak about therapeutic alliance. I think an emotional attachment with the therapist is something that develops with time. But the therapeutic alliance, which is more about the conscious part of the mind that says I need help. And the therapeutic alliance is more at the level of, of the conscious part of the ego. And some of Sandler's work is about that part, that healthy, conscious part of the ego that makes the choice to go to therapy, and how can we encourage that part, to engage in a much deeper and more meaningful process in the future*" (4, 223-229).

By contrast, Steve talked about whether the word alliance was appropriate when working with adolescents. For this participant "**building a connection and cooperation is not alliance**" (7, 537-545). Steve argued that:

"*The alliance is a strong term, I think we were struggling to find a way of having a connection but whether we had an alliance in the sense that we were united in a joint effort of reaching goals and this and the other I think it's far too heavy. I think we kind of kid ourselves as psychotherapists if we think that we have an alliance with these kids. I don't believe many of them have a sufficient sense of self. I think they're very narcissistic. I mean it's very difficult to have an alliance with them because they're more interested in themselves"* (7, 537-545).

There seemed to be the view that **younger adolescents are not as self-aware of the need for help** as older adolescents and might need more time to develop their ability to understand and own their problems as suggested by Steve: "*And I think you have to also remember that most of the adolescents who came were in their late adolescence, not in their early adolescence. And there's an enormous difference between the two. In late adolescence there is the beginning of self awareness and self observation"* (7, 325). It also felt important **to contain the adolescent's wishes to fail** (7, 258-259). Participants also spoke of some adolescents being **scared about the possibility of moving forwards in development** (1, 244- 248). Moving forwards in their development would entail owning their difficulties and need for help as opposed to remaining in a state of dependency on others.

4.3 Working with adolescents to understand the meaning of their difficulties

Several participants spoke about the importance of AET in **helping adolescents to understand that there is meaning** (5, 433-437) behind their thoughts and feelings. For example, in interview 5, Jane stated the following in her interview:

"*I think the thing that we're trying to show them is that there is meaning behind how they're thinking and feeling and behaving. So, um... that's another thing that we do a*

lot, which is to help adolescents see that the situation they're in at the moment might have a different meaning underneath it" (5, 433-437)

4.4 Empowering adolescents to become an active agent of their own change

Several participants discussed how they saw AET as helping adolescents reflect on the part they play in their own difficulties. Therapists often talked about how taking ownership of their difficulties stops adolescents from projecting their problems onto others. Therapists discussed that adolescents' ability to **own their difficulties stops them projecting their problems** (6, 272-274), Stephanie in interview 6, put it in the following way:

"*Well, I think the first thing is that you stop projecting it, or projecting it all over the place, it stops being, you know, the teachers, my parents, my friends, and you feel you can do something about it. If I understand that this is me doing this to myself, then it means I can get help, I can do something about it"* (6, 272-274).

Owning of difficulties and the need for help was associated with the idea of a r**eduction of feeling paranoid anxiety** (6, 282-283). One participant talked about how their work aimed at showing the adolescent that they are an active agent in their difficulties. Becoming aware of their own agency could help adolescents to have a greater sense of control over their psychological difficulties. Jane described this point in her interview:

"Because if you don't show them that they play a part in it, then there's no chance of them having any effect on it. You know, so it doesn't give them any, any agency or, any things they can do. The main point of, or one of the main points of AET, is for them to be able to take responsibility, and in that way, take control of what's happening to them, both internally and externally" (5, 354-355).

The ability of AET to foster in the young person a sense of playing a part in their own psychological struggles which could in turn bolster their sense of agency and ability to take control of their psychological difficulties was seen as **empowering adolescents to become an active agent of their own change** (5, 354-355).

5.Theoretical category 5: Pros and Cons of Transference work

Figure 16

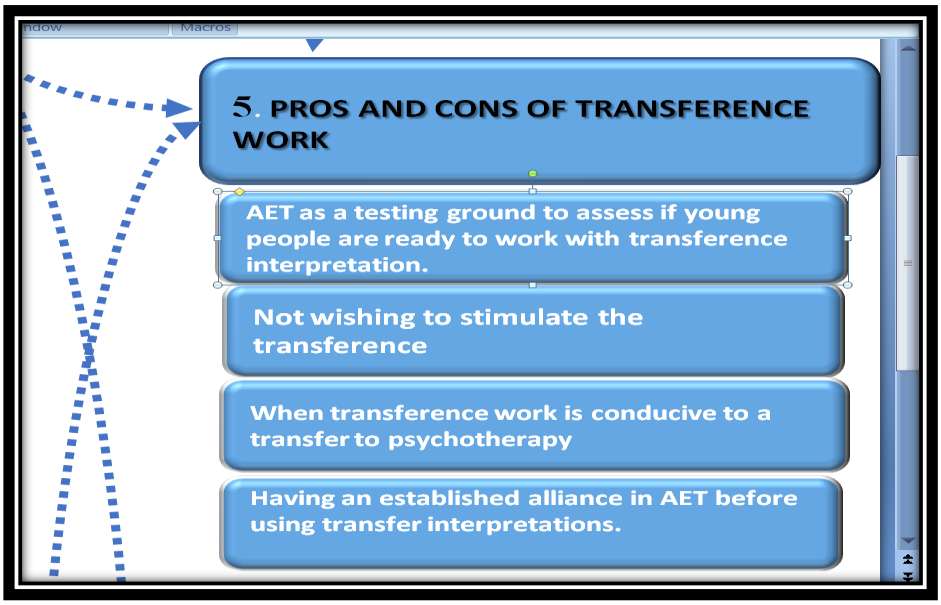


Diagram of Theoretical Category 5.

The issue of the transference was a particular issue when thinking about technique when working with adolescents. The overall sense was that participants were cautious when they used transference interpretations with the adolescent. I will now consider the focused codes that make up the main theoretical category of "pros and cons of transference work".

Figure 17

5. PROS AND CONS OF TRANSFERENCE WORK

Name	Files	References	Created on	Created by	Modified on	Modified by
5. PROS AND CONS OF TRANSFERENCE WORK	8	257	03/07/2022 07:01	TC	22/01/2023 17:55	TC
AET as a testing ground to assess if young person are ready to work with transfere	4	24	03/07/2022 07:01	TC	23/06/2024 22:31	AC
Having stablished an alliance before using transference interpretations	4	13	03/07/2022 07:01	TC	23/06/2024 22:24	AC
Not wishing to stimulate transference	8	117	03/07/2022 07:01	TC	05/01/2023 06:18	TC
When transference interpretations are conducive to a transfer to psychotherapy	7	102	03/07/2022 07:01	TC	23/06/2024 22:25	AC
Interpreting the transference when helpful to self-understanding	3	21	03/07/2022 07:01	TC	22/01/2023 18:00	TC
Showing transparency about how insight is gained	4	20	03/07/2022 07:01	TC	05/01/2023 06:38	TC
Staying with difficulties the adolescent can relate to	5	22	03/07/2022 07:01	TC	05/01/2023 06:17	TC
Transference interpretations do not allow a space for adolescents to think	5	15	03/07/2022 07:01	TC	29/01/2023 15:42	TC
Using transference to understand blocks to thinking	5	23	03/07/2022 07:01	TC	22/01/2023 18:00	TC

Focused codes from Category 5 and incidence across interviews.

5.1 AET as a testing ground to assess if young people are ready to work with transference interpretation.

Participants discussed how AET could be useful as a testing **ground to assess if young people are ready to work with transference interpretations** (2, 388-394). This point was discussed by Sarah in her interview:

> "*Another benefit is if you see that the, the adolescent doesn't respond to a transference interpretation, that either they find it too intrusive, or they find it too scary, or they… are..um.. not really ready to explore the more, you know, the deeper anxieties, that you then know that this is an adolescent that's not ready for psychotherapy, and that rather than embark on committed therapy that would fail, that you can gauge that through… through… the trial and error with that "*(2, 388-394).

Similarly, for Martha, seeing the patient in AET could serve as a testing ground to see how the adolescent responds to transference interpretation: "*And then I think sometimes, as AET progresses, you can start to kind of test that out, you know, and then think, what the young person does with it? And what can they... can they take that in overtime"* (3, 115-118).

From this extract, interpretative work would involve commenting on unconscious processes and/ or the transference relationship that can be seen as fostering intimacy and dependency which could be felt by the young person as scary. This suggests that AET could be used as a testing ground to gauge how the young person responds to it and how they use transference interpretations.

5.2 Not wishing to stimulate the transference

Participants in general found it helpful to **monitor the transference and counter-transference** (2, 265-271), to inform their understanding of the patients as highlighted by Sarah:

> *"I use the transfers as much as I would use it in doing psychotherapy in the sense that I do pay attention to what the adolescents say to me in terms of the impact, the conscious impact it has on me, how it might make me feel, where my mind might go, how I tend to respond to this adolescent. So, in terms of you know, the countertransference I use it all the time to inform my own understanding, to make formulations about what might be going on in terms of the internal life of the adolescent and their internal object relations and so on"* (2, 265-271).

Participants underscored that even though they always paid attention to the transference and countertertransference, they did **not interpret as explicitly or as frequently** (3, 254-257) the transference as they would do in ordinary psychotherapy as discussed by Martha:

"But I may not, as I say, interpret as explicitly, or as frequently as in ordinary psychotherapy. I would be more careful, if it's not an established adolescent exploratory therapy to, to um gather the transfers more, because it's not a long term therapy that, you know, there is time to deepen it and work it through" (3, 254-257).

Participants' reasons for not interpreting the transference were linked to several issues, a) they are aware that the work with the young person is time limited and b) making transference interpretations was seen as fostering intimacy and dependency. In terms of point a), the issue seemed to be that the transference could gather in AET and that its time limited frame is not suitable to work in the transference. Jane in her interview described the scenario where:

"*making transference interpretations and finding myself in a situation where I think, well, I can't stop AET now and transfer the patient to someone new because I think I would like to offer psychoanalytic psychotherapy and be the clinician to continue to offer it. So, there are dilemmas, because you don't have the capacity, you know, the vacancy available or whatever, there might be certain… lack of resources to refer the person on even to someone else. Yeah, so I think there are limits in terms of limited resources and in terms of transferring the patient to another therapist"* (5, 403-409).

From the extract above, interpreting the transference was regarded as counterproductive in that it could lead to the transference gathering while not having a structure in place to continue to work with the young person as AET is coming to an end. In terms of point b), making transference interpretations was seen as stimulating the gathering of the transference, and could lead to **disappointment in the adolescent and disrupt the transfer** (2, 396-398). as discussed by Sarah:

"*So if you, I suppose the drawback can be that you find yourself in not being able to offer the adolescent something that they have come to experience and expect and that that could be disappointing and disrupt a process that that was, that could potentially be very beneficial"* (2, 396-398).

Related to point b) some participants raised the issue that making transference interpretations could stimulate feelings of intimacy and dependency which **did not allow the space for the adolescent to think** (6, 237-238) as it directs focus on to the relationship. This was discussed in interview 7 by Steve:

> *"I think they find it (transfer interpretations) confusing, threatening and maybe overly intense, overly intimate, overly close. This is what you're feeling towards me. It directs the whole focus on the patient and me. I mean, unless there's some self-observing function alive in the ego of the patients, it'll just become another terrifying, threatening experience, overwhelming and misunderstood. And where we bring about the termination now"* (7, 458-463).

This seems important since one of the aims of AET was to help adolescents to engage with their capacity to think about their difficulties and problems in order to work on these issues in psychotherapy or psychoanalysis. Interpreting the transference without the young person's capacity for reflection could become an overwhelming experience which could result in the adolescent dropping out of AET.

In connection with the issue that making transference interpretations could foster feelings of dependency and intimacy in AET with adolescents, participants reflected that it was helpful **to address the transference to the institution** (4, 190-194) while doing AET rather than to address the transference to the therapist. This was highlighted by William in his interview:

"*Now, the transference in this case, it's not only to you, it's a transference to the institution as well. So you can use the Brent Centre, for example, as the institution they are having a series of feelings towards. So you are addressing the transference to the Brent but you're not bringing it into the room into something very one to one. Because I am not the only person who will be working with the young person and there might be another therapist in the future"* (4, 190-194).

Making transference interpretations in relation to the Centre seems to help to lessen possible feelings of intimacy and dependency. It also seems to help to prepare the adolescent for the possibility that there may be a transfer and change of therapists in the future.

5.3 When transference work is conducive to a transfer to psychotherapy

As discussed in section 4, AET was helpful in enabling adolescents to engage with their capacity to think about their difficulties and problems in order to work on these in psychotherapy or psychoanalysis. Interpreting the transference without the young person's capacity for reflection could become an overwhelming experience which could result in the adolescent not coming back.

Some participants argued they interpreted the transference when they thought **it led the young person to self-understanding** (2, 253-255) or when it leads to experience something important in the relationship with the therapist. This particular point was underscored by Sarah:

> *"It's how explicit you want to make it to the patient as well, if you think it would be helpful for the patient to understand themselves better. So if it is clear, that it can help them to understand their own internal relationships and their own internal workings*

better. Then I would interpret in the transference, when I think there isn't quite an obvious link that will enhance their understanding by experiencing something in quite a direct way in the room with me" (2, 253-255).

It was evident that **interpreting the transference to understand blocks to thinking** (6, 235-239) was important when helping adolescents that are developmentally stuck. In interview 6, Stephanie discussed this very point: "(...) *what we do about understanding the transference and when and how we interpret it. It's according to, I think, what is preventing movement in the session. That is, when the thinking gets troubled, gets stopped or prevented"* (6, 235-239).

Transference interpretation could be useful to deal with the young person's difficulties engaging with the thinking and/or engaging with the process of AET as suggested by William: "*I will only use it if I feel that this is about a resistance to engaging in the process of thinking about themselves"* (4, 125-126).

In this sense it seemed helpful to **stay with the adolescent's conscious difficulties** (2, 90-92) and help the young person to become more involved in trying to find out what their difficulties are and take ownership of them. In interview 2, Sarah reflected on this aspect as follows:

"*But that's not…. you're not necessarily going to make an interpretation to bring an unconscious issue to the surface, you may explore more with…um… the adolescent, and what…. what they consciously bring as an issue"* (2, 90-92).

In contrast, interpreting in the transference something with adolescents who had a limited reflective capacity or limited insight into their difficulties could be experienced by the young person as confusing and threatening. In addition, interpreting the transference might bring up issues of agency involved as transference interpretations could draw attention to the

knowledge and power disparity between the therapists and the young person as highlighted by Steve in his interview:

> *"But a lot of kids come in and they know they're in trouble, but they think they will sort it out and then you start pointing out something else that they're just not aware of. I think they find it confusing, threatening and maybe overly intense. I think in a proper full analysis, you would want the transferences to be expressed and to be explored and to be experienced in order to hopefully understand it better. I don't think you have that privilege. You don't have that time or permission from an adolescent to do that"* (7, 457-463).

When they offer a transference interpretation one participant pointed out that it is important to show the young person **how the therapist had gained insight from their difficulties** (5, 318-320). Being able to show the adolescent how the therapist gains access to how they feel can help to mitigate anxieties about agency and dependency. In interview 5, Jane said this:

> *"Because I think that's the other thing, is that you don't want them to think that you've got this magical insight about how they're feeling, you want to show them where you are. This is how I work; I like to show them where I got that from"* (5, 318-320).

5.4 Having an established alliance in AET before using transfer interpretations.

Having established a solid therapeutic relationship and **knowing their patient well before making transference interpretation** (5, 386-342) was regarded as helpful. The following extract from Jane highlights the importance of knowing the patient well:

> "*If are you going to make a transference interpretation like you would in psychotherapy, but you're also relating it back to the transference from other objects, you know that from their past, from their past history. I think you have to, um... I think*

you have to be quite careful to know your patient well enough to make it because it's only once a week. So you know, you can stir up things and, um... and then not come back to them. It's not like three times a week work" (5, 386-342).

Laura's interview suggests that the patient needs to have been able to own their problem before transference work can take place. As we saw in section 5, AET could lead to the young person gaining insight into their problems which could work in psychotherapy:

"And maybe if we're thinking about transference, maybe I can use that a bit. And it feels like there's a solid relationship so that they're not going to be frightened if I make an interpretation. So, I suppose that they might feel a bit less defensive and they're owning the problem a bit more" (1, 327-331).

6. Theoretical Category 6: Signs of readiness for long-term Psychotherapy

Figure 18

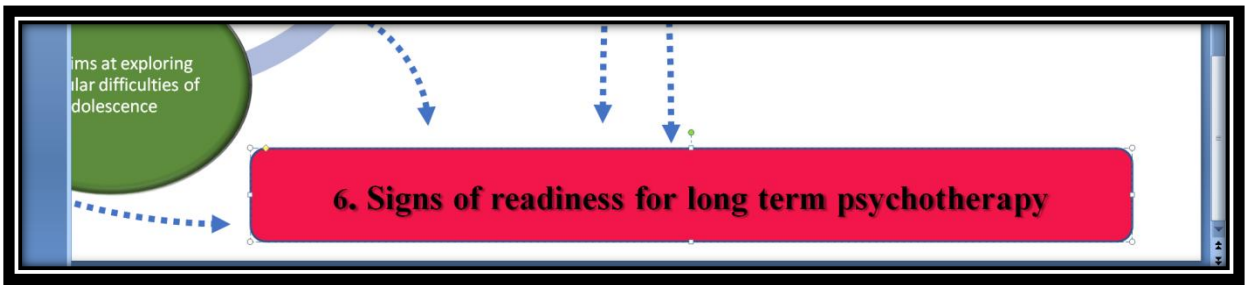
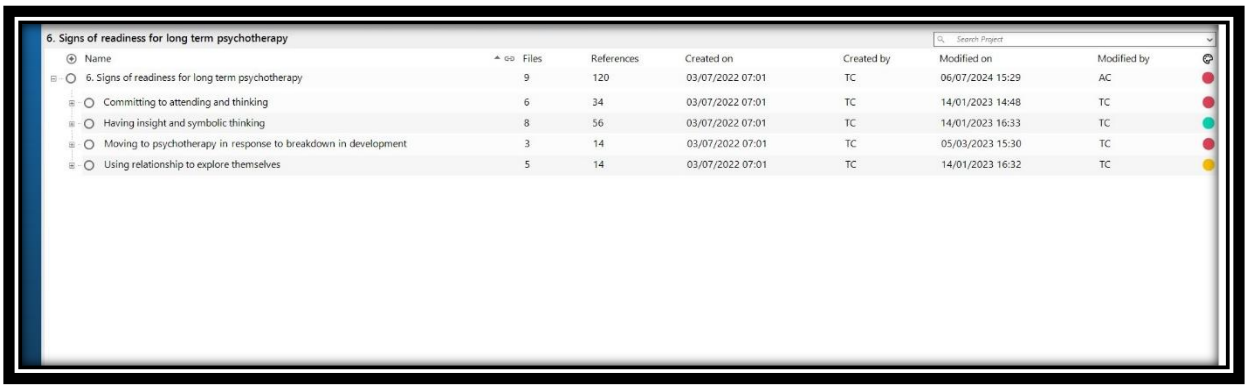


Diagram of Theoretical Category 6.

This theoretical category comprised how therapists understood the signs in their patients that indicated to them that the adolescent was ready for long term psychotherapy.

Figure 19



6. Signs of readiness for long term psychotherapy

Search Project

Name	Files	References	Created on	Created by	Modified on	Modified by
6. Signs of readiness for long term psychotherapy	9	120	03/07/2022 07:01	TC	06/07/2024 15:29	AC
Committing to attending and thinking	6	34	03/07/2022 07:01	TC	14/01/2023 14:48	TC
Having insight and symbolic thinking	8	56	03/07/2022 07:01	TC	14/01/2023 16:33	TC
Moving to psychotherapy in response to breakdown in development	3	14	03/07/2022 07:01	TC	05/03/2023 15:30	TC
Using relationship to explore themselves	5	14	03/07/2022 07:01	TC	14/01/2023 16:32	TC

Focused codes from Category 6 and incidence across interviews.

6.1 Committing to attending and thinking

Participants reflected on the internal change that they noticed when adolescents were ready to move on to formal psychotherapy. This depended on showing **committing to attending and thinking** (3, 366-340) as sings of readiness for psychotherapy. In this regard, commitment was understood as the adolescent's ability to use the AET frame in terms of attending regularly, responding to the contact with the therapist and thinking about their problems. This suggests that the adolescent is ready for more regular contact with the therapist. Martha, in her interview touched on this point:

> *"I think it has quite a lot to do with to what extent, I feel they can make use of it. So, in terms of whether they are…responding to more, more in depth work, and also their motivation in terms of…of how they use it in terms of turning up and responding to the setting. I wouldn't offer it to someone who doesn't, doesn't attend regularly, who doesn't respond to, to the contact or the thinking"* (3, 366-340).

This last excerpt highlighted that the adolescent seemed to be able to make use of **the AET frame and the relationship with the therapist** (3, 524-529) while respecting the setting,

including its gaps and boundaries and frame as less of an imposition from the therapist as discussed by Martha:

> *"That means that they can tolerate interpretations, they can tolerate the gaps between sessions, they can, you know, they can tolerate the boundaries that one has to put in place, they can tolerate you going into depth with them. But the cases that we've had here in psychotherapy, I just think there's no way she would have managed that, even if they hadn't been carefully prepared to get there"* (3, 524-529).

6.2 Using relationships to explore themselves

Several participants discussed the extent to which the adolescents **showed evidence they can use relationships to explore themselves** (2, 354-359) as a marker that the young person was ready to explore their readiness to work in psychotherapy. This was highlighted by Sarah in her interview:

> *"I think it's a patient who comes and, and wants to make contact, who you know, so we will talk about who seemed to have a sense of being able to make use of the object or not, not necessarily in a nice way, of course. Also, if they could be angry with me or, or sad, but who can, who can… make use of the relationship in terms of exploring themselves"* (2, 354-359).

Related to this, it seemed important that the adolescent has some capacity **to think about the transference** (1, 127-128). In the extract below, Laura talked about how AET could help the adolescent to move towards being able to use transference interpretations:

"how did they respond to these kinds of more um… , what would I call it, um…you know, the transference, the transference interpretations that you did make in a session where they're able to kind of use it and could… could manage it" (1, 127-128).

6.3 Having insight and symbolic thinking

Participants talked about noticing that those adolescents who had **developed insight and symbolic thinking** (5, 354-355) were ready for psychotherapy. In interview 5, Jane reflected on this particular aspect of what she understood as a sign of readiness for psychotherapy:

"*And the people who go into therapy are people who can use it, you know, who have a lot of insight into, you know, people who understand about symbolic thinking, you know, who could, you know, really use it"* (5, 354-355).

From the extract above, one can see that participants saw patients that went into psychotherapy as being able to reflect and have more insight into their difficulties than those who were not ready to explore more deeply their difficulties. There was a sense that participants looked for specific evidence in terms of the adolescent's capacity to explore their difficulties at a deeper level as discussed by Martha:

"So, I think it is about some, showing some evidence that they perceive that whatever the external difficulties are, that there's also internal difficulties that they're interested in understanding better and wanting…um…to know about. So, a real wish to know themselves at a deeper level and a real wish to understand that" (3. 357-361).

6.4 Moving to psychotherapy in response to a breakdown in development

Another reason for moving to psychotherapy was because of a **breakdown in development** (1, 320-323) and the adolescent becoming riskier during AET. This point was discussed by Laura in her interview:

> *"I mean, there are some I've got someone in psychotherapy twice a week at the moment, who I think is still at the stage of me helping her to own the problem. But it happened because this patient was risky and needed a bit more containment and that's why we increased it to the twice a week. So sometimes, I think it can be a sign of development that they're able to think more and then we would offer psychotherapy, but sometimes it's because they become riskier, or they start to break down. The AET perhaps has opened up something that needs more thinking about"* (1, 90-96).

From the above passage it can be gleaned that some young people transfer from AET to more intensive treatment because the young person has started to breakdown and regress during their time in AET. In these cases it seemed important to see the young person more intensively to help to contain them and monitor risks. It also suggests that for some patients where there is the risk of violence towards self or others, suicidal thoughts or obsessions and compulsive behaviours, there is a need to be monitored and assessed. In connection to Laura's point, Jonathan highlighted the importance of **striking a balance between confidentiality and involving parents and carers** (8, 37-39) if there is increased risk or deterioration in the adolescent: "*Obviously, we are referring to adolescents. It's important to evaluate the family situation but only involve them closely when there is a strong risk element, family disturbances or psychotic developments. It is important to convey to the patient the particular and exclusive relationship between him/her and his/her*

psychotherapist. The family, if necessary, will be approached by another clinician" (8, 37-39).

This illustrates the importance of striking a balance between respecting the confidentiality and setting in AET, while involving parents and carers and other professionals, to help support and contain these risks that could develop during AET itself.

Chapter 4: Discussion

4.1 Chapter overview

In this chapter I will present a summary of the overarching theory, addressing the research question before a more in-depth exploration is offered of the grounded theory presented in light of the existing research in this area. In addition, I discuss some of the limitations of the study and provide some suggestions for future avenues of research. To conclude, I provide some reflections on the study.

Theoretical Category 1: The difficulties and challenges of engaging adolescents in psychotherapy

1.1 Considering the impact of adolescence to self, family and community

In this study participants saw adolescents as engaged in a process of structuralisation. In discussing this topic, Blos (1980) sees adolescence as a second individuation process during which permanent sexual development and the associated changes in the body give rise to a reworking of the Oedipus complex, and related changing image of themselves, as well as a changing image of their parents, and sense of their identity. Similarly, during late adolescence there is an inclination to form love relationships and a more stable sense of identity emerges (Waddell, 1989).

For one participant this task of finding an identity for one self could trigger feelings of claustrophobia or agoraphobia. This was connected to claustrophobic and agoraphobic syndrome described by Rey (1979) in which the adolescent may fluctuate between on the one hand, feeling subjugated by the adult from whom they are trying to separate while also feeling abandoned and left to struggle on their own.

Another important aspect to the adolescent process is that of "re-experiencing previous losses" which was suggestive of loss of childhood and linked to an increase in depressive anxieties linked to the task of individuation and separation (Waddell, 2018; Bronstein, 2020).

Participants touched on how some adolescents feel that the loss of control was rooted in the development of the body during puberty. This thinking has been explored by Laufer & Laufer (1989), who have highlighted how up until the onset of adolescence, the child feels himself and his body '*to be the extension of the mother who first cared for him'* (Laufer 1978, p. 310). Some adolescents however, have a passive relationship to their body and experience their feelings and phantasies as being forced upon them which can make the young person behave in ways which are out of his control. Participants underscored that some adolescents could become too frightened to engage with their development as it revives intense anxiety and the need to deny the changes that are happening resulting in developmental breakdown (Laufer & Laufer, 1984).

1.2 Prospect of engaging adolescents in intensive treatments is bleak

Given the changes described in the previous sections it makes sense that participants understood that adolescents find it difficult to come to adults for help due to feelings of threat evoked by the prospect of entering into a relationship of dependence with an adult, especially

one whom the adolescent may view as authoritarian and enclosing. Meltzer (1973), believed that the adolescent is affiliated to his adolescent community, and perceived adults as "tyrannical" and adolescents were therefore often difficult to reach by adults.

It was understandable that given the changes and anxieties evoked by the adolescent process, participants were concerned that adolescents did not respond particularly well to long term psychotherapy or psychoanalysis. Participants had the view that a different type of therapy is required that can accommodate some of the anxieties and defences adolescents might present when entering into more intensive treatment. Bronstein & Flanders (1998), argue that more intensive treatments often fail with adolescents due to the way adolescents experience coming for help in: "*very paranoid terms, as if being taken over, as they fear they have been in puberty, by the changes which take place in their bodies, changes which colour their experiences of their inner objects, which erupt as primitive and primitively sexualized*" (p. 32).

Participants were aware that this loss of control and agency is particularly problematic when young people enter into psychotherapy or psychoanalysis. Bronstein & Flanders (1998) write about how initiating intensive treatment evokes in young people fear of the loss of omnipotent defence which had been deployed to cope with adolescent change. AET was created based on psychoanalytic theory of adolescent development and ideas on developmental breakdown that take into account the difficulties of engaging adolescents in psychoanalytic based treatments (Shillito, 2020).

I have decided to include this first theme as it provides a background rationale based on the development during puberty and adolescence that makes a strong case for the necessity of offering a different form of therapy than psychotherapy or psychoanalysis.

2 Theoretical Category 2: Structural and procedural facilitators in engaging adolescents in AET

2.1 AET as a hybrid form of therapy with a different frame.

AET seemed to work as a hybrid form of therapy, which included time limited treatment. Participants highlighted that not all adolescents referred need psychotherapy or psychoanalysis and it seemed that they were able to be helped in AET. In addition, there was the problem of resources that also had a limiting effect on the number of young people that psychotherapy or psychoanalysis could be offered to. In addition, AET was described as helping adolescents to develop reflection, individuation and agency. In this sense, AET could be regarded as a psychoanalytic based psychotherapy with a developmental focus. The focus revolves around the exploration of the meaning of the patient's difficulties and symptoms within the process of adolescent development and change. Briggs (2019), suggests that developmentally informed psychotherapies are based on the "relational and cognitive changes that follow puberty, necessitating the re-evaluation of relationships to self and others, including relating to the adult sexual body; the process continues through the development of subjecthood ('becoming a subject') leading to the taking up of adult roles" (p. 76). AET can offer those adolescents who are struggling with development the opportunity to address issues of separateness and intimacy that stem from the process of becoming more separate from parental figures, mourn childhood ways of relating and help find more mature ways of relating intimately to others.

However, it seemed that some adolescents might need more intensive work and AET could be used as a form of extended assessment to gauge whether the adolescent can make use of the frame and method AET offers.

In this regard, AET is a form of therapy that combines assessment and therapeutic clinical sessions (De Sauma, 2005; Shillito, 2020). In relation to the assessment aspect of AET, Alfillé-Cook (2009), describes the aim of assessment as trying to understand the internal and external factors affecting the adolescent, and thus to help the young person to take ownership of their difficulties. She suggests that when the recommendation is: *"*ongoing once weekly, twice weekly or intensive psychotherapy, she has to have made the decision about whether the particular adolescent is ill enough to need it, but well enough to use it. A series of assessment sessions allows the adolescent and the child psychotherapist to explore the level of help needed by and tolerable to the adolescent" (p. 72).

AET could also be used as an extended assessment to determine the adolescent's level of need, development and capability to use once-a-week therapy or more intensive psychotherapy. On the other hand, the time-limited nature of the AET did not lend itself to treating the more primitive levels of the unconscious functioning of the patient which is one of the limitations of this form of intervention.

2.1 Establishing a therapeutic alliance by fostering a sense of control and agency

Participants discussed the AET intake system where the adolescent had to refer themselves to the centre through their GP. It was important to differentiate between adult and adolescent worries in order to understand where the referral was coming from. Bird (1989), argues that if the adolescents ask directly for help for themselves this can be an indicator of the strength of the adolescent's motivation to seek help. This seemed important in two ways. First, young

people tend to be referred to treatment by adults around them and seldom seek therapy themselves. Second, unwell and younger adolescents in particular might have limited insight into their own emotional and behavioural problems, and therefore might not understand or agree with the need for therapy. For example some adolescents might come to therapy at the initiative of adults which can add to the adolescent's sense of not having agency and control over the process and potentially burdening the therapeutic alliance (de Haan et al., 2013). For older adolescents, on the other hand, the difficulty in seeking therapeutic help lies in the conflict with adolescents' developmental needs to belong to their age group and be seen as "normal" and "accepted by peers", achieving greater autonomy from parents, as well as achieving high reliance on self and peers to resolve problems (Gulliver et al., 2010). Being a Centre for adolescents could help to minimize feelings of stigma which often accompany attending mental health services.

Participants raised the issue that adolescents tend to experience the frame in psychotherapy/ psychoanalysis as an imposition from the adult world. This point was mirrored by several authors who have highlighted that adolescents' anxieties about engaging in treatment are linked to being passively overwhelmed due to the adolescent feeling that the omnipotent defence used to cope with adolescent change is under threat (Bronstein & Flanders, 1998; Baruch, 2001; Creegen et al., 2017).

This links with Bronstein & Flanders (2008), who in their work at the Brent discussed the benefit of involving the adolescent in the *"*process of establishing the boundaries of the interviewing situation. He or she learns the experience of establishing boundaries; this makes commitment to a treatment less threatening. At the same time an adolescent has time to voice anxieties, to have them recognized and contained" (p. 32).

Involving adolescents in the process of co-construing the therapeutic frame was key in two ways; first, it promotes control over the therapeutic process and the development of trust in the process as well as lessening some of its overpowering associations of entrapment and submission. Second, it fosters a sense of agency by taking ownership of psychological problems and need for further help.

Participants discussed how the two main elements of fostering a sense of control and agency over the therapeutic process as well as taking ownership of psychological or behavioural problems and need for help could cement the establishment of a therapeutic alliance early in the therapeutic process. As suggested earlier, participants were concerned about premature dropouts when transferring adolescents to more intensive treatments. The establishment of a strong therapeutic alliance early in treatment is associated in the empirical literature with increased engagement and positive treatment outcomes across various treatment types for adolescents (O'Keeffe et al., 2018; Cirasola et al., 2024). This means that forming an early alliance might be instrumental in helping adolescents during the process of a transfer to more intensive psychotherapy.

Similarly, the familiarity of the setting and increased regularity of the sessions in AET can be important in providing a sense of trust and containment. This linked to Wilson's idea that a "stable relationship with the therapist, a reliable place and a time to meet, alongside the safeguarding of confidentiality can foster a sense of trust and safety which facilitates expression and exploration of difficulties" (Wilson, 1987, p. 4).

2.2 Building a secure base before going into psychotherapy

Engaging with the adolescent's parents and their network is a standard practice in child adolescent psychotherapy. It seemed beneficial for the AET therapist to build the understanding of the young person and support any possible acting out. This building of a secure base is akin to the building of a secure framework for treatment, and the establishment of a secure base that can help the development of the treatment. According to Bronstein (2022), this secure base: "should be established prior to starting the analysis. It is essential to gain the support and understanding of the parents, who will also need to see a therapist who can help them support the treatment, and at the same time allow the adolescent to have his/her therapeutic space without their interference" (p.147). From this point of view, it seemed important to start to build the understanding and support from the family in the time of AET before the young person begins more intensive treatment. Younger adolescents might benefit from caregiver involvement as some studies suggest that a strong alliance between adolescents and their caregivers is associated with better treatment outcomes (Gatta et al., 2009). This suggests caregivers support could be crucial to support the transfer from AET to more intensive psychotherapy especially for more unwell or younger adolescents (Cirasola, Martin, et al., 2022; Gulliver et al., 2010). For older adolescents, it might be appropriate to develop an alliance with the young person to foster a sense of respect for their independence and confidentiality from their caregivers once they have transferred to more intensive treatment. However, striking the right balance on when to share information with caregivers can be difficult (Novick & Novick, 2013)

2.3 AET as preparatory ground for psychotherapy now or in the future

The findings in this study confirm that AET is designed to serve as an extended assessment and exploration of weekly sessions which can lead to a transfer to psychotherapy if needed (Shillito, 2021). One of the rationales offered for the need to prepare adolescents in AET before transferring them to psychotherapy was linked to the concern that adolescents who were offered psychotherapy after an assessment tended to drop out. De Sauma (2005) elaborates this point further and suggests that: "If we try at this point merely to make an assessment and refer them for psychotherapy, most adolescents would not understand what psychotherapy entails or why we are suggesting such a thing and would either leave prematurely or passively accept the recommendation only to drop out later" (p. 8).

De Sauma's point seemed to be linked to the idea that the adolescents who are referred in for AET might be unaware or do not understand their problems or symptoms have a psychological base with meaning. Secondly, the adolescent might deferentially accept the offer for psychotherapy due to the power dynamics involved with the AET assessments only to drop out later.

The concept of AET as a preparatory ground for psychotherapy now or in the future seems to be based on the idea that adolescents might need time to leave and come back before they might be able to engage in more intensive psychotherapy or psychoanalysis should they need it. This point links with Bronstein & Flanders (1998), who describe how some adolescents decide that they do not need or want help and leave after a number of sessions in AET. They advised that many adolescents return after a gap of some months. They argue that the flexibility of the frame allows adolescents to "leave with a different feeling from the one they would have experienced after leaving therapy in that they do not feel they have attacked or destroyed the setting, or that the attack on the object-interviewer is one that would prevent them from coming back" (p. 15).

2.4 Advantages and disadvantages of having delineation between AET and psychotherapy

As part of AET there was a demarcation between AET and long-term psychotherapy at the BCYP, which the adolescent is made aware of from the outset. This demarcation, as discussed earlier, usually entails a transfer from the therapist delivering AET to a different therapist who will offer long term psychotherapy or psychoanalysis. The ending phase of AET and change of therapist was seen as helping with the process of separation and individuation. This links with Bronstein & Flanders (1998), who discuss a case where they describe how the change from AET to psychotherapy had become identified for the young person with the struggle to give up an outgrown dependency on their parents. On the other hand, they argue, the fear of dependency on more intensive treatment could be offset by the extent to which each adolescent is able to own it as an active choice to opt for psychotherapy rather than to remain in a state of passive submission or dependence on the AET therapists. Hurry (1986), suggests that the transfer from the AET therapist to a new therapist "tends to counteract the development of a pathological dependency as a solution to the conflicts of adolescence" (p. 45).

Hurry (1986), has suggested that this phase of the termination of AET can present the AET therapist and adolescent with an important opportunity to explore the young person's level of dependency on the AET therapist. She described in her work at the Brent how some adolescents could become so attached in a few sessions that they would be "unable to transfer" (p. 34). She alerts us of how it might be difficult for the AET worker to be able to contain the pain of the "adolescent's dependency needs or separation anxiety" (Ibid).

Briggs (2019) suggests that it is important to pay attention to how the adolescent reacts to the ending of time limited psychotherapy and the "change of therapists and how the young

person is experiencing the adolescent process and their positioning as a subject within it" (p. 102). In this sense, the ending of AET can help to glean the adolescent's ability to position themselves as active agents of their experiences and own their problems and wish to change.

It seemed important that the ending of AET could be used to work through the ending of AET before the transfer to psychotherapy. The time-limited nature of AET can also provide an opportunity for the young person to work through separation and mourn the loss of childhood relationships within a meaningful therapeutic relationship (Mann, 1973). Exploring the adolescent's reaction to needing more help was underscored as important, participants discussed that some adolescents might interpret the mere recommendation for more intensive psychotherapy as confirmation of the severity of their disturbance. Lemma et al. (2011), suggest that it is important to explore the young person's phantasies about the reasons for ending and offering further treatment.

2.5 The transfer can break the connection between patient and therapists

From the data, one can see that this delineation between AET and psychotherapy that Steve alluded to was problematic at the practical level as also described by Laura. Similarly, Steve brought up the issue that the transference from AET to psychotherapy could break the connection between the AET therapist and the youth patient. Bronstein & Flanders (1998), write of their experiences of how the transfer from AET to psychotherapy could break down due to the loss of the AET therapist. However, they suggest that by the time an adolescent has owned the need for treatment and with the hope for change that this it implies, it can outweigh the loss of the AET therapist. From the data, it seemed that sometimes the adolescent would transfer to more intensive treatment with the same therapist they saw for AET. In other cases it sounded as if it was helpful for the adolescent to transfer to new therapists as highlighted by Stephanie in her interview. In this study, participants did not

directly discuss alliance or ruptures in the alliance, yet Jane, Stephanie and Steve highlighted the importance of exploring any possible negative feelings from the part of the young person during the ending phases of AET. In the literature, Cirasola et al. (2022), in an empirical case study, describe an adolescent who had been referred to CAMHS for STPP. At the time of the referral the young person was seeing a counsellor with whom he had developed a positive relationship. The patient was advised by his STPP therapist that it would be better to end counselling before starting STPP. This created great tension in their relationship. Despite his initial resistance, the young person stopped seeing his counsellor and, over time, became committed to his new treatment with the STPP therapist. In their study, they looked at the alliance rupture ratings and reported that the lowest rating in the alliance was found in the session when the STPP therapist suggested ending the community-based counselling, something the young person was reticent about.

This raises important questions about the connection between the AET therapist and the young person especially if there is a change of therapists. The connection discussed by Steve is akin to a construct of the therapeutic alliance and has been linked to the real relationship, (transference-free) between patient and analyst (Greenson, 1971). The findings suggest that for younger adolescents or those who remain unable to own their difficulties and need for help; a therapeutic alliance based on a connection with the AET therapist might be more important in keeping the young person in AET until a later point when they have gained greater insight into their difficulties and are ready to work on these in more intensive treatment.

2.6 Questioning the distinction between AET and psychotherapy

As described in the findings section, there was some disagreement with the premise of this study which in some ways rested on the idea that AET and psychotherapy are in some ways different. I found Steve's interview both challenging and interesting as it brings into the picture the disadvantages of having delineation between AET and psychotherapy. It highlights the issue that a change of therapist could break the connection which had been formed between the adolescent and the AET therapist. I wondered if the connection or the bond component of AET could be more important for younger adolescents than for older adolescents.

I was under the impression that the delineation of AET and psychoanalysis or psychotherapy was a contentious issue among participants. Looking at the literature, this distinction between psychoanalysis and psychodynamic or even psychoanalytic psychotherapy is a longstanding issue. For example Lemma (2006), suggests that these distinctions do not hold up to close scrutiny: "even psychoanalytic therapy can stretch in an open-ended manner over many years and its goals can be as ambitious and far-reaching as those of a full analysis … looked at dispassionately, the aims of the two approaches are not significantly different; nor are there differences in the techniques used or in the theories that purport to support them … although some might argue that psychoanalytic therapy makes use of a broader range of interventions than psychoanalysis proper … no analytic treatment relies exclusively on interpretation alone*"* (Lemma, 2006, p. 57). She goes on to suggest that a definitive and clear cut distinction between psychoanalysis and psychoanalytic or psychodynamic psychotherapy is no more tenable in theory than it is in practice. Nevertheless, Steve described a case where he highlighted the limitations of AET and how the patient would be better helped by working with another therapist more intensively.

This debate about the change of therapists is also found in the literature from those writing about work at the BCYP, for example Novick (1979) suggest that the person the adolescent first sees in AET should also be the person who treats the adolescent's difficulties. On the other hand, Hurry (1986) writes about how she first ascribed to Novick's view but over time she describes the benefits of having a change of therapists. She states: "the knowledge that any future psychotherapy would be with another person, lays the groundwork for the adolescent being able to choose therapy not in order to prolong a relationship of dependency on the interviewer but because he is aware of that in himself which he wishes to change, and has hope of achieving that change. Such a transfer tends to counteract the development of a pathological dependency as a solution to the conflicts of adolescence" (p. 45).

2.6.1. AET as a transitional vs stand-alone intervention

AET was found to have similar elements to other forms of short-term or time limited psychoanalytic based psychotherapies. In terms of its duration, participants saw patients in AET up to a year. Short-Term Psychoanalytic Psychotherapy (STPP) (Cregeen et al., 2016), offers adolescents weekly psychotherapy sessions for up to 28 sessions. There was evidence to suggest that AET also serves the function of assessment and exploration of the adolescent difficulties with the aim to help them to own their difficulties and then move into a more intensive therapy if necessary. STPP shares some aims with AET such as promoting better self-understanding of feelings and difficulties and addressing the underlying dynamics of the symptoms (Cregeen et al., 2016). In the same way STPP therapists pay close attention to the therapeutic relationship and used transference work to address difficulties in the context of the developmental tasks of adolescence.

Like AET, STPP also gives consideration to how long term commitment needed in intensive psychotherapies can make young people fearful of being trapped in a long-term commitment.

The time-limited therapy can offer a therapeutic experience "without arousing too great fears of dependence or too much claustrophobia" (Cregeen et al., 2016, p. 120). Although the STPP manual does mention the possibility that after termination of STPP the young person might still be in need of "prolonged work" (Ibid) they suggest that offering treatment before the ending of STPP could "gloss over the experience of ending" (Ibid). There is some discussion of the importance of exploring the adolescent's ambivalent feelings about the end of the therapy in relation to the idea of further sessions. Cregeen et al. (2016), suggest that six months after the end of STPP allows enough time for "both the gains and the limitations of the STPP therapy to become clear, without risking either an overhasty offering of further treatment or losing the patient altogether through too lengthy a delay" (p. 125).

Briggs and colleagues' (Briggs et al,. 2015) 'Time limited Adolescent Psychodynamic Psychotherapy' (TAPP) discussed in the literature review is also a type of psychoanalytic based therapy with a therapeutic aim that emphasises the exploration of the meaning of the patient's difficulties and symptoms within the process of adolescent development and change. Briggs (2019) suggests that developmentally informed psychotherapies are based on the "relational and cognitive changes that follow puberty, necessitating the re-evaluation of relationships to self and others, including relating to the adult sexual body; the process continues through the development of subjecthood ('becoming a subject') leading to the taking up of adult roles" (p. 76).

They also describe the importance to understanding the young person in the ending phase which takes into account their phantasies about the reasons for ending. In TAPP, Briggs (2018), described how time-limited and longer-term therapies are complementary but have different aims. However, "it is possible in some circumstances that a young person may go on to long-term therapy after completing TAPP, and that this may constitute a good outcome".

Similar to AET, TAPP also involves a process of discussion of future needs including for further therapy during the ending phase.

To sum up, AET is similar to other forms of short term psychotherapy in terms of its duration and aims. One exception would be that AET does aim explicitly to move young people onto other forms of more intensive psychotherapy for those adolescents who need it. What's more, in AET there is more room to involve the adolescent in the co-construction of the frame and the commitment asked of the young person is not as great compared to either STPP or TAPP.

Theoretical Category 3: Exploring commitment before agreeing to treatment.

3.1 Asking to commit to long term psychotherapy is unhelpful

Participants highlighted that due to the adolescents' transitional developmental state they might not be ready to make the long-term commitment that long term psychotherapy requires. Therefore, entering into a relationship of dependence might conflict with adolescents' developmental needs for autonomy from parental figures. Bronstein and Flanders (1998) argue that AET does not require a commitment of the young person, unlike more formal psychotherapy where there is a fixed contract. The flexibility of the frame in AET "makes the adolescent feel more secure, less anxious about being trapped in a claustrophobic situation with the interviewer but also sufficiently looked after" (p.15). Briggs (2018), suggests that a significant factor in offering time-limited therapy is whether the youth is fearful of being trapped in a relationship from which there appears to be no way of escaping.

In this study, participants saw patterns of commitment in adolescents as developing in different ways to that of adults and seem to regard its development as part of the adolescent process of separation. As described in previous sections, entering into a relationship of

dependence might conflict with adolescents' developmental needs for autonomy from parental figures. This is important given that developmentally, adolescents are different from adults, and these differences will affect commitment and its development (Gulliver et al., 2010).

3.2 Exploring commitment in AET before moving to Psychotherapy

Participants discussed that AET could be used as a period of extended assessment where the therapist can explore the adolescent's ability to make the long term commitment needed for psychotherapy or psychoanalysis and their capability to commit to a relationship of dependence. Therefore, it made sense that the therapist explores the adolescent's readiness to commit to both the frame and to the understanding of their difficulties within the therapeutic relationship at the start of AET. Amiel (2001), argues that the capacity of some young people to develop commitment to a therapeutic relationship may have been more prolonged than is usual and the process of the adolescent committing to therapy is "more circuitous, requiring even more flexibility and adaptability" (p.107). Therefore, it makes sense that therapists found it helpful to monitor adolescent commitment over a period of time before considering whether the adolescent is ready for a long-term commitment to psychotherapy.

In contrast, starting psychotherapy with an uncommitted and ambivalent adolescent could lead to withdrawal and alliance ruptures of the type described in the literature. Research on alliance ruptures with young people found a preponderance of withdrawal over confrontation ruptures. Alliance ruptures are typified by challenges in collaborating on therapy tasks/goals, deterioration in the therapeutic bond, and breakdown in the negotiating between patient and

therapist of the young person's therapeutic needs (Cirasola et al., 2024; O'Keeffe et al., 2020; Schenk et al., 2019).

The reason behind this could lie in the power imbalances involved in working with an (adult) therapist. Adolescents tend to hide their disagreement or even claim to agree with the therapist in a deferential way. Withdrawal ruptures, such as minimal response or being complacent, are more subtle than confrontation (e.g., complaints about the therapist and/or the tasks of therapy) and can be confused with pseudo-alliance (Muran & Eubanks, 2020). This is in line with a qualitative study of Everall and Paulson (2002), where adolescents in the initial stages of therapy expected to be treated as insignificant and inferior and required to submit to adults. Similarly, offering psychotherapy to an uncommitted young person could lead to the interaction structure found by Calderón et al. (2019), where they describe a dynamic which they explain as a difficult therapeutic relationship between a non-committed young person and a "therapist working hard to make sense of the young person's experiences, but without making much progress" (p. 45). Asking the adolescent to commit to therapy before they are ready can be experienced by the adolescent as having to passively submit to the therapist who can increase their resistance to the transfer from AET to psychotherapy or passively accepting the offer for psychotherapy only to drop out later (Bronstein & Flanders, 1998; De Sauma, 2005).Participants appeared to have seen commitment as coming with maturation, greater insight into their difficulty and wish to change.

Another important aspect to consider when contemplating a transfer from AET to more intensive psychotherapy are developmental cross roads such as exams, change of school, and going to university. Not taking into account these external points of transition in the

adolescent's life could play a part in the transfer and in these cases, time limited therapy seemed more indicated.

Theoretical Category 4: Facilitating insight and ownership of difficulties as a step to engaging in psychotherapy

Linked to issue of commitment explored in the previous sections is that of insight. Some adolescents might have limited understanding of their psychological difficulty and they might therefore not understand or agree with the need to commit to psychotherapy (Rickwood et al., 2005).

4.1 AET aims at exploring particular difficulties of adolescence

The findings in this study suggest that AET was a developmentally orientated and exploratory type of therapy aimed at exploring adolescent developmental difficulties as well as helping adolescents develop the capacity for reflection, individuation and agency.

Some studies suggest that time limited therapies are better at engaging adolescents when they have an exploratory aim (Løvgren et al., 2019). Dunne, Thompson, & Leitch (2000), in their qualitative study found that adolescents favour treatment that emphasizes emotional exploration. The idea of exploring internal and external difficulties seemed important and was associated with the development of an awareness of the adolescents' difficulties within a space that facilitated reflection (Church, 1994; Wilson, 1987).

4. 2 Helping adolescents to own their difficulties and needing help

The findings in this study are in line with those suggested by Flanders and Bronstein (1998), who have highlighted the importance of AET as a space where the adolescent can start to think about their difficulties as belonging to them. It seemed helpful to participants to help adolescents reflect on the part they play in owning their difficulties. Participants saw projection and projective identification as leading to disempowerment and disposal of responsibility as interfering with adolescent agency and ability to take responsibility for their difficulties. Meltzer (1968), argues that during adolescence there is an increased tendency towards projection. This is connected to sorting out one's own sexual and adult identities (Meltzer, 1992). Participants highlighted that it was important to help the adolescent to see the role they play in their difficulties. Some authors have argued that it is important to empower adolescents to a sense of responsibility as a protagonist in their therapeutic change which can lead to a deeper collaboration from the part of the adolescent (Páramo, 2011; Philips et al., 2007; Gergov et al., 2021).

The development of insight into one's own difficulties and need for help was seen as crucial in enabling adolescents to move onto longer-term psychotherapy. This point finds resonance in the wider literature, where several authors have written on adolescents' tendency to disown their difficulties and project them into others (Meltzer 2011; Crits-Christoph, Gibbons, & Mukherjee, 2013; Sommers-Flanagan 1995). In the Context of AET, Hurry (1986), suggests that helping adolescents to gain an awareness that their problems are internal, and therefore susceptible to change, can foster an active attitude towards the process of change rather than remaining passive in expectation of a cure.

Participants felt important that identifying the issues the adolescent could work on in more intensive psychotherapy was associated with the idea of forming a therapeutic alliance with the conscious part of the youth who seeks help. This linked with the work of Richard Sterba

(1934), who suggested that the idea of a healthy split in the ego is the basis for the development of the concept of the therapeutic alliance. He suggests that dissociation within the ego can lead to the development for self-observation, and for that part of the ego to identify and ally itself with the therapist.

For Sandler and colleagues (1980), who considered the alliance from a developmental standpoint: "while for a young child the bond might constitute 'the main basis for the therapeutic work'" (p. 47), an adolescent is expected to develop "a proportionally greater awareness of his problems and greater wish to work towards their solutions; for him less of the work should depend on a positive relationship with the therapist" (Sandler, et al., 1980, p. 45). This suggests that cognitive components of the therapeutic alliance necessary for collaborative effort between patient and therapist are needed in order for the young person to transfer into more intensive psychotherapy to work on these issues. This highlights the importance of considering the cognitive capacity involved in agreeing long-term therapeutic goals in AET and the young person's capacity to extrapolate this agreement to working on those tasks in more intensive psychotherapy (Shirk, 2013; Zack et al., 2007). This suggests that for adolescents who have been able to gain insight into their difficulties and own them to an extent, they might feel more motivated to work on those difficulties in more intensive treatment. For these adolescents, the collaborative aspects of the therapeutic relationship might play a more important role in determining the success of possible transfer to more intensive treatment.

4.3 Working with the adolescents to understand the meaning of their difficulties

Involving adolescents in thinking about the meaning of their difficulties and that they can be thought about rather than acted out, is an important theme that participants identified as significant in facilitating the transfer from AET to psychotherapy. Bronstein & Flanders

(1998), suggest that it is very important to help adolescents develop some understanding that "their behaviour is symptomatic of something else that is not random and meaning can be thought about" (p.11). This finding is supported by Løvgren and colleagues' (Løvgren et al., 2019), qualitative study of adolescents' experience of gaining insight into psychotherapy, which suggested that achieving insight and becoming more aware of the meaning of their difficulties was experienced as gaining control and autonomy.

4.5 Empowering adolescents to become an active agent of their own change

Participants described the importance of showing adolescents that they are an active agent in their difficulties. This links with Kennedy's (1998) distinction between being "subject of" and "subject to". Being 'subject of' implies the capacity to appropriate the forces acting in and on the subject, while being 'subject to' means being on the receiving end of internal and external forces that appear to happen to the subject. The movement from being 'subject to' and 'subject of' occurs through a reflective process, involving ownership and symbolisation; being 'subject to' leads to repetitions and not understanding cause and effect (Briggs, 2019).

Kennedy's distinction is helpful in highlighting how the aim in AET is to give adolescents the chance to opt for more intensive treatment by taking ownership of their problem as something belonging to their internal and psychological world that can be affected and changed. In the empirical literature, becoming more aware of the meaning of their difficulties has been associated with a positive predictor of the adolescent motivation to accept further intensive treatment when suggested (Gatta et al., 2010; Baruch et al., 1998).

Theoretical category 5: Pros and cons of transference work.

5.1 AET as testing ground to assess if young people are ready to work with transference interpretations

In discussing transference work, participants reflected that AET could be used as a testing ground to assess how young people react to transference interpretations and understanding their level of readiness to move into psychotherapy where transference work is central to its aim. Participants recognized the difficulties that young people have in responding to transference interpretations (Coren, 1999; Hall, 2012; Gretton, 2012; Golombek & Kozenblum, 1995). In this study, the findings suggest that participants tended to gauge the "temperature and distance" (Meltzer, 1976) in an attempt to understand the emotional "temperature" with the young person.

5. 2 Not wishing to stimulate the transference

The results highlighted that therapists tended to monitor the transference and counter-transference. In terms of their counter-transference it was used as a way to gain insight and understanding of what is going on in the patient's mind. Counter-transference responses can be particularly helpful in initial meetings given the power of the adolescents' forceful aggressive and sexual feelings, and the defences used against these such as extreme forms of splitting and projective identification and denial (Laufer and Laufer, 1989). Therapists can become easily confused by the strength of the countertransference. It might be particularly important to pay attention to one's own counter-transference as a useful and essential tool to understand the anxieties and fears of the young person in order to figure out how to engage them in AET (Alfillé-Cook, 2009). Findings in this study suggest that the main aim is to begin to think with the young person about their difficulties; carefully monitoring the

counter-transference could be helpful in avoiding colluding with the adolescent in thinking about their anxiety and need for help (Laufer & Laufer, 1989).

Interviewees discussed how therapists did not gather the transference as actively or routinely as they would do in more intensive psychotherapy (Meltzer, 1967). Normally, gathering the transference would involve therapists commenting on their observation of the patient's behaviour (verbal and non-verbal) or on the transference between therapist and patient. "Gathering of the transference" (Meltzer 1968), in the initial phase of the analysis refers to the task of understanding the variety of identifications which are split off and projected on to the analyst, who needs to "gather them" in, in order to get a sense of how the patient is feeling and relating to others. Similarly, interviewees seemed weary that making transference interpretations could foster a sense of intimacy and dependency within the therapeutic relationship which could be seen as anathema to the aims of AET in terms of promoting agency and individuation. This was a particular issue brought to the fore by Sarah, who underscored that AET did not have the structure in place to continue to work with the young person as AET is time limited. This was seen as problematic in terms of stimulating the transference in particular if the AET therapist, for whatever reasons, could not continue to see the adolescent in more intensive treatment. This could lead to feelings of disappointment in the adolescent and potentially disrupt the transfer. However, it seemed important to balance the emotional implication of the therapeutic experience without stimulating the development of a deeper relationship (Petit & Midgley, 2008; Bronstein & Flanders 1998).

Furthermore, making transference interpretations brings the relationship between therapist and adolescent into focus which was viewed as unhelpful given some adolescents' anxieties about emotional closeness and issues of dependency. Some have argued that making transference interpretations might trigger defence mechanisms which might hinder the

capacity of the adolescent to observe and reflect on themselves and can lead to heightened anxiety and defensiveness (Westen, 2002; Gabbard, Piper et al., 1999). In contrast, the main results of the FEST (Ulberg et al., 2021) study suggest that adolescents benefited equally from intervention with and without transference interpretations. However, those adolescents with low-quality of object relations benefited from unique positive effects of transference interpretations compared to patients with high-level of object relations. Participants were concerned about how the ability to reflect on experiences was key for the young person to be able to reflect on the experiential aspect of the therapeutic relationship. Moreover, it seemed important for therapists to bear in mind that the developmental maturation levels among adolescents differ from individual to individual and the capacity for reflection is age dependant (Compas et al., 1995).

In connection with the issue that making transference interpretations could foster feelings of dependency and intimacy in AET with adolescents, participants reflected that it was helpful to address the transference to the institution. Coren (1999), suggests that therapists should consider the exploration of the transference to the institution rather than an exploration of the transference relationship, which may foster regression at a time when independence is paramount and the relationship between the AET therapist and patient is limited. Bronstein & Flanders (1998), suggest the transference to the institution is present from the start and suggest that the institution can reduce the adolescent's "anxieties about their destructiveness as well as paranoid anxieties about being taken over by the therapist. The institution also eases the anxiety about being abandoned*"* (p. 16-17).

5.3 When transference work is conducive to a transfer to psychotherapy

Interpreting the transference without the young person's capacity for reflection could become an overwhelming experience which could result in the adolescent not coming back. The use of transference interpretations was perceived to be helpful if it led to self-understanding of the adolescent's psychological or behavioural difficulties. As discussed in section 4, the AET was helpful to adolescents to engage with their capacity to think about their difficulties and problems in order to work on these in psychotherapy or psychoanalysis. Participants discussed the importance of interpreting the transference to understand the blocks to thinking in the young person. This was significant given that one of the main tasks of AET is to develop the young person's capacity to think and reflect about their psychological difficulties. This connects with Anna Freud who thought the analyst should be more concerned with helping the young person overcome the defences which are hindering his developmental process. In this regard, the focus of treatment needs to shift to the provision of developmental support for missing capacities necessary for therapeutic work with adolescents (Midgley, 2013).

Participants highlighted how adolescents might only be aware of conscious difficulties. Pointing out unconscious difficulties or dynamics that the young person is not aware of was felt to be unhelpful as it was related to the triggering of defences. The findings suggest that the main aim is to understand the anxieties that underpin the defences in the adolescent that interfere with their engagement. One participant spoke about not having permission from the adolescent to interpret the transference. This suggests that there was a preoccupation with how adolescents might react to an interpretation as a breach of their autonomy.

Therapists spoke about the importance of showing transparency about how the therapist has gained insight into the transference. Participants seemed to bear in mind issues of knowledge

and power when disclosing transference interpretations. Meltzer (2011), writes about the perceptions adolescents have of adults and their knowledge. He explains that during adolescence young people begin to question previously held 'truths' such as that their parents knew everything which comes with confusion and scorn towards those 'in charge'.

Perhaps by showing the adolescent something about how the therapist gained knowledge, the adolescent might be more willing to accept the therapist's insight and knowledge as highlighted by Della Rosa (2017). This suggests that therapists were aware that adolescents can be very sensitive to the asymmetric nature of the analytic relationship at a stage of their development when they are challenging parental/adult figures and their knowledge.

5.4 Having an established alliance in AET before using transfer interpretations.

The findings suggest that therapists were aware of the need for a strong working alliance before making transference interpretations, particularly with more disturbed patients in AET due to the short nature of the treatment and that time was needed to get to know the patient before using transference interpretations (Høglend, 1996; Bond et al, 1998; Ryum et al., 2010; Anastasopoulos, 1997).

Theoretical Category 6: Signs of readiness for transitioning to Psychotherapy

6.1 Committing to attending and thinking

This finding suggests that participants were aware of the importance of the adolescent's regular attendance. Participants highlighted the need for the therapist to look for attendance as a sign of commitment. Commitment to the process was identified as a prerequisite for longer term psychotherapy. Attendance is regarded in the literature as a marker of motivation to engage in therapy. Nevertheless, in this study attendance was discussed in relation to the adolescent having gained some awareness of their difficulty during AET. Similarly, the

findings suggest that participants saw adolescents as more likely to attend and commit to seeking further help in the form of AET if the adolescent was older and had greater insight into their difficulties (Baruch et al., 2009).

6.2 Having insight and symbolic thinking

Insight seems to have been regarded as playing a significant role in helping the young person to know themselves more deeply. The findings suggest that a reduction in defensiveness was understood not only as a sign of readiness for therapy but also evidence that the young person may function more flexibly and reflectively (Laplanche & Pontalis, 1973; Messer, 2013; Bateman, Brown, & Pedder, 2010).

In this regard, showing less defensiveness was related to the ability to get deeper into the work in order to help the adolescent understand their difficulties which in turn could lead to them seeing the benefit of transferring to long term psychotherapy. Significantly, the ability to reflect and think about meaning was felt to be an important element of the young person's readiness to engage in therapy. This in turn was linked to introspection and maturity; both these aspects were associated with the adolescent developing their own mind which suggests that something might change in the adolescent's reflective and cognitive capacities as they mature (Baruch et al., 1998).

Increased psychological awareness was also highlighted as a sign of readiness for long term psychotherapy. It seemed that participants saw greater self-awareness of the adolescent's problems as contributing to their wish to work towards their solutions. It seemed important for them to work with these adolescents to empower them to own their need for help, by

helping them develop some understanding that their behaviour is symptomatic of something else (Sandler et al., 1980).

6.3 Using relationships to explore themselves

The findings suggest that the ability to sustain a relationship of dependence was regarded as an important factor that participants understood as signalling that the young person might be able to engage in psychotherapy. Related to this was the capacity to sustain a relationship of dependency as part of moving into psychotherapy, suggesting that the adolescent feels less threatened by the relationship to the therapist. Similarly, being able to work in the transference was regarded as a good indication of adolescent readiness to reflect about their experience and greater capacity to explore their difficulties more deeply.

6.4 Moving to psychotherapy in response to a breakdown in development

Ironically, a transfer from AET was predicated upon the adolescent's increasing ability to take ownership of their own thoughts and struggles and through greater symbolisation and separation from others. However, one participant highlighted how a transfer to more intensive treatment could be motivated by the young person breaking down in their development and becoming riskier during their time in AET. In this sense, it is conceivable that the adolescent could be offered twice weekly psychotherapy but with the aim to get the young person back on their developmental track. For Laufer, the adolescent can become convinced that the only solution to their psychological suffering is to attack and destroy the mature body, or the move to a break with the world and a consequent psychotic organization. They describe how these symptoms of breakdown must never be considered to be a transitory crisis. Intensive psychotherapy intervention aims therefore to "undo the result of the breakdown in the

developmental process" (Laufer 1998, p. 121). Even after breakdown of the developmental process, Laufer believes it was possible to restore development to a more progressive trajectory. In these cases intensive treatment is "not only indicated but urgent" (Laufer & Laufer 1995, p. 19).

In the context of AET it seemed important to consider adolescents' ability to own their difficulties, separate and move forwards in their development vis-a-vis strong regressive pulls and difficulty to separate (Malan, D. 1992; Molnos, A. 1995). It seemed that some more vulnerable young people might be able to initially make use of AET. However, becoming more aware of one's own difficulties might make some young people start to regress and deteriorate within the context of AET. In these cases, where the young person clings onto their old symptoms, behaviours or risks, they might need more intensive treatment where the meaning of these communications is to be understood, contained and attended to. (Malan, 1992).

7. Summary and conclusions

This study has sought to examine the advantages of offering adolescent exploratory therapy (AET) in preparing adolescents to engage in more intensive psychotherapies.

An important finding was that traditional forms of intensive psychotherapy or psychoanalytic treatments were viewed as not well suited to treat adolescent patients because of the ways some young people react to the experience of coming into psychoanalytic therapies. AET was designed to accommodate some of the anxieties and defences adolescents develop to cope with the adolescent process which might interfere with their ability to access traditional forms

of psychotherapy and psychoanalysis. AET was viewed as a type of psychoanalytic based therapy of short duration. AET could also function as a form of extended assessment to gauge the adolescent's ability to make use of more intensive treatment. AET was described as having developmental aims such as fostering the development of reflection, individuation and agency. These qualities were in turn seen as instrumental in helping adolescents to transfer from AET to more intensive treatment.

A second important finding was that the AET frame was described as being set up to aid the fostering of a sense of control and agency over the therapeutic process as well as taking ownership of psychological or behavioural problems and the need for further help early in the AET process. This was seen as helping to cement the establishment of a therapeutic alliance that contributed to the adolescent transferring into more intensive treatment.

Participants underscored how AET could be used to build a secure base before transferring the adolescent patient to more intensive treatment. From this point of view, it seemed important to start to build the understanding and support for the need for further treatment in the family during AET before the young person begins more intensive treatment. Related to this, it was important to assess the young person's ability to separate from their family, especially considering that the ability to be more separate from internal and external figures was seen as a capacity needed for more intensive treatment.

My hypothesis had been that AET also aimed at preparing young people for more intensive treatment. However, there were some mixed findings in this section and some participants saw the distinction between AET and psychotherapy as problematic. This was a contentious point and participants highlighted how having delineation between AET and psychotherapy that included a change of therapists could be helpful in some cases but unhelpful in others.

The findings in this study suggest that for younger adolescents or those who remain unable to own their difficulties and need for help; a therapeutic alliance based on a bond or connection with the AET therapist might be more important in keeping the young person in AET until a later point when they are able to own their difficulties and need for help. In contrast, for those adolescents who have been able to gain insight into their difficulties and own them to an extent, they might feel more inclined to work on those difficulties in more intensive treatment. For these adolescents, the collaborative aspects of the therapeutic relationship might play a more important role in determining the success of possible transfer. This study highlighted that the transfer from AET to more intensive treatment could give rise to strong ambivalent feelings in the adolescent. Therapists should explore any phantasies and possible negative feelings about the transfer and be alert to possible alliance ruptures during the ending phases of AET and aim to solve them. This study also raises question about the fate of the therapeutic alliance when the patient is transferred from one type to therapy to another, especially if there is a change of therapists.

Participants discussed the idea of commitment and highlighted how some adolescents could feel trapped in the long term commitments needed for more intensive treatment. In this sense, AET could be used to explore and address the young person's ambivalence in AET before a decision to start psychotherapy is made. On the other hand, asking the adolescent to commit to therapy before they have insight into their difficulty can be experienced by the adolescent as having to passively submit to the therapist. This can increase their resistance to the transfer from AET to psychotherapy or they may passively accept the offer for psychotherapy only to drop out later.

AET was described as fostering the development of insight into one's own difficulties and need for help. Insight was seen as crucial in enabling adolescents to move onto longer-term psychotherapy. In AET, the development of insight was based in helping the young person to understand that their difficulties have meaning and can be thought about. This was regarded as allowing the adolescent to opt for psychotherapy by taking ownership of their problem as something belonging to their internal and psychological world that can be affected and changed rather than remain in a state of passivity and dependency as solution to the conflicts of adolescence. Participants felt it was important that identifying the issues the adolescent could work on in intensive psychotherapy was associated with the idea of forming a therapeutic alliance. This highlights the importance of considering where the adolescent is in their cognitive development. Therapists should pay particular attention to the adolescents' cognitive capacity which is needed in agreeing to long-term therapeutic goals in AET and the young person's capacity to extrapolate this agreement to working on those tasks in more intensive psychotherapy.

AET can be used as a testing ground to assess if young people are ready to work in the transference depending on how they respond to transference interpretations. The use of transference interpretations was perceived to be helpful if it led to self-understanding of the adolescent's psychological or behavioural difficulties. Participants discussed the importance of interpreting the transference to understand the blocks to thinking in the young person. This was significant given that one of the main tasks of AET is to develop the young person's capacity to think and reflect about their psychological difficulties. Similarly, interviewees seemed weary that making transference interpretations could foster a sense of intimacy and dependency within the therapeutic relationship.

Working in the transference was seen as problematic in terms of stimulating the transference in particular if the AET therapist, for whatever reasons, could not continue to see the adolescent in more intensive treatment. This could lead to feelings of disappointment in the adolescent and potentially disrupt the transfer.

There were three major signs which were helpful to ascertain the readiness from some young people to transfer to intensive treatment. The ability to commit to long term treatment was underpinned by the young person's greater development in their capacity for symbolic thinking and insight into their psychological difficulties and greater wish to work on these. Similarly, the ability to use the relationship to explore them was an important indication that the young person might be feeling less threatened by the degree of closeness and dependency necessary for more intensive or ongoing treatment. More importantly, AET was helpful in enabling young people to become the agents of their own change and growth. These capacities were fostered by the process of AET and key to the development and enabling of the capacities to reflect and become the subject of one's internal experiences. This in turn could help the young person to become more interested in their own internal processes and emotional development which could enable them to transition to more intensive treatment. It is important to highlight that some adolescents were seen in more intensive psychotherapy not because they had become more able to reflect and own their difficulties but because of developmental break down during AET and/or increased risks.

8. Limitations

There are multiple limitations to this study. For example, this was a small-scale study involving a small number of participants. Similarly, the participants were practicing at the

BCYP in London, and thus differences in context must be accounted for when applying these findings more widely. Similarly, there were some therapists that no longer worked at the BCYP and this produced some variation in the results. AET was referred to by some participants as interviewing. The results seemed to indicate that there were some differences between interviewing and AET that have changed over time. Similarly, I decided to incorporate Jonathan's interview which was not gathered via a recorded interview as the others were but through written correspondence. This precluded me from being able to gather rich, detailed data and follow the iterative process by which areas of interest could be further explored and theoretical sampling followed as indicated by Grounded theory. Similarly, I decided to include Laura's interview even though her training differed slightly to the other participants.

However, it is clear that these findings are reflective of the wider themes found in the literature, and therefore suggest applicability to the wider psychoanalyst work with adolescents in similar settings. This study highlights which aspects of AET therapists viewed as helpful to engage adolescents in AET generally and in longer-term psychotherapy specifically. However, another limitation is that the current study lacks the perspectives of the young people who take part in AET and future research would benefit from this inclusion. Similarly, participants in the study were clear about the importance of clinical supervision and diagnostic meetings as tools for deciding when young people might be ready for transferring to longer term psychotherapy. In addition, group supervision was also mentioned by participants regularly as an important linchpin in their work with adolescents, in particular when understanding transference issues. However, due to space constraints I was not able to include and discuss these findings. Studying the factors and processes involved in the

decision-making aspect of referring adolescents to longer term psychotherapy or psychoanalysis would be a fruitful area of future research.

9. Implications for practice

This study has highlighted the ways in which psychotherapists working with adolescents see the need to have a frame that is simultaneously flexible and containing. This frame should adopt and accommodate the adolescent's need to have some degree of control over the process of seeking help and address the anxieties related to dependence and independence in relationship to adult therapists.

This study suggests that it is important for therapists working in AET to pay close attention to possible alliance deterioration, particularly when the patient is in the ending phase of AET and is about to transfer to more intensive treatment. This can be more pronounced if the patient is a young adolescent or remains unable to own their difficulties and there is a proposed change of therapists. Similarly, it highlights what aspects of the therapeutic process, its frame and techniques, are best suited to maximizing adolescent's transfer from AET to psychotherapy. Interestingly, there is a need to understand the way therapists work with adolescents with a developmental aim and a limited time frame. In particular within the context of Child and Adolescent psychotherapists' training where the emphasis lies on long-term and intensive cases.

10. Future research

As stated above, a possible area of future research might involve studying the factors and processes involved in the decision-making aspect of referring an adolescent to longer term

psychotherapy or psychoanalysis. It would also be interesting to include young peoples' experiences and views of AET and what aspects they find helpful in accessing longer term psychotherapy. Lastly, further research is needed to find out more about the outcome of the therapeutic alliance in short term psychotherapy treatment where there is a transfer from one therapist to another in work with adolescent populations.

11. Ending thoughts: self-reflection and reflexivity

I found the research process daunting to begin with and it took me quite a while to get into it. In some regards I found myself feeling out of my depth suffering from imposter syndrome given that I knew very little about AET and how it might work in practice.

In the process, I have learned a lot about my own clinical practice as a child and adolescent psychotherapist working with adolescents. In particular how my own experience of my intensive training case and my own analysis might have influenced my decision to investigate AET. I also wondered about how these experiences might have shaped some of my assumptions about the therapeutic process and techniques with adolescents.

Taking part in the interviews was incredibly rewarding but also frustrating at times. I found some of the interviews were quite challenging to my initial assumptions and misconceptions. I felt that the interview with Steve threw up some findings that I did not expect to come across and there was a part of me that struggled to think about his experiences and views and how they fitted with the rest of the participants' views of AET. Initially, it was a struggle to make sense of his views but eventually I learned to accept and appreciate the plurality of views that each participant brought to the interviews.

I found myself identifying with the participants' passion and commitment to helping adolescents to engage in AET and also in psychotherapy. I often found myself thinking about my own experiences of helping adolescents to transition to more intensive psychotherapy. In particular, I thought about what could have been done differently to help adolescents engage in long term psychotherapy. Going through my training I sometimes wondered about how therapists see and understand what they do in their work with this age group.

Moreover, with many participants reflecting on the ethos at the BCYP, I found myself considering my current practice in the CAMHS team where I work. This process has helped me further consider how I can help these settings think about what can facilitate adolescent engagement with psychotherapy and health services more generally. The ethos of respect and a drive to understand adolescent difficulties and how to best adapt processes within the institution to respect the issues that adolescents might have when engaging with institutions and adults in them was extremely helpful. I was also prompted to think about how adults might see commitment as a necessary ingredient to engaging in psychoanalytic psychotherapy. However, adolescents might struggle to understand the idea of commitment at a time where developmentally commitment might be difficult.

During the process, I often pondered what I was bringing to the research interviews. I also wondered to what extent my own constructs, experiences and ideas were impacting the codes during the analysis. I was aware of what the literature review had highlighted, my position as researcher, and the possible way I was being nudged by these aspects. I did my best to remain reflective about these influences and I made notes of them when appropriate in my memos, research diary and also in my meetings with my supervisor. I found my reflections and memos helpful when doing my coding and theory building, which I believe helped me to create a theory which was grounded in the data.

In addition, it was helpful for me to see the value of reflection as a way to highlight what I brought into each of the interactions with others. I also realized that my position as the researcher in this study was one of being somewhere on the boundary of being an outsider with limited understanding and practice of AET while gaining a deeper understanding over time of how participants might understand and use AET.

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Appendices

Appendix 1Table of search terms

In order to cover as much of the literature available I came up with relevant synonyms linked to some key concepts regarding the aims of AET. I have showed the synonyms I used in the table below. Quotation marks were used to search for exact expressions and the * symbol allowed me to search for terms and words irrespective of their ending.

Concept one	Concept two	Concept three	Concept four
adolescent	psychoan*	Dropout	Rupture*

youth	Psychoth*	development	
teen	Psychodyn*		
adolescent	therapeutic	alliance	
adolescent	Transferen*	interpretations	
youth	Psychoan*	insight	
"Brent"	"Centre"		
"Adolescent"	"Exploratory"	"Therapy"	

Appendix 2 – Recruitment (email to Brent Centre)

The Tavistock and Portman
NHS Foundation Trust

Dear colleagues,

My name is Antonio Cano and some of you might already know me. I am a fourth year Child and Adolescent Psychotherapist trainee at the Tavistock and Portman NHS Trust.

As some of you are aware, I am hoping to interview psychotherapists who have some experience of offering inhouse AET (interviewing) and Adolescent Psychotherapy at the Brent Centre for my qualitative PhD research project. So far two therapists have kindly volunteered to be interviewed, however, I am still looking to interview another 6 to 8 psychotherapists but I have fallen behind schedule with recruitment and time is running out for me to carry out the project within the given time. The aim is to discuss your views and experiences of offering Adolescent Exploratory Therapy and how this intervention might benefit adolescents for later work in Adolescent Psychotherapy.

The working question title for my project is: *"What are the advantages of offering adolescents Exploratory Adolescent Therapy in preparing them for later engagement in Adolescent psychotherapy?"*

Insight into technique and processes that therapists use when working with adolescents who are troubled and are struggling with serious mental disorders is little known about. This research project aims at exploring child psychotherapists' views on the benefits of offering Adolescent Exploratory Therapy and its positive effects on helping adolescents to transition to Adolescent Psychotherapy.

These interviews will be guided by me and will last between 50 and 60 minutes. They would take place via zoom, and I am flexible and can accommodate a suitable time for you to be interviewed. Once interviews are transcribed and anonymized, the resulting data will be donated to the Brent Centre for its own research benefit.

If you are interested and willing to help me with my project, please see below for my contact details where you can get in touch with me to arrange an interview or discuss further details or queries you might have.

Best wishes,
Antonio Cano.
Child and Adolescent Psychotherapist in Doctoral Training,
Oxford Central CAMHS, Raglan House, 23 Between Town Roads, Oxford, OX4 3LX
Antonio.cano@oxfordhealth.nhs.uk

Appendix 3 – Public Facing Documents

NHS
The Tavistock and Portman
NHS Foundation Trust

Participant Information Sheet

ProfDoc research project title: *"What are the advantages of offering Adolescents Exploratory Adolescent Therapy in preparing them for later engagement in Adolescent psychotherapy"*

Researcher: Antonio Cano

Thank you for expressing an interest in participating in this qualitative research study which will form part of my professional doctorate. This information sheet describes the study and explains what will be involved if you decide to take part.

Who am I?

My name is Antonio Cano, I am a Child and Adolescent Psychotherapist in doctoral training at the Tavistock and Portman NHS Trust on clinical placement at Oxford CAMHS (Child and Adolescent Mental Health Service) from 2018-2022. I am the principal investigator of this study and I have designed the research study and will conduct the interviews and data analysis.

What is the purpose of this study?

The purpose of this research is to understand more about adolescent psychotherapists views on the benefits of offering Adolescent Exploratory Therapy and its positive effects on helping adolescents to transition to Adolescent Psychotherapy. I am interested to discuss their views and experiences of offering Adolescent Exploratory Therapy and how this intervention might benefit adolescents for later work in Adolescent Psychotherapy. I am also interested in exploring their general experience and their views on technique, the therapeutic alliance and how the two therapies differ from each other.

What are the possible benefits of taking part?

I believe this research could potentially represent a significant contribution to understanding psychotherapists views of the processes and techniques involved in Adolescent Exploratory Therapy that facilitate and promote adolescent transition to and engagement with Adolescent Psychotherapy. For this very reason, knowledge about how therapists view on process and factors involved in different treatment modalities and how they use different interventions in therapy is needed.

Having a dedicated opportunity to reflect upon and share your views and experiences of the benefits of offering Adolescent Exploratory Therapy and its positive effects on helping adolescents to transition to Adolescent Psychotherapy may be beneficial in a professional field where opportunities to think about these matters can be experienced as limited or even absent.

Your participation may fulfil or enlarge a personal interest and may aid your self-development. Could participation in this contribute to professional requirements around CPD hours?

What will participating in this study involve?

A discussion of your views and experiences of offering Adolescent Exploratory Therapy and how this intervention might benefit adolescents for later work in Adolescent Psychotherapy.

An interview lasting 60 minutes to take place at your earliest convenience: if you agree to participate, we can arrange an interview time that is convenient for you. The interview will be conducted via Zoom video conference rather than in person.

I will also provide you with a post-interview confidentiality form and debrief letter which will provide specific information and serve to secure your privacy.

What will happen to what I say in the interview?

The interviews will be audio-recorded using a voice recorder which I will use to playback and transcribe in full at which point the recording will be destroyed by recording over. I will anonymise and analyse your transcript in order to complete the write-up of the research study.

Your name and personal details will be stored separately from the transcript in accordance with the University of Essex Data Protection Policy and the General Data Protection Regulations 2018 (GDPR, see below). This means that all electronic data will be digitally encrypted and stored on a password protected computer which only I will have access to.

Any paper copies will be kept in a locked filing cabinet in my office. All data will be destroyed no later than 3 years after the study has been written up for academic submission.

What risks are there?

This is a small-scale study and, as such, there is a very small risk some identifying features may be discoverable, however, every effort will be taken to ensure confidentiality. I am an experienced practitioner in managing information and confidentiality.

What will happen with the results of the study?

The documented results of the study will form my doctoral thesis and may also form an academic paper and feature in relevant published academic articles, books and/or presentations.

Do I have to participate after I agree?

No: participation in the study is entirely voluntary. Although your contribution would be very valuable, if you agree to take part but then change your mind, you can decide to withdraw and withdraw any unprocessed data previously supplied from the study up to two weeks after the initial interview has taken place without needing to give me a reason.

General Data Protection Regulation (2018) arrangements

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 for 2 years after the study has finished.

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

What approval has been gained to protect you, and information about you, in the research study?

This research study has received formal approval from the sponsor of the research, the Tavistock and Portman Trust Ethics Committee (TREC). These processes ensure I conduct the study within legal and ethical standards. If you have any concerns or queries regarding my conduct you may contact Simon Carrington, Head of Academic Governance and Quality Assurance, Tavistock and Portman NHS Foundation Trust (academicquality@tavi-port.nhs.uk).

Additional accountability is provided by the study sponsor for this project, Mr Brian Rock, Director of Postgraduate Studies, Tavistock and Portman NHS Healthcare University Foundation Trust, 120 Belsize Lane, London NW3 5BA, (BRock@Tavi-Port.ac.uk).

Contact details:

I am the main contact for the study. If you have any questions about the study, please do not hesitate to ask. My contact details are:

Antonio Cano M.A.
Child and Adolescent Psychotherapist in Doctoral Training,
Oxford Central CAMHS, Raglan House, 23 Between Town Roads, Oxford, OX4 3LX
01865 902153
07900405405
Antonio.cano@oxfordhealth.nhs.uk

You can also contact my research supervisor Dr Elena Della Rosa at: elenadellarosa@hotmail.com

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 accompanying consent form.

Appendix 4 – Public Facing Documents

NHS
The Tavistock and Portman
NHS Foundation Trust

Consent Form

Project title: *"What are the advantages of offering Adolescents Exploratory Adolescent Therapy in preparing them for later engagement in Adolescent psychotherapy?"*

Name of researcher: Antonio Cano

- I_____voluntarily agree to participate in this research project. ☐
- I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
- I understand that my participation in this study is voluntary and that I am free to withdraw, without giving a reason, at any time up to three weeks after the completion of the interview. ☐
- I understand that the interview will be digitally recorded and transcribed as described in the ☐

participant information sheet.

- I understand that the information I provide will be kept confidential, unless I or someone else is deemed to be at risk. ☐
- I understand that direct quotes from the audio recording may be used in this research study but will be made anonymous to the reader and held securely by the researcher. ☐
- I understand that it is my responsibility to anonymise any examples referring to cases I chose to discuss during the interview. ☐
- I understand that the results of this research will be published in the form of a Doctoral research thesis and that they may also be used in future academic presentations and publications. ☐

Contact details:

Researcher: Antonio Cano Email: Antonio.cano@oxfordhealth.nhs.uk

Supervisor: Dr Elena Della Rosa Email: elenadellarosa@hotmail.com

Participant's Name (Printed): _____

Participant's signature: _____ Date: _____

Thank you for agreeing to take part in this study.

Your contribution is greatly appreciated

Appendix 5 – Public Facing Documents

NHS
The Tavistock and Portman
NHS Foundation Trust

Post-Interview Information and Debrief Letter

Prof Doc research project title: *"What are the advantages of offering adolescents Exploratory Adolescent Therapy in preparing them for later engagement in Adolescent psychotherapy?"*

Principal Investigator: Antonio Cano

Thank you very much for taking part in my study.

I hope that through your invaluable contribution, this study will help to enhance understandings of how Adolescent Exploratory Therapy can help adolescents to engage with Adolescent Psychotherapy. Additionally, I hope your insights may be of help to future

trainees and practitioners, enabling them to better understand their experience of their clinical practice.

Unforeseen questions or concerns may arise for you now your part in the study has ended. If you would like to speak with someone, please do contact The Brent Centre for Young People, who will help or signpost you:

By telephone: 0207 328 0918

By email: info@brentcentre.org.uk

By post: The Brent Centre for Young People, Laufer House, 51 Winchester Avenue ,London, NW6 7TT

If you have any concerns about my conduct over the course of this interview or any other aspect of this research study, you can discuss this with me (Antonio.cano@oxfordhealth.nhs.uk , 01865 902153), my supervisor Dr Elena Della Rosa (elenadellarosa@hotmail.com) or Simon Carrington, Head of Academic Governance and Quality Assurance, Tavistock and Portman NHS Foundation Trust (academicquality@tavi-port.nhs.uk).

Thank you again,

Antonio Cano M.A.
Child and Adolescent Psychotherapist in Doctoral Training,
Oxford Central CAMHS, Raglan House, 23 Between Town Roads, Oxford, OX4 3LX
01865 902153
07900405405 Antonio.cano@oxfordhealth.nhs.uk

Appendix 5 – Indicative Interview Schedule

The Tavistock and Portman
NHS Foundation Trust

Indicative Interview Schedule

Researcher: Antonio Cano.

Research question: *"What are the advantages of offering Adolescents Exploratory Adolescent Therapy in preparing them for later engagement in Adolescent psychotherapy?"*

Introduction.

Question 1 – Can you tell me what AET is for you and what makes it a specific therapy for Adolescents?

Question 2 – Does the referral process for intake affect the way AET is structured and if so in what way?

Question 3– In you view, to what extent do you think the aim and purpose of AET has changed over time?

Question 4 – How Does Adolescent Exploratory Therapy differ from traditional forms of Adolescent Psychotherapy/ psychanalysis with adolescents?

Question 5 – What are the benefits of offering Adolescent Exploratory Therapy to adolescents?

Question 6– When and how do you use transference and transference interpretations in Adolescent Exploratory Therapy?

Question 7 – Can you tell me what condition are necessary both internal and externa that indicates the patient is ready for Adolescent Psychotherapy?

Question 8 – In your experience, do you think one can help build the therapeutic alliance in Adolescent Exploratory Therapy without using transference interpretations?

Part 9 – Closing statements

- Have we missed anything? Is there anything you would like to add?
- Is there anything you would like to clarify?
- Do you have any questions? Any final comments?
- Thank participants for the time and effort and explain next steps of project.

Appendix 6 – Post-interview Confidentiality Form

NHS
The Tavistock and Portman
NHS Foundation Trust

Post-Interview Information and Debrief Letter

Prof Doc research project title: *"What are the advantages of offering adolescents Exploratory Adolescent Therapy in preparing them for later engagement in Adolescent psychotherapy?"*

Principal Investigator: Antonio Cano

Thank you very much for taking part in my study.

I hope that through your invaluable contribution, this study will help to enhance understandings of how Adolescent Exploratory Therapy can help adolescents to engage with Adolescent Psychotherapy. Additionally, I hope your insights may be of help to future trainees and practitioners, enabling them to better understand their experience of their clinical practice.

Unforeseen questions or concerns may arise for you now your part in the study has ended. If you would like to speak with someone, please do contact The Brent Centre for Young People, who will help or signpost you:

By telephone: 0207 328 0918

By email: info@brentcentre.org.uk

By post: The Brent Centre for Young People, Laufer House, 51 Winchester Avenue ,London, NW6 7TT

If you have any concerns about my conduct over the course of this interview or any other aspect of this research study, you can discuss this with me (Antonio.cano@oxfordhealth.nhs.uk , 01865 902153), my supervisor Dr Elena Della Rosa (elenadellarosa@hotmail.com) or Simon Carrington, Head of Academic Governance and Quality Assurance, Tavistock and Portman NHS Foundation Trust (academicquality@tavi-port.nhs.uk).

Thank you again,

Antonio Cano M.A.
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Appendix 7 – Ethical 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
Fax: 020 7447 3837

Antonio Cano

By Email

14 April 2021

Dear Antonio,

Re: Research Ethics Application

Title: "What are the advantages of offering Adolescent Exploratory Therapy in preparing in adolescents for later engagement in Adolescent psychotherapy?".

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

Please note that any changes to the project design including changes to methodology/data collection etc, must be referred to TREC as failure to do so, may result in a report of academic and/or research misconduct.

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

I am copying this communication to your supervisor.

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

Yours sincerely,

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

cc. Course Lead, Supervisor, Course Administrator

Appendix 10- Sample of Codes and their description

Focused Codes for Category 1. CHALLENGES AND DIFFICUTLIES OF ENGAGING ADOLESCENTS

Name	Description

Name	Description
1. CHALLENGES AND DIFFICUTLIES OF ENGAGING ADOLESCENTS	
Adolescent tending to project difficulties into their bodies	Refers to the idea that adolescents tend to see their bodies as wrong, it seemed that adolescents might experience their bodies as the epicentre of their distressed where the body becomes the receptacle of projections.
Adolescents can experience changes of adolescence as difficult and unhappy	Refers to the fact that adolescence can experience the changes brought about by puberty as and difficult and unhappy period for most people.
Adolescents feeling something was wrong with body	Here, this code refers to the idea that some young people can present or experience their body as being wrong or feel alienated from it. This code is connected to the focused code it is imbedded in and it adds to the main code and its idea that the body during adolescence can become the receptacle and source of difficulties that seem concrete.
Being awareness of feelings towards developing body	Here the idea was that adolescents might not feel aware of the changes in their body brought about by adolescence. This code hits at the idea that there is some need to increase the
Not having insight of changes in the body	Here, there is the idea that some adolescents might find it difficult to have an insight into their bodily changes taking place during adolescence. The young person might be frightened of the changes taking place in their bodies.
Being able to think deeper about issues vs body issues vs surface issues.	This code refers to difficulties that can be thought about are expressed through the body in adolescence and the difficulty for adolescence to think psychologically about their problem.
Experiencing psychosomatic pain when under stressed from exams	This code refers to the way some adolescents will express their difficulties or anxieties through the bodies. There was a sense that the young person would take time for them to get past the physical symptoms and think that they might be symptomatic of something else that is psychological.
Psychological difficulties becoming expressed through the body	This refers to the way participants described the way adolescents might expressed their psychological difficulties through their bodies
The changing body of adolescence and impact on mind	This refers to the idea that the changes during puberty have an impact on how the mind is reconfigured. In a way the participant was alluding to the need to be aware of how these changes during adolescence affect the mind of the young person.
Traumatic memories becoming	One of the interesting ideas that this code referred to was that of sexuality becoming more prominent during adolescence. And it alluded to the idea that

Name	Description
active in connection with sexual body	past sexual traumatic experiences could become active or reactivated during adolescence where sexuality seems to become more significant.
Adolescents finding difficult to come for help to adults	This focused code referred to the idea that adolescents find it difficult to come to adult for psychological help because of their developmental stage but also because some anxieties that seemed to be particular to adolescents.
Authoritarian figures that the adolescent would not trust	This code reflected the idea that participants saw adults and by extension themselves as a threat to the adolescent's sense of autonomy and agency. Also, it hints at the idea that adolescents might feel mistrust when they seek help with adults.