What is Psychoanalytic Psychotherapy Like for Adolescents? An 'Experts By Experience' Enquiry Using Interpretative Phenomenological Analysis

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Contents

Abstract

Objectives:

This project set out to understand the experience of adolescents of their psychoanalytic psychotherapy. I had noticed that the majority of outcomes-based research failed to include the perspective of young people, and, when on the rare occasion that they did, used quantitative research methodology thereby limiting what could be said to a selection of prescribed options. This lack of rich data formed the basis of my motivation for the project of an 'experts by experience' enquiry.

Methods:

I interviewed five young people between the ages of sixteen and twenty-five, using a semi-structured interview schedule, allowing each participant the time needed to reflect on their experience of their therapy. This data was analysed using Interpretative Phenomenological Analysis.

Results:

Personal Experiential Themes (PETs) were identified for each participant and, after a cross-case analysis, I identified five Group Experiential Themes (GETs), 'Feeling desperate and in need of help', 'Recognising a firm framework' 'The importance of the therapeutic relationship' 'Managing frustration' and 'Benefit and help' noting the convergence and divergence of the accounts of the young people within each of these. I then selected three of the GETs, Recognising a firm framework, The importance of the therapeutic relationship and Managing frustration, to discuss further, linking them with relevant Psychoanalytic Theory.

Conclusions:

The findings of this study identified the importance of speaking directly to young people about their experiences of their therapy. They noted the difficulty in having to wait for access to mental health treatment, the importance of feeling heard and contained in a therapeutic framework as well as being able to acknowledge separation from their therapist, a position that facilitated a different kind of thinking. The participants spoke of a wish for the perfect therapist as well as wanting to be the perfect patient and how outcomes and goals became more realistically defined as the work progressed. Young people noted their frustration and feelings of uncertainty during the process, advocating for mental health and speaking out in opposition to stigma.

Keywords: Psychoanalytic psychotherapy, adolescents, patient experience

1.Introduction

This research project has gone through several changes and adaptations but throughout the intention has remained the same, to hear directly from young people themselves, in their own words, about their experience of being in psychoanalytic psychotherapy. This is linked to the title 'experts by experience' in which it is acknowledged that participants are best placed to give an informed view of their experience of psychoanalytic psychotherapy. The benefit of hearing from young people can inform our clinical practice, for example, efficacy appears to increase if young people feel more of a sense of agency in their treatment (Lavik, 2018). It however remains important to bring the experience of young people together with the expertise of our profession in a meaningful way.

I became interested in this topic as a Child and Adolescent Psychotherapist in Doctoral training, required to complete three training cases in each of the following developmental stages, 'Under Fives' (under five years of age), Latency (between the ages of six and eleven) and Adolescence (twelve to twenty-five). It was while working with the adolescent young person in 'intensive psychotherapy' (three sessions per week) that I began to wonder about the different points of view of the therapeutic treatment. What was the experience of the young person, did this differ from the way that the treating clinician felt the therapy was progressing, and what were the moments of difference and the times when there was a congruence of thought and feeling? Macran et al., (1999) note the importance of considering the view of the patient in the therapeutic process as well as in research in psychoanalytic psychotherapy. They state that 'in the search for objectivity many researchers appear to have forgotten that psychotherapy is very much a subjective, interpersonal experience' (p. 327). Perhaps it is also important to reflect on why it is that the voice of the young person has been missing, or at best under-represented? What might make it difficult for us as clinicians to invite a young person to tell us about how they have experienced their therapy?

Standard methods of outcome monitoring in Child and Adolescent Mental Health Services are predominantly quantitative, requiring the young person to select one of several pre-determined options thereby limiting the scope and depth of response. There has also been a focus on symptom reduction, something that appears to be less important to service users than other aspects of their well-being such as 'Increased emotional regulation, self-awareness, and connectedness in social relationships' (Lavik et al., 2018).

In the quest to make research more collaborative Macran et al., 1999, believe that clients should be allowed more scope to determine what is important and meaningful to them. Meaningful participation of Service Users in guiding the way that treatment is offered has recently been acknowledged as an important component in the efficacy of the therapy itself

(Lavik et al., 2018). Lavik et al., 2018, also note that there is still a lack of knowledge in mental health services of the perspectives of adolescents themselves. Adolescence was found to be particularly interesting to me as it is under-represented in research, has seen an increase in the need for mental health resources for young people, represents an age in which identity, independence and a real sense of agency predominate as well as the ability to clearly express an experience and the wish to be understood and heard.

1.1 Clarification of the terms, 'adolescence' and 'psychoanalytic psychotherapy'

Before embarking on the literature review the term 'adolescence' and 'psychoanalytic psychotherapy' need further clarification. The period of adolescence is commonly thought of as beginning at the onset of puberty and ending at the age of eighteen. Indeed, mental health provision in the United Kingdom has been influenced by this thinking and in most Child and Adolescent Mental Health Services (CAMHS) young people transition to adult services just after their eighteenth birthday. Blos (1962) uses the term adolescence to 'denote the psychological processes of adaptation to the condition of pubescence' (p. 2). He goes on to note that there has always been a very broad range of 'onset, duration and termination of pubescence' (p. 5). Copley (1993) agrees with Blos, saying that adolescence is the move from dependent child to adult and that it involves the responses to the bodily change of puberty (p. 84). Gluckman and Hanson (2006) identify a shift in the mid-twentieth century in which the biological and psychological aspects of adolescence were separated, thereby allowing for the recognition of a period in which to adapt to the bodily experiences of puberty. The earlier developmental work of 'triangulation' (Britton, 2004), the acceptance of a third in the previously dyadic relationship between mother and infant sets the foundation for the adolescent to be able to move to this more independent position and form sexual relationships of their own.

Waddell (2018) speaks of the importance of understanding the 'liminal position' of the adolescent, saying that it is 'a state in which previous identities are dissolved before new ones are formed' (p. xv). She suggests that both the internal and external changes need to be acknowledged and recognises adolescence as a state of mind rather than a specific chronological age, experienced differently in different cultures (p. xvi). Waddell (2018) suggests that there are times in which we might even briefly see an adolescent state of mind in a toddler or in an elderly person. Perret-Catipovic and Ladame (1997) note that although the end of adolescence is harder to determine than the beginning, there *is* an end, which, if avoided or short circuited runs the real risk of resulting in maladaptation or psychopathology.

For the purposes of this research project, it was necessary to delineate the age group to be studied and, with carful thought it was felt that adolescents between the ages of sixteen and twenty-five would be considered for the project. It is important to note that the Association of Child Psychotherapists, the regulatory body for child and adolescent psychotherapists in the United Kingdom, stipulate twenty-five as the upper age limit in which patients can be treated by Child and Adolescent Psychotherapists. This also acknowledges the importance of the recognition of the developmental drift of the age of adolescence, some young people reaching this point later on than others.

The term 'psychoanalytic psychotherapy', includes the notion of 'thinking' as described by Bion (1963), something facilitated by the containment of feelings. It is through thinking together and getting to know the mind of the other that progress is made. Bion (1963) emphasised the importance of being able to bear reality, something particularly difficult in adolescence as the tendency to split and either idealise or denigrate becomes more pronounced. Waddell (2018) notes that in work with adolescents the re-integration of disavowed or projected parts of the self forms the basis of the work and is of enormous importance. Psychoanalytic psychotherapists pay particular attention to the 'transference', a term used by Freud to describe what happens in the relationship between the therapist and the patient, 'the transference, which, whether, affectionate or hostile, seemed in every case to constitute the greatest threat to the treatment, becomes its best tool' (Freud, p. 26, 1949). It provides a valuable opportunity for the clinician to understand how the young person relates to others and how experiences in the past have coloured this.

The therapeutic element is to progress beyond repetition compulsion (Lemma, 2015) to a healthier relationship which can then be transferred to encounters with others. The focus on the transference:

> 'enables intense unconscious conflicts and developmental pressures to be understood and processed, with less need to express them in symptoms, regression from developmental achievements and so on' (Target, 2018, p. 18).

The aim of therapy:

> 'promotes the process of individuation, establishes firm ego boundaries, stabilises the distinction between self and object and enhances the faculty of reality testing' (Blos, 1967 p.166).

The idea of entering into a more dependent relationship at the moment in which young people are beginning to separate from their parents and forge new, independent relationships can run counter to embarking on psychotherapy and, for many young people this produces

profound ambivalence in their being able to seek help and sustain the intimacy (and feelings of dependence) required in the therapeutic relationship.

1.2 Adolescence in psychoanalytic theory

Psychoanalytic theory appears to have taken quite some time to pay attention to adolescence as a distinct developmental phase and many reasons for this have been suggested. Perret-Catipovic and Ladame (1997) note that infantile sexuality occupied the centre ground for quite some time, relegating adolescence to the periphery. They go on to suggest that the second reason for the neglect of adolescence is due to the fact that psychoanalysis has traditionally treated neurotic disorders arising from the struggle with unconscious wishes, primarily the domain of infantile sexuality. They ask the challenging question of whether the difficulty in the full recognition of adolescence in psychoanalysis might also have to do with 'sexuality enshrined in the reality of the adult body' (p. 4).

Although psychoanalysis as a whole took some time to recognise the particularity of the developmental stage of adolescence more fully, it should be noted that Sigmund Freud did indeed treat several adolescent women, the most notable being Dora (Ida Bauer) who was eighteen years old at the time of her treatment (1900). Perrit-Catipovic and Ladame (1997) explain that the word 'adolescence' was not in common use in German at the time of Freud's writing but that a close reading of his work shows that he recognised the important psychological changes made during puberty (p. 6).

In 1905 in *Three essays on sexuality* Freud wrote that the forming of sexual identity, finding a sexual partner and the bringing together of the sensual and the tender completed the tasks of the period of adolescence. Waddell (2018) suggests that the next important psychoanalytic thoughts on adolescence came from Ernest Jones in 1922 in his paper titled, *Some problems of adolescence* in which Jones recognised the infantile parts of adolescence saying that 'at puberty a regression takes place in the direction of infancy, and the person lives over again, though on another plane, the development he passed through in the first five years of life' (p. 39). Other analysts, Siegfried Bernfeld and August Aichorn, both working in Vienna added to the literature on adolescence. Bernfeld described the tension between the 'normal adolescent processes and the impact of internal frustrations and external, environmental pressures (in Freud, A 1958, p. 256). Anna Freud herself (1958) was interested in the way that the ordinary conflicts of adolescence provide the therapist with 'instructive pictures of the interplay and sequence of internal danger, anxiety, defense activity, transitory or permanent symptom formation, and mental breakdown' (p.256). More broadly, Aries (1960) in Waddell (2018) stated that it was not until the First World War that

'the awareness of youth' (p. 28) became more difficult to ignore as young men on the front lines made their opposition to the older generation known.

It is in the aftermath of the war that three women, Melanie Klein, Anna Freud and Hermine von Hug-Hellmath started to apply the methods of psychoanalysis to their work with young children. In fact, work with adolescents began much later as Anna Freud states:

> 'Analytic treatment of adolescents is a hazardous venture from beginning to end, a venture in which the analyst has to meet resistances of unusual strength and variety' (1958, p. 261).

More recently Briggs (2009) has addressed this as a current concern too, saying that adults and professionals need to engage with adolescents and 'not take flight from the impact of adolescent emotionality' (p.49). Interestingly when the Tavistock Clinic, one of the largest mental health clinics in the United Kingdom, itself was opened in 1948 it included two departments, one for adults and the other for children and their parents. It was not until the 1950's that the Young People's Consultation Service was established to undertake brief work with young people up to the age of thirty years old. In 1967 the Tavistock moved to its current premises in Swiss Cottage and the new building included a department for adolescent services.

1.3 Research and psychoanalytic psychotherapy

The next section of this project will look more specifically at the way in which research has been attended to in psychotherapy and how at times the relationship between the two has been fraught, with clinicians initially finding the idea difficult. Michael Rustin (2010) speaks of the 'highly politicised scientific environment' (p. 381) that psychoanalytic psychotherapy found itself in when Lord Layard unveiled the 'Improving Access to Psychological Therapies Programme', prioritising Cognitive Behavioural Therapy due to its larger evidence base than Psychoanalytic Psychotherapy. Rustin (2010) states that the schism between psychoanalysis and empirical research lies in the feeling of the two being incompatible:

> 'grudgingly, these empirical methods may be accepted to be useful for *political* reasons, responding to the demands of the health service commissioners, but are believed to have little intrinsic psychoanalytic interest' (p. 383).

He continues by suggesting that the way that psychoanalysis itself has evolved has been based on research of sorts with the consulting room being the laboratory, the object of study

the unconscious mind of the patient and the method of study the close scrutiny of the transference relationship. As Freud (1927) himself wrote:

> ‘There has existed from the very first an inseparable bond between cure and research. Knowledge brought therapeutic success. It was impossible to treat a patient without learning something new, it was impossible to gain fresh insight without perceiving its beneficent results’ (p. 256).

However, Rustin (2010) argues for the formalisation of empirical research in psychoanalytic psychotherapy (something accommodated in the new structure of the training for Child and Adolescent Psychotherapists), in order to strengthen the evidence base of the profession.

Target (2018) suggests three crucial reasons as to why there are challenges to doing research in the field of psychoanalytic psychotherapy. The first is that unconscious processes cannot be measured and that diagnostic criteria are too crude a measure of the state of mind of the patient. The second reason is that the technique of psychoanalysis is based on shared concepts and principles, something very difficult to standardise and replicate (although this has been attempted in more recent studies, for example Goodyer, 2017). Finally, what happens in the therapy sessions between a therapist and her patient is extremely delicate as well as confidential, a process difficult to expose to research.

Interestingly, Macran et al., 1999 argue that for both political and philosophical reasons research, specifically that focusing on the view of clients, is important. They note that ‘we cannot fully know about client’s experiences, and therefore fully understand how psychotherapy facilitates change, without asking them’ (p. 330). It is equally important to understand that the perspective of the patient forms one part of the fuller understanding of the experience and they add that it should be put together with that of researcher and/or clinician. McLeod (2019) argues for a more ‘differentiated, client-orientated perspective’ (p.41) in research that could influence both policy and practice in psychotherapy.

2.Literature review

In the literature review I sought to clarify the following questions:

- What research had been done in psychoanalytic psychotherapy?
- What research had been done directly with service users, the young people themselves, parents etc?
- What qualitative research had been done with service users who had been treated in psychoanalytic psychotherapy?
- What studies have set out to understand the adolescent experience of psychoanalytic psychotherapy using a qualitative research methodology?

I began the literature review by using the relevant databases in the Tavistock and Portman Library catalogue, EBSCO Discovery, PEP . In order to identify the pertinent books and journal articles I thought which key words to use in my title. I initially used the following words:

- Adolescent
- Psychoanalytic
- Psychotherapy

I added the word ‘experience’ in order to ascertain whether the search would be more specific. Unfortunately, this particular amendment confounded the results rather than being useful. I also used the limitations of literature published in English as well as specifying the age range of the research participants. The key words were done individually at first and then brought together to further refine the study. I noticed that the recommended literature fell into broad categories which I then had to look at and decide what was relevant to this study. Research in psychotherapy was a relatively recent phenomenon and research in psychoanalytic psychotherapy even more so. I have attempted to present the research in the following way: beginning with the broad reviews of research in psychotherapy, this was followed by qualitative studies that included the perspective of the patient or young person of therapy and, finally, qualitative papers that include the perspective of adolescents of psychoanalytic psychotherapy will be looked at in more detail.

Du Plock (2014) states that a literature review serves the purpose of stimulating curiosity for the task ahead as well as helping the researcher to refine and formulate the final topic. I found both to be true whilst scanning and selecting thoughts and potential literature for this project. This narrative literature review will be divided into the following sections: The first section will begin with a broad review of the research in psychotherapy, most of the studies being focused on the efficacy of the treatment. It should be noted that in these studies the

treatment is predominantly described as psychotherapy, not necessarily psychoanalytic psychotherapy, the treatment being considered in this study. The second section refines the search more, noting the studies that used a qualitative methodology. In this section I have paid particular attention to the studies that have focused on the view of patients themselves, adolescents specifically. The studies contextualise this project, noting the similarities and the way in which this study both builds on and extends the thinking.

2.1 Review of research

In the following section of this project I will turn my attention to four papers (all focusing on efficacy) that provide a broad review of different areas of research in psychotherapy, listed in order of the dates of publication: Fonagy and Target (2002) *The history and current status of outcome research at the Anna Freud Centre*, Midgley and Ellis (2011) *Psychodynamic psychotherapy for children and adolescents*: *a critical review of the evidence base*, Midgley et al., 2017, *Psychodynamic psychotherapy for children and adolescents, an updated narrative review of the evidence base* and, Target (2018) *20/20 Hindsight: A 25-year programme at the Anna Freud Centre of efficacy and effectiveness research on child psychoanalytic psychotherapy*. After looking at these papers I will then go on to consider the individual studies that match this project, noting the quality of the research itself, as well as the similarities and differences between that research and this project.

Fonagy and Target (2002) begin their paper by noting that there has been a dearth of research into any psychoanalytic work done with children and adolescents and that the upholding of the randomised control design as the 'gold standard' of research has further impoverished the field. They add that research to enhance the evidence base of psychoanalytic psychotherapy is extremely important for the future of the profession and *can* be done thoughtfully in the service of helping clinicians to provide improved (evidence based) services. The Anna Freud Centre (formerly the Hampstead Clinic) has a strong history of research into psychoanalysis and one of the first studies done with young children (1991) explored the impact of psychoanalytic psychotherapy on children with 'brittle diabetes'. It was a quantitative study relying on physical improvement to maintain blood glucose levels and growth. The next group of studies coming out of the clinic, Moran et al.,1991 and Fonagy and Moran (1991) were also quantitative in design and took physical improvement as the indicator of progress. This highlights the importance of questioning outcome measures and the idea of what is deemed to be an improvement in functioning and who contributes to these ideas, the clinician, the child or young person themselves, or both? In the paper under discussion the authors note that psychoanalysis at the Anna Freud

Centre was done with children ‘with a view to restoring them as far as possible to the path of normal development.’ (p. 31). Conducting research to conform to the strict scientific requirements of the mental health community at the time meant formulating outcome measures that were appropriate to the treatment of psychoanalytic psychotherapy too, something that Emanuel et al., 2014, have more recently considered whilst thinking about Goal Based Measures.

The next set of studies were based on material that had been previously gathered from work with children and young people. Seven hundred and sixty-three cases of intensive, psychoanalytic treatment were retrospectively studied, divided into three projects to determine outcome of the treatment. The first project looked at children and adolescents who had a DSM-III-R diagnosis of anxiety or depressive disorders and rated the effectiveness of treatment by using process notes, outcome measures and demographic information. They concluded that ‘children with depressive, over-anxious and specific anxiety disorders had different predictors of favourable outcome, underscoring the heterogeneity of this group’ (Fonagy and Moran, 1991, p. 61).

The second project was a comparative study, looking at children with emotional disorders versus those with disruptive disorders. The children were matched for demographic, clinical and treatment variables and found that those with disruptive disorders had lower overall improvement rates (Fonagy and Target, 1994). Finally, in the third study, the age at which the child or adolescent came into treatment was examined and correlated to outcome. All the studies are useful in contributing to the evidence for the efficacy of psychoanalytic psychotherapy, but it is important to note that few included adolescents as subjects, none utilised a qualitative methodology, and neither were the view or voice of the young person invited at all.

A study looking specifically at young adults (18–24-year-olds) was conducted by Anne-Marie Sandler (in Fonagy and Target, 2002). Young people were divided into two groups and matched for age, socio-economic status and DSM diagnosis, one group being offered five time’s weekly psychoanalytic treatment and the other once weekly treatment. The study was longitudinal and at eighteen-month intervals two senior psychiatrists independently evaluated the participants using structured interviews to make a diagnostic assessment. The study was limited by the lack of a manualised treatment, which, although extremely challenging, does potentially impact the results as it is unknown if each of the patients are receiving the same treatment. This study holds particular interest as adolescents were the identified group to be studied, but once again highlights the need for a qualitative framework

in order to reach experiences and to explore them more fully from the perspective of the service user themselves, something that this project hopes to address.

The authors include one qualitative research project at the end of the paper, introducing it by noting that 'methods of qualitative data analysis have only recently emerged and are not as well agreed upon as quantitative methods in the scientific literature' (p. 63). This project reviews 'narrative psychoanalytic data' and identifies themes that can include the relationship between the therapist and the child, the behaviour of the child in the sessions or the technique used.

The next paper to be looked at in more detail is that of Midgley et al., 2011, which reviews the evidence base for psychodynamic psychotherapy. The authors begin by noting that both psychoanalytic and psychodynamic therapies have been criticised for lacking the evidence base that other mental health disciplines have developed over the years. They suggest that this is because of the reluctance of psychodynamic therapists to acknowledge and support quantitative methodology, something previously raised in this paper (p. 8) by Rustin (2010). They continue by noting that although there have been more studies with adult participants, research focussing on children and adolescents is still lagging behind. The aims of the narrative review of the literature were to 'identify and describe' any study of the treatment efficacy of psychodynamic psychotherapy with children and adolescents, to rate the studies according to the efficacy of the therapy and finally to look at the outcome in different clinical groups. The authors identified thirty-four studies that met the inclusion criteria for the review but clarify that the studies are categorised according to research design, not quality. For example, a qualitative study is automatically placed at 'Level 4', while a 'randomised control trial' will be at Level 1, neither indicative of the quality of any part of the study itself.

For the scope of this project, it is too consuming to look at all the studies under review in Midgley et al., 2011, but some hold particular relevance to this project. One example of this is the study by Urwin (2009) which looked at how children who had received psychoanalytic psychotherapy in community centres had improved. The outcome measures were based on the hopes and expectations of the parents themselves and shows a significant shift in including the perspective of those other than the clinician or a diagnostic criterion. Although the study was small and did not include a control group it retains the important shift of including the views and experience of parents. The second study to be noted is that by Bury et al., 2007 in which semi-structured interviews were conducted with young people between the ages of sixteen and twenty-one to understand their perspective. This study will be looked at in more detail in the next section of the project as it provides a context for this project. Midgley et al., 2011, conclude that what became evident during the review was the lack of

systematic progression of research, research that used previous studies as a jumping off point but that also provided something unique:

> ‘research to date has also been hampered by the fact that it is lacking in systematic co-ordination and there has been little sense that the findings of any one individual study have been used as the basis for conducting further studies that would move towards developing a systematic evidence base’ (p.16).

Rather than discounting what has already been done, my project is in response to work that has been completed. The next paper to be looked at will be that by Midgley et al., 2017 *Psychodynamic psychotherapy for children and adolescents: an updated narrative review of the evidence base*. In this paper the authors note the findings of their previous review, stating that they came to the following conclusions: that studies showed that psychodynamic therapies with children and adolescents were effective as assessed by standard, research methods; that psychodynamic therapies were equally effective compared to other treatments; that there are different patterns of improvement, with psychodynamic therapies showing a more sustained improvement; the ‘sleeper’ effect was evident in psychodynamic treatments; responsiveness to treatment was seen, for example younger children being more so than older children and children with ‘internalising disorders’ responding more quickly to treatment than those young people with disruptive or externalising behaviours and finally that the intensity of the treatment is significant when working with young people with severe emotional disorders. Although there were several studies it was difficult to generalise from them as the authors note that the sample sizes were too small, heterogeneous and included a variety of interventions rather than focusing on a particular one.

Broader debates have developed around the ideas of the centrality of the ‘randomised control sample’ and the way in which the efficacy of treatment is researched. Midgley et al. ,2017, include the *IMPACT* study Goodyer et al., 2017, which has provided ‘a crucial development in the evidence base for this treatment’ (p. 311). Although this study is still concerned with the efficacy of treatment, it looks exclusively at the short-term psychoanalytic psychotherapy treatment with adolescents, something of particular relevance for this study. The authors note that there have been considerable improvements in evaluating the effectiveness of treatment since the last review that they completed in 2011. The most important of these being the manualisation of treatments and large randomised control studies that could potentially ‘focus not just on whether a treatment works but how it works and in what situations’ (p. 323). This project might be able to contribute in some way to the question of how psychotherapy works, what is experienced as helpful in psychoanalytic psychotherapy, drawing as it does directly from the experience of young people themselves.

The last paper to be reviewed in this section is that by Target (2018), *20/20 Hindsight: A 25-year programme at the Anna Freud Centre of efficacy and effectiveness research on child psychoanalytic psychotherapy*.' She notes that the field of psychoanalytic psychotherapy has concentrated on efficacy studies in order to, understandably, promote the treatment modality but adds that, if we are not providing something that makes sense to the patient, we are limiting the efficacy of the treatment itself. She says:

> 'but I recognised then that their (patients) subjectivity is at the centre of the picture, the whole point of it, and that if we as clinicians and researchers get more focused on our own methods and careers than on what our patient's experience, we lose our way' (p. 43).

Previously, all the studies that have been looked at in detail have been those looking exclusively at the efficacy of child psychotherapy, some more specifically psychoanalytic psychotherapy. Understandably, this has been a very important area of research and has been used to support the use of this treatment in NHS settings. However, there has also been the slow realisation that it is necessary to add the voice of young people about their experience to this research as it further enhances our understanding of efficacy itself. The literature review began with a review of the body of research that had been conducted in psychotherapy, this very general beginning will now be systematically refined to arrive at those studies most closely matched to this research project. With this in mind I will now look at those qualitative studies that have been identified as considering the perspective of the child, young person or parent. The first group of studies (three of which were conducted in the United Kingdom and one in Norway) explore the experiences of children and young people of mental health services.

2.2 Review of qualitative research

All the studies, Buston (2002), Harper et al., 2014, Jones et al., 2017 and Lavik et al., 2018 use semi-structured interviews and a qualitative methodology in their projects. Buston (2002), used 'purposive sampling' through the recommendation of suitable participants from the psychiatrists treating the young people but argues for the depth and quality of research rather than representation. All the young people were being treated in either CAMHS or the Adult Services as the age range included 14–20-year-old young people. Superordinate themes of the doctor-patient relationship, treatment, the system, and the location of the hospital/clinic emerged, the most important being identified as the value of clinical relationship. Recommendations from the study were made to consider the perspectives of young people and to make the sampling more representative in the future.

Harper et al., 2014 and Jones et al., 2017 both concentrated their studies on sixteen- to eighteen-year-olds in mental health services, arguing that they are at additional risk of suffering from mental health difficulties than those under the age of sixteen (p. 90). Once again, both studies used a purposive sampling strategy to identify participants who were then interviewed, and the qualitative methodology of Interpretative Phenomenological Analysis was used to analyse the data collected. Two superordinate themes emerged in the Harper et al., 2014 study, 'Developmentally Attuned Services' and 'Power Differentials', each one having further sub-themes. The limitations of both the studies were recognised as excluding the voices of those less able to articulate their experiences and perhaps predominantly including that of those who might have had a positive experience.

Lavik et al., 2018 began their study by stating the limitations of the current outcome monitoring in mental health services. They believe that the articulation of what is a meaningful outcome should be set by the service users themselves and that in order to do this the experience of the young people of mental health services needs to be looked at first. The way in which young people are often infantilized, particularly in mental health settings, was actively fought against by the researchers and the voice of the young people found expression in the formulation of meaningful outcomes, both the vocabulary used as well as the emotions expressed. Young people aged between fourteen and nineteen years old were allocated to study groups as well as individual interviews to ensure that each participant felt comfortable enough to articulate and express their thoughts and feelings. They found that 'positive outcome experiences were formulated as achieving a sense of a stronger autonomy and safer identity. Thus, good outcomes were understood as ongoing processes towards the life they wanted to live' (p. 4). In all these studies, the broader experience of engaging with mental health services was sought but, within these also lay the experience of the therapy itself. This leads to the next set of studies, qualitative studies that consider the experiences of the service user themselves of their psychoanalytic psychotherapy. These studies were chosen as they further contextualise the current project.

Midgley and Target (2005) have written about the recollections of being in Child Psychoanalysis, interviewing twenty-seven adults who had attended the Anna Freud Centre between 1952 and 1980. The participants ranged in age from three to eighteen at the time of the treatment and, interestingly, age seemed to be a factor in experience with those younger reporting a more positive experience. Semi-structured interviews were exploratory, looking at adulthood and functioning as well as the memories of childhood and the analysis more specifically. The significance of this study is the focus on the experience for the children and adolescents of their psychoanalytic psychotherapy, but the authors also note that one of the limitations was that some of the participants had been very young when in analysis and

therefore memory had diminished somewhat. A wide range of themes were identified including memories of the therapy and the therapist and the accompanying feelings.

Midgley et al., 2006 take the same sample group and focus specifically on the question of 'the participants perceptions of the impact the child analysis had had on their lives' (p. 260), using Interpretative Phenomenological Analysis to analyse the data. One of the difficulties reported was distinguishing whether it was the therapy itself that had had an impact on the individual or whether the ordinary developmental progression had facilitated the change. Participants also questioned whether a 'self-reported' improvement was reliable enough to be included. Interestingly, two thirds reported that the experience was helpful but focused on internal changes rather than something more behavioural. They conclude with an important remark 'how these former child patients have made sense of their experiences is of importance in itself and gives us another perspective on the analytic encounter' (p. 267).

The next set of studies all have adolescents as the target demographic but each one focuses on a different aspect of the therapeutic process. Philips et al., 2007 conducted their study in Stockholm and asked the question, 'What are young adult's ideas of cure prior to psychoanalytic psychotherapy?' Binder et al., 2011 working in Norway looked at, *Adolescent patients experience of useful psychotherapeutic ways of working at an age when independence really matters* and Lavik et al., 2018 wondered, *What adolescents need from psychotherapists in change processes*? I will now return to the study by Bury et al., 2007, mentioned previously in the literature review. This study will be looked at in more detail as it is very similar in the area of research as well as the methodology used and as such provides a clear context for this project.

Bury et al., 2007 explored *Young people's experiences of individual psychoanalytic psychotherapy* using Interpretative Phenomenological Analysis as their methodology. They note again the lack of research focusing on adolescents and their mental health, particularly qualitative research with a preponderance of studies looking at efficacy and outcome. They identify a link between 'therapeutic alliance' and clinical progress and the need for this to be carefully considered, particularly in the context of adolescents (p. 80). This coupled with the neglect of the client's perspective and the importance of increasing the evidence base for individual psychoanalytic psychotherapy have provided the motivation for their study. The inclusion criteria were for the young people (recruited from a community mental health centre) to be between the ages of sixteen and twenty-one years old, to have had regular (at least weekly) individual psychoanalytic psychotherapy for at least six months and had finished their treatment no less than three months ago but no longer than eighteen months ago. Six adolescents participated in the study with the researchers noting the challenge of

recruiting adolescents and the probability that those that did take part had felt more engaged in the process of their therapy. They also argue for the importance of depth and richness of experience rather than a large group of participants (p.82). The age range of the young people who agreed to participate were between the ages of seventeen and twenty-one and all of them had engaged in weekly psychotherapy to help them with difficulties ranging from depression, self-harm, eating disorders and emotional and relationship difficulties. A semi-structured interview was used to facilitate the expression of the young people of their experience of their treatment, from the referral to the conclusion. The themes ranged from 'Being in Difficulty', 'Expectations of Therapy', 'Therapist's Response', 'Facilitative Aspects', 'Power' and 'Endings'. Valuable insights were gained from the young people and both the need to provide a concurrent feedback process throughout the duration of the treatment as well as the importance of service users perceptions of outcome were noted. As previously mentioned, the engagement of the young people in the research project could be indicative of their engagement in their therapy. Therefore, this study was perhaps limited in the scope of experience it was able to gather. The study shares several similarities with this research project (qualitative methodology, 'experts by experience stance and similar age range) and as such was of particular interest and I hope to see whether my project corroborates what Bury et al., 2007, discovered. In the next section of this paper I will describe the research design that was used to complete this project.

3.Research design

3.1 Methodology

In this research project, I wanted to understand the experience of psychoanalytic psychotherapy in the lives of five adolescents and young people, aged between sixteen- and twenty-five-years-old. I will now go on to look at the method of analysis that I have chosen to use in this project, Interpretative Phenomenological Analysis (IPA). In the material below, I will explain why Interpretative Phenomenological Analysis was my analytic method of choice and set out how ethical practice was considered and assured. IPA is a qualitative method of data analysis that is used when studying the essence of an experience, the lived experience. It draws from phenomenology, hermeneutics and idiography, each of which I will now briefly explain. Smith et al., 2009 explain that there are four key contributors to phenomenology, i.e., Husserl, Heidegger, Merleau-Ponty and Sartre making the endeavour at once 'singular, but also pluralist' (p. 12). Husserl began by encouraging the move away from taking something for granted, the lived experience, to reflecting on our experience of experience. This introduced the idea of reflecting on an experience as well as noting who is doing the reflecting and with what preconceived ideas.

Heidegger, a student of Husserl wanted to acknowledge the person in relation to things, such as the relationships with people, immersion in a system of pre-existing language and the importance of interpreting the 'meaning making' of people (Smith et al., 2009, p.18). The third contributor, Merleau-Ponty described the 'primacy of the situated viewpoint' (p.18). He explains that while we may be able to observe another's behaviour, we will never know exactly how someone feels in the moment as it is distinct and in relation to their bodily place in the world. These thoughts become particularly meaningful when thinking about the experience of marginalised people such as the LGBTQIA+ communities, people of colour, with a disability or older people.

The last contributor, Sartre, viewed human existence as a process and explained that each person is 'in the process of becoming' (Smith et al., 2009, p. 19). As such what we are to become is not yet present and, with this understanding he introduced the idea of absence into his thinking. Although Sartre believed that human beings are ultimately responsible for their actions, he did acknowledge 'biographical history and the social climate in which the individual acts' (Smith et al., 2009, p. 20).

Heidegger, Schleiermacher and Gadamer are the principal theorists in Hermeneutics, the theory of interpretation. All three are interested in how sense is made of the appearance of

phenomena but, more importantly, how ‘the analyst is implicated in facilitating and making sense of this appearance’ (Smith et al., 2009, p. 28). This idea is encapsulated in the concept of the ‘double hermeneutic’ and can be linked back to the idea of ‘experts by experience’, the focus of this project.

The last of the three components in IPA, Idiography, is one of the main reasons that this method was chosen to analyse data for the project. It pays attention to the particular, to the details of something and as such has both a depth as well as richness of understanding, something that I felt was missing in other research projects. It is important to note that this is also used as a criticism of the method, the lack of generalisation but:

> ‘Thus, idiography does not eschew generalizations, but rather prescribes a different way of establishing those generalizations. It locates them in the particular, and hence develops them more cautiously’ (Smith et al., 2009 p. 29).

Lastly, it is important to note that the young people communicated as much as they were able to, and that I did not take this at face value but rather set about analysing both what they did say and what they did not.

3.2 Ethical considerations

This process was the most challenging aspect of the methodology due to the delicacy in the developmental age of adolescents, the upheaval in emotional life and the consideration of the legal parameters of the age of assent and consent. After careful consideration (with my supervisor culminating in Ethical approval see Appendix A) I began by emailing Team Leads in the clinic in which the study was conducted with a brief description of the study, the Advert for the study (see Appendix B) as well as the Participant Information Sheet (See Appendix C). The Team Leads took this information to the Business Meetings (a monthly meeting in which all clinical and administrative staff participate) and cascaded the information through the teams. I then met with the psychotherapists in each team and they described the young people that they had identified as potential participants. Their selection was based on the assessment of risk, disregarding any young person deemed to be high risk, as well as carefully considering the point at which the therapy was at, for example, no young person either at the beginning of therapy or in the very end stages of the treatment were put forward. All of this thinking was done collaboratively and thoroughly, foregrounding the knowledge of the designated clinician working with the young person. The next step, following the ethical approval closely, involved the treating clinician asking each of these young people whether they would be willing to take part in the project. They were given all of

the information mentioned above and given time to consider whether they would like to take part in the study. If they felt able and willing to participate, I was given their contact details and then emailed them directly. They read the information, took time to digest and think it through, ask questions if they wished to and then after careful thought advised me if they were willing to consent for the interviews to proceed. This part of the process allowed for 'informed consent', consenting with the full knowledge of the project and the opportunity to ask questions should they not have understood any of the information provided. I included the option of any of the participants being able to leave the study up to one week after the interview had been completed should they choose to do so.

Interestingly, none of the young people asked any questions prior to the interview and I wondered about the sense of trust they had in the clinic and their clinician. I thought about them potentially feeling less able to object to the interview, an obligation of sorts. However, during each of the interviews it became clear that they had felt free to say no should they have wished to and three of the participants went on to explain why thy had agreed to take part in the project, speaking about wanting to advocate for help for mental health support and encouraging their peers to request help as well as destigmatise support.

Due to the global COVID Pandemic, it was not possible to meet in person and as such, each young person selected either Zoom (video calling) or telephone call for their interview. I decided not to record the Zoom interviews on the Zoom platform itself, recording them all on a Dictaphone thereby limiting the places in which the data was saved. I then went on to manually transcribe each interview and it was at this point that I removed any identifying information, for example, names, university courses and any other feature that could lead to any of the young people being recognised. I wondered about what the difference might be of not having the interviewee in the room with me, what might I miss of the communication and how would this impact the data collected? I also wondered whether some might feel freer to express parts of the experience while for others it could prove limiting in some way. Each of the participants understood that should they read the paper in the future, they could potentially recognise themselves but others would not be able to do so. The data was kept securely in line with familiar protections for safe management of clinical data (password protected files, limited circulation, excerpts shared in a limited way for a specific purpose, regular meetings with supervisor).

3.3 Context

The project took place in a large mental health clinic made up of different teams as well as a training facility. Each team is multi-disciplinary, comprising disciplines such as psychotherapy, clinical and educational psychology, systemic therapy, and psychiatry. Young people who are offered individual psychotherapy are assessed for the intensity of the treatment, in other words, individual weekly sessions or more 'intensive' work with sessions being twice or three times per week. Considerations for this range from the complexity of the challenges the young person is facing to how they manage the breaks between sessions and how much containment or 'holding' they might need. Young people who take up the offer are also offered 'parent work' for their parents or carers, this can take the form of weekly, fortnightly, or monthly sessions with another clinician who meets with the parents for them to explore their experience of parenting. Older adolescents frequently do not take up this offer as they wish their therapy to be more separate from their parents (careful consideration is given to risk and whether some link between their clinician and others needs to be encouraged if they do not have parent work, for example, with their General Practitioner).

The catchment area is a metropolitan area with considerable diversity in terms of race, class, culture and sexual orientation of the local population. It should be noted that the young people who did agree to participate were culturally diverse and were able to communicate and had the means to do so, for example, access to electronic devices and the know how to use them. None of the participants disclosed a disability of any sort and this needs to be held in mind in terms of representation although Smith et al., 2022, note that online interviewing is helpful in including participants from different geographical regions as well as those who might have mobility issues. There was representation in terms of class, two being what could be described as 'affluent', while the other three coming from 'comfortable' or 'working class backgrounds. It should also be noted that I had a particular position in relation to the clinic, having completed my training there and perhaps having a vested interest in the way treatment was viewed, and needing to be very aware of this while both interviewing the young people and analysing the data. I used the frequent meetings with my supervisor to check this as well as reflecting on the analysis by reading the interviews many times and checking that all of what the young people said was represented in the final analysis.

3.4 Sample

The following inclusion and exclusion criteria were adhered to when identifying suitable participants:

Inclusion Criteria

- Adolescents, young people between the ages of sixteen and twenty-five years old
- Currently (or no longer than six months after the end of their treatment) in Psychoanalytic Psychotherapy
- Low to medium risk (assessed by the treating clinician)
- Access to video platform or telephone to participate in interview
- Consent to participate

Exclusion Criteria

- High risk (assessed by the treating clinician)
- Nearing the end of their therapy, less than four months away from end of treatment

3.5 Risk

Risk was managed very carefully in the inclusion criteria, ensuring that no young person would be approached to participate that would not be able to manage the process. Therapy is an extremely important but also unsettling process and as such the treating clinician made sure that they only put young people forward that were robust enough to participate. I thought about what it might be like for the young people to speak about their therapy, noting the benefits, that it may be useful to share the experience of psychotherapy with someone else. This could provide them with an opportunity to think about what it might have meant to them as well as the possibility of it being used to help to shape and develop the services for young people. I understood that it may also be uncomfortable to speak about certain elements of their therapy and as such gave them the name of a staff member not involved in the study to approach should they need to do so. Five young people, three who identified as female and two identifying as male, ranging in age from sixteen to twenty-three responded to the request. Of the five young people, two were in intensive treatment and the other three in weekly treatments. Each young person was asked for their preference on how the interview would be conducted, either via ‘Zoom’ or on a telephone call. Two of the participants requested Zoom interviews while the others felt more comfortable with telephone interviews.

3.6 Interview schedule

I conducted a semi-structured interview (See Appendix E) beginning with introductions and an explanation of what to expect in the interview. Allowance was made for a settling in period in order for the participants to feel comfortable enough to answer the questions as fully as possible. The questions began by asking each young person to tell me a little bit about themselves and what had led up to the therapy as well as whether this was their first experience of therapy. The following questions explored the helpfulness of the therapy as well as the difficulties and how these might have changed over the course of the therapy. I asked each person what they might tell themselves about the experience of therapy if they could go back to the beginning. Elements of surprise or what was unexpected were also thought about and ideas of the remaining part of the treatment and how they might envisage it were investigated in more depth. Each person was given the opportunity to reflect at the end of the interview and add anything that had not been captured by the questions but that were felt to be an important part of their therapy. To finish the interview, I asked what had made them agree to participate in the project before thanking them for taking part.

3.7 Participants

Five young people agreed to participate in the project and I would like to briefly describe each of them. I have not included any identifying features and have sought to maintain the anonymity of each young person. The purpose of the description is both to bring them to life a little more as well as acknowledging how factors such as race, ethnicity etc can influence the transference and hence what the young people felt comfortable talking about. Within this there are also factors that I bring to the dynamic, an important one being as a trainee child and adolescent psychotherapist, invested in this particular treatment modality. I have chosen to name them as follows, Aisha, Batseba, Chloe, David and Eric. In order to have some sense of the diversity of the group, the names broadly match that of the ethnicity of the young person, helping to locate and understand the position they speak from.

The first young person I will describe is Aisha, she is one of the participants in intensive psychotherapy, attending three times a week and was still in therapy at the time of the interview, having completed one year so far. She is a young person of colour with dual heritage and had an experience of trauma as she describes it in her interview. She chose to have the interview via Zoom, an interesting choice and perhaps reflecting a wish to be seen by me, given her ethnic minority status. The second person Batseba, was attending one session per week of psychoanalytic psychotherapy. Batseba is a young person of colour and had recently completed university and begun working. She chose to be interviewed by

telephone. Chloe was the third young person identifying as female and was still in school at the time of the interview. She was in intensive psychotherapy, attending two sessions per week and I spoke with her via Zoom. David, was one of two males in the study, is White, and he requested the interview be conducted on the phone. Eric had received treatment that included both psychoanalytic psychotherapy and psychiatric reviews due to being on medication.

3.8 Validity

Smith et al., (2022) note that validity is equally important in qualitative research but that it also needs to be assessed in terms of its own particularities rather than being compared to quantitative methods (p. 148). They go on to say that there have been a number of attempts at formulating lists of criteria but that this process could become 'prescriptive' and 'simplistic' (p.148) and that the basis of valid research is for the data to be presented in a way that the process can followed from the initial data to the final report (p.153). Similarly Nizza et al., 2021) say that 'the interpretative process becomes transparent, grounded in the data and thus more trustworthy.' (p. 383) Following these guidelines I would like to highlight the criteria for validity in this research project:

- Example of initial data (Appendix F)
- Example of tentative themes (Appendix G)
- Full data analysis process with examples (Data Analysis p. 28)
- Links from interpretations back to the initial data (Findings p. 31)
- Recognition of the position that I worked from as a researcher and how this might impact my interpretations as well as trying to limit this by regular meetings with my supervisor

3.9 Data analysis

I carefully followed the recommendations of Smith, Flowers and Larkin (2022) who note both a general structure to this method of research, as well as a flexibility that allows for creativity and playfulness. They propose seven steps to the analysis of data and I will now proceed, noting each one, describing how I did this in my analysis and giving examples where necessary. Linking my experience of this process to the reflections of Smith et al., 2022, I too noticed that some of the steps bled into each other and were not as clearly delineated in practice as in theory. They recommend that the material for each participant is done to

completion before moving onto the next set of data thus ensuring the development of the individuality of each young person, as well as then being able to bring them together, noting congruence and divergence across the cohort of participants. I will now go through each of the steps, beginning with ‘reading and re-reading’.

3.9.1 Reading and re-reading

I chose to transcribe each of the interviews manually, taking time to play the recordings through and write down everything that was said. The process was both time consuming as well as valuable in allowing me a thorough view of the way in which each person spoke of their experience. There were idiosyncratic uses of language or pauses in each one, some spoke freely while others struggled more, searching for the words to best convey what they felt. More than one young person noted that perhaps there were no words to describe the experience and that what they did manage to communicate somehow fell short of what had transpired.

As I read I noted a feeling of being immersed in the detail but also becoming aware of the totality of the experience, the way in which each participant might touch on something, develop another thought and then come back to the first idea in order to flesh it out a little more. In both this process of transcription as well as the subsequent reading and re-reading I felt the constant change of lens, moving from an intimate focus to panning out in order to get a broader sense of the experience. In moments I had to relinquish the desire to note something down and just allow the words to flow. I observed that for some participants there appeared to be a wish to convey a powerful and central feeling, for example, David’s feeling of being ‘infantalised’, a word that he used throughout the interview. In Aisha’s interview her sense of the system losing her referral was key to what transpired and she returned to the idea of a neglectful system on a number of occasions.

3.9.2 Exploratory noting

Smith, Flowers and Larkin (2022) describe this as a step that pays attention to ‘semantic content and language use on a very exploratory level’ (p. 79). For this step of the process I printed off a hard copy of each interview and began with an open state of mind, as far as is possible, noting any interesting or unusual use of language. When I came upon anything I marked this in the margin alongside the sentence, working through the interview in this way. For example, Aisha uses the words ‘born again’ and Chloe describes the time limited counselling in school as not being ‘viable’. Each of these phrases are evocative and both reference birth, while Eric used the terms, ‘broken apart’ and ‘put back together again’, also signifying a fragmentation and a re-assembly. The similarity between these three powerful uses of language suggest beginning again in some way. I retained the hard copy exploratory

notes for each interview but then chose to work on the laptop for the next level of analysis, i.e., identifying the linguistic, descriptive and conceptual statements. I made a column for conceptual statements on the left-hand side of the page, inserted the body of the interview into the broad middle column, numbering each line of the interview and finally using the third column for the linguistic and descriptive statements. To further define each, I chose a different font colour for the three descriptors. I then proceeded to go through the entirety of the interview, marking the relevant sentences alongside in each column. At this stage of the analysis I met with my supervisor to think through what I had done as the process had felt intriguing as well as anxiety-provoking, my concern being whether I had done justice to the content, had I overlooked central experiences or over-emphasised others? It felt helpful to link up and talk through how I had arrived at my choices and whether any changes needed to be made and why.

3.9.3 Constructing experiential statements

Smith et al., 2022 note that in this stage there is a shift of focus from the original transcript to the exploratory notes that have been made. They say, ‘However, if exploratory noting has been conducted comprehensively, it will also remain very closely tied to the original transcript.’ (p. 86) This echo’s the initial anxiety I had of doing the data justice and capturing the essence of the experience. I used the notes that I had made alongside the transcript to identify experiential statements and link this to some verbatim script, for example, one of the experiential statements for Batseba was, ‘Relationship facilitates thinking: Not only my way’. This reflected the observation that Batseba made about a shift in her thinking and being able to think differently with her therapist, and consider that there may be an alternative, ‘Not only my way.’

3.9.4 Searching for connections across experiential statements

This step involves noticing and mapping out the ways in which experiential statements can be drawn together. I made a hard copy of the experiential statements, cutting each one out and placing them on a piece of card, allowing them to momentarily stand-alone before grouping them with other similar experiential statements. I tentatively placed them in groupings, leaving them like this for a day or two, scanning them as I walked past or spending more time thinking about the groupings. Each cluster was changed a number of times as I began to explore the different ways in which they connected, refining and revising the groups many times. My supervisor and I then met together to think through the process, discuss the reasoning behind what had been done and making the final changes.

3.9.5 Naming the personal experiential themes (PET) and consolidating and organising them in a table

Once the experiential statements had been grouped together I read through each group and decided on what to name the Personal Experiential Themes. For example, after analysing Eric's interview I settled upon three Personal Experiential Themes (PET), Feeling Frustrated, How do I do This and Recognising and valuing help. In the Findings section of the paper I have compiled a table of PET's for each participant.

3.9.6 Continuing the individual analysis of the other cases

Smith et al., 2022 note 'Here it is important to treat the next case on its own terms, to do justice to its own individuality, to treat each case as a complete universe of inquiry.' (p. 99) To help with this challenge, I decided to take a break between each full analysis, hoping to return to the process without too much of the previous analysis in mind. After two or three days I began looking at the next participant and the process was repeated for each of the five young people.

3.9.7 Working with Personal Experiential Themes across cases

The task of this step is to notice similarities and differences across the Personal Experiential Themes and arrive at a set of Group Experiential Themes (p.100). As I had a table of the Personal Experiential Themes for each participant I lay them together on a large surface. I scanned across each of them, reading the themes carefully and then going to the next table and reading them. I noticed that similar wording was used in some themes that spanned the group, for example, each of the young people spoke about the relationship with their therapist, whether this was perceived as predominantly positive, Aisha and Batseba, or whether it was problematic and challenging, David, or a combination of both in one participant, Eric. Some Personal Experiential Themes were exclusive, such as Batseba's PET '*This* Psychotherapy and other psychotherapies' which described a comparison between CBT and Psychoanalytic Psychotherapy as Batseba had experience of both. I tentatively arrived at a set of Group Experiential Themes, explored them more, refined them and then settled on the final set (see 4.1, p.31) .

In the next chapter, Findings, I begin with a visual representation of the GET's of the group, followed by the PET's of each participant and then go on to discuss these in more detail.

4.Findings

In this project I wanted to understand more about what the experience of psychoanalytic psychotherapy is for young people. I used the method of Interpretative Phenomenological Analysis (Smith, Flowers and Larkin 2022) to analyse the data as outlined in the Methodology section (p.21), firstly identifying Personal Experiential Themes (PETs) for each of the participants followed by Group Experiential Themes (GETs), experiences that were common to the group as well as acknowledging those that diverged from the group, noting the importance of an idiographic analysis as well as a cross-case analysis. I identified the GETs as follows: 'Feeling desperate and in need of help', Recognising a firm framework', 'Building a meaningful relationship, 'Managing frustration' and 'Benefit and hope'. The sequence follows the trajectory of the therapeutic journey, beginning with the reasons for referral to a mental health clinic and culminating in the outcome after the therapeutic intervention. I will now begin the section with a visual representation of the GETs followed by that of each of the participant's PETs. This will be followed by a discussion of each GET, following the guidance of Nizza, Farr and Smith (2021) who note that indicators for good quality research are ,'Keeping focused while offering depth, presenting strong data and interpretation and engaging and enlightening the reader.' (p.371)

4.1Visual Representation of GETs (with occurrence for each participant)

	Aisha	Batseba	Chloe	David	Eric
Feeling desperate and in need of help	X		X	X	X
Recognising a firm framework	X	X	X	X	X
Building a meaningful relationship	X	X	X	X	X
Managing frustration	X	X	X	X	X

Benefit and help	X	X	X	X	X

4.2Visual Representation of PETs

Aisha
Creating and entering the framework
Building a meaningful relationship
Bearing discomfort
Batseba
Crossing the threshold and making space
Connecting with my therapist in the space
This psychotherapy and other psychotherapies
Chloe
Beginning an uncertain therapeutic journey
Thinking together in a different way: the basis of growth
Combatting the stigma of mental health
David
Feeling ‘infantalised’
Trying to be hopeful
Therapy is not a cure all
Eric
Feeling frustrated
How do I do this?
Recognising and valuing help

As can be seen from the above, I identified three PETs for each participant and I went on to do a cross-case analysis, being mindful of the use of different language but still identifying similarities in the experience. As you will notice, each GET acknowledges difference within it, for example, while all of the young people spoke of the importance of the therapeutic relationship, one participant, David, felt that it had not developed at all and hoped that it would in the remaining time of his therapy. While not every participant features in each GET, where they do I have decided to discuss them in alphabetic order, beginning with Aisha, followed by Batseba, Chloe, David and Eric. I have done this in order to recognise the importance of each of them individually and not to sequence them in a way that suggests some material is more noteworthy than others.

4.2.1GET 1:Feeling desperate and in need of help

In this GET participants noted how they felt before they had begun their therapeutic journey, what drove them to seek help and the process of asking, and then waiting, for help. This theme was common to four of the participants. Only one, Batseba, commented on a change of modality but did not indicate any feeling of desperation (perhaps feeling more contained as she had already had one therapeutic intervention, allowing her to draw on this experience while she waited) .

In contrast, Aisha, Chloe, David and Eric each noted the significant difficulties they encountered with their mental health and how this prompted the process of referral. Aisha remarks that ‘In the first six months of uni my mental health declined and got worse and worse and eventually I was kind of like picked up by the system and given a counsellor.’ She goes on to add that after travelling abroad for her studies ‘I was just in a very fragile place because I was having really bad insomnia and I guess what you would call flashbacks, but at the time I did not really have a word to give to it.’ There is a sense of something being wrong but Aisha not quite understanding what it is and as a result of this feeling vulnerable and confused by her difficulty (and in desperate need of help). She notes that she was ‘picked up’ by the system and this connotes passivity rather than an active search for help, relinquishing her sense of agency.

Similarly, Chloe articulates her feelings of desperation, saying that she had a ‘breakdown’, adding that it was ‘not good’. She adds ‘It wasn’t pretty, like it wasn’t good’, conveying that it felt messy, that the level of desperation left her feeling out of control in some way, broken down. Chloe approached her GP who then recommended therapy and made a referral to a local clinic. As an interim measure counselling was put in place for Chloe in school. I wondered about the concern for Chloe in the adults around her as she was given a full year of counselling in school, something that more ordinarily would only have lasted for

approximately six sessions. Chloe used a number of interesting words to describe her counselling such as 'I knew I *couldn't* be in school counselling', it wasn't '*viable*' and 'I knew my time was *limited'.* The word viable had an association with a viable pregnancy and I wondered about Chloe's need for a long term (full term) commitment from a therapist who could acknowledge the depth and intensity of her difficulty and robustly stick with her and help her think about these 'messy' feelings.

Three of the participants, Aisha, David and Eric all had the experience of their mental health struggles being picked up by adults around them who then encouraged them to seek help, perhaps a strong unconscious communication (projective identification), the owner of which becomes obscure prompting the question, 'who is desperate?' David explained that he felt 'obligated' to go to therapy and there is an idea that this felt like him being prompted by something more external, the staff in his school (who became concerned about his chronic low mood and suicidal ideation), but also something internal, that he felt that he *had* to do as he was in a desperate state, both of which left him with little or no sense of a choice that he had arrived at independently or of him having agency. David did in fact use the word 'infantalised' in his interview, a feeling of other people making choices and decisions on his behalf. I wondered whether David was more able to recognise, and be angry, with those around him who left him feeling like a much younger child, while being unable to articulate his own feelings of being overwhelmed and out of control, perhaps something more along the lines of, why can't I cope, why do I need help from adults and the discomfort that this generates in him. Central to the feeling of desperation for these participants is a feeling of lack of agency and vulnerability, needing help, needing the support from those around them but this also leaving them with a feeling of being younger than their years. David's choice of the word 'infantalised' occurred throughout his interview and he goes on to speak of his wish to be seen and heard as he describes responding to a communication between his therapist and colleagues in the team by stating that 'I would want to know what they talk about, be recognized as someone capable of understanding these things.'

Eric, was the third young person whose mental health difficulties were noticed by those around them, his parents (with his consent) submitting a referral via his GP. Eric was in a very academic, high achieving secondary school and his peers were readying themselves with thoughts of what they wanted to do at university. In sixth form he observed them preparing for interviews early as some of them were applying for rigorous degrees such as medicine. This felt at odds with his mental state at the time, an enormous feeling of desperation, which highlighted the difference between him and his peers. There was a sense of loss in what he was missing out on and he says 'I had this strong thought like, I am wasting this amazing time that I have at this school because of the state I am in and that was

what I was worried about.' Eric spoke of feeling desperate and that he would have listened to 'any advice' from his clinicians in order to improve. There was an interesting correlation in Eric's observation of his peers doing well while he struggled, this external placement of an internal battle between good and bad which he described as follows 'The only thing that I was scared about was that it (therapy) wouldn't work because at the time I had such strong circular thoughts and no matter what anybody would say to me, like five minutes later I would be back at square one. I was really worried that it wouldn't work, I knew it would work but I was worried that it wouldn't work fast enough and I would end up botching my exams or my school friendships or waste my precious time.' Just as his peers responded to challenge he wondered whether he would have the resources to progress and shift his circular thinking and join them in what he perceived to be an exciting time in life.

David and Eric, while both feeling desperate, respond differently to help, David feeling infantalised, while Eric is willing to listen 'to any advice' that will support him, his experience of adults perhaps being more helpful (and him being more in touch with his vulnerability and need for others) to him than David's. I want to link Eric's feeling of being left behind with that of David's ubiquitous experience of 'infantalisation' and the idea of development in adolescence, when feeling dependent puts the young person in touch with their need for others and can feel like an obstruction to what they perceive to be 'ordinary' (or normal) adolescent development.

Once each of the young people had made a referral, a period of waiting followed and this evoked powerful ideas of the mental health system and what waiting felt like for each of them. Two of the participants, Aisha and Chloe spoke in detail about the wait for help, Aisha noting that her original referral was lost but eventually picked up and she was then offered counselling sessions in a haphazard and irregular way, leading to an experience which left her feeling that the treatment was unstructured and lacking a firm framework (as well as questioning the commitment of the clinicians to her treatment). Aisha goes on to use the term 'place holder' which conjures up an idea of merely filling up a space without anything meaningful happening and, while unfulfilling, it provides an illusion of getting help. Aisha adds that 'They kind of have a quota and they can only help so many people with the resources that they have and so I guess I really felt like it wasn't really very constructive and it wasn't working through any of my issues.' Her use of language evoked thoughts of the perception of the system as an inattentive and under resourced maternal figure, unable to manage the demand placed on it (Aisha had in fact been supported by social services when younger and so this perception feels transferential).

For both Aisha and Chloe there is an enormous sense of relief when the referral is accepted and they near their treatment, Aisha explaining ‘So, once I had the reassurance that I was in the system I was told that I would hear back in like six months and I felt better because I was genuinely closer to having support.’ Chloe says that she was ‘no longer on the waiting list’ and that she will now have a treatment that is more ‘permanent’, contrasting this to her school counselling interim treatment and she adds that ‘It made me feel better that I could get treated in a more permanent way for my mental health.’ Similarly, after a period of assessment Aisha is offered intensive (three per week) psychoanalytic psychotherapy and she describes feeling relieved as well as appreciating the attunement of the therapist in providing what she needed. There is a shift for both participants from an idea of a very depersonalized experience to one in which they feel seen and heard and are sensitively responded to. They have been claimed and assured of treatment and what before felt like a lack of resource is now experienced as attentive and generous. I will now discuss the second GET ‘Recognising a firm framework.’

4.2.2GET 2:Recognising a firm framework

This GET consisted of two ideas, that of containment, both physical (building, time, and regularity of sessions) and emotional (the mind of the therapist) as well as the observation of the clinical stance of the therapist, their theoretical framework. Three of the participants, Aisha, Batseba and Eric all spoke directly or alluded to the notion of containment, Aisha noting ‘When I was in therapy it sort of felt contained because you go to this building, you are in the same room every time and they try and establish some sort of stability or routine through having everything be exactly the same.’ (p. 3). Aisha says that it ‘sort of’ felt contained and that the therapist ‘tries’ to create a notion of stability and I wondered about her communication being ambiguous, that although the clinicians try and create this feeling, containment can feel different at different times to each of the young people. Aisha proceeds to elaborate on this range of feelings, noting that the framework, while reassuring at times, took on more of a restrictive feeling when she grappled with challenging, emotional material. She says ‘In the beginning of therapy because there is literally a clock on the table, I was really aware……By the time we actually got to talk about the important things, which would usually be upsetting and I would be in a bit of a state, it would be time to leave. I think I found that really difficult. I still find it difficult but I accept it as a part of the process.’ (p. 6). In this moment the stability (framework of time) created by the therapist feels restrictive (and perhaps even limiting or persecutory) and I would like to make a link with Aisha’s previous idea of limited resources, where time running out evokes the same feeling of there being a limit on what she is offered. Will she be able to process her difficulties in the time that she has, will she get enough of what she needs?

Batseba also goes on to speak of time, and she does so in two different ways, the first is her feeling of generosity at the length of time of the actual treatment, traditionally psychoanalytic psychotherapy being a significantly longer-term intervention (than CBT, her first treatment modality). Batseba then turns her attention to the timing of each of the sessions and how she regulates this as her therapy progresses. Initially, she found the open-ended format of each session challenging, and on occasion was left feeling very fragile at the end of a session when she had not emotionally tapered down and prepared for the ending and she notes

'The sort of sessions in a way are led by me and what I say and so you know, if I would see that we were nearing the end of a session I could say, there is this thing that I want to talk about but we don't have time right now can we keep it in mind for next session.' (p.7).

I noted a shift in the perception of both Aisha and Batseba when they first spoke of time as something more brutal and authoritative (paternal) that leaves them feeling exposed but, having learnt to prepare for the endings of each session, become more able to enjoy the fluidity in the session itself and the feeling of time as a reassuring boundary begins to develop.

Aisha, Batseba and Eric all spoke of the nuances in their experience of containment, feeling comforted and reassured at times, while at others being more persecuted, more in touch with the strictures of the framework. Eric observed that the frequency and consistency of the sessions were very important to him 'I was surprised that I found comfort in it being so regular because before that with anything regular I would start dreading it and I was pretty worried that I would start hating it and it would stop working because like, maybe I would start disliking it and I would shut myself off.' Although Eric was concerned that the regular offer of something might be experienced by him as an unwanted demand, it in fact proved to be reassuring.

The physicality of containment, the building, time of the session and duration, led to a further experience of entering and leaving this boundaried space and Aisha, Batseba and Eric all mentioned this in their interviews, Aisha contrasting the experience of attending her therapy sessions in person to having them online during the COVID pandemic. Once Aisha had begun her treatment, there were a number of points at which she crossed over the threshold into her therapy as such, attending her very first session with her therapist and then doing so again each time they met. There was both an internal shift when she attended, readying her mind for what lay ahead and she speaks about how she entered and exited this world of therapy, 'decompressing' after a session and then re-joining the ordinary world of lectures, and friendships 'Like, in the beginning I just really needed to go for a walk afterwards and just really decompress and process what had just happened before I could carry on with my

day.' Aisha spoke of the journey to her therapy and back and how this formed part of the ritual that she became accustomed to, a bridge of sorts. When this differentiated space for therapy, university and home is collapsed into one during the COVID Pandemic Aisha notices the lack of preparation she has for her therapy and how the re-entry into 'life' afterwards feels abrupt, both the physical space and the thinking space in her mind made smaller and limiting her ability to reflect on what had occurred in her sessions.

Like Aisha, Batseba and Chloe also had both in person and online therapy, Batseba contrasted the experience of these, saying that she recalls a feeling of relief that she had when she was granted permission to have flexible working hours that allowed her to attend her therapy. This marked her entry into psychotherapy and she then spoke of moving between her therapy and her 'life' and how this differed once the pandemic had begun 'One thing that sort of became harder now is like I would have time to reflect on what we had spoken about on my commute home because I would just be listening to music and sort of be mindless. Whereas now it is sort of, 'Okay bye'. I can then sort of watch TV or have dinner and there is no sort of like, interim point between, so like, I think sometimes it feels as if I almost forget to properly think about and have a moment to reflect on what we spoke about.' (p. 8). For Chloe the change from having to go into the clinic to having her therapy online created an opportunity for her to be able to increase her weekly sessions, 'I guess my main worry was like how was I going to set it into my timetable but then COVID happened, so everything kind of went online. In a way that was good because I go twice a week right now and I know for sure one of the sessions I would not be able to make in person.'

David too wondered about how he should integrate his therapy into the rest of his life, both physically, as he has to travel quite some distance, but also, emotionally, what does he do with the experience of his therapy in the rest of his day, how does he manage his feelings, 'It is only once a week but I live quite far away so it is quite a trip….and it is how I begin every Monday, every week and it is difficult to continue with the day afterwards. I don't know whether to try and brush it off or to spend more time thinking about it which will impact how the rest of the day will go.' David is unsure of what to do, should he allow himself to think about it and have it infuse his life, or should he brush it off, compartamentalise it and keep it at surface level. A reminder that further on David describes feeling that therapy can feel as if it is a thing in itself rather than related to other aspects of his life, and I wondered whether this thought contributed to that in some way-his difficulty in integrating the experience and his wish to keep it separate.

Eric, like David, did not make the contrast between in person and online as his therapy had ended before the beginning of remote working had commenced. He does however say that

his weekly session was on a Friday and that he would arrive at the clinic about ten minutes early. He used the time to listen to music and think of what he would say and he observes that he felt ‘calm’, allowing us a glimpse of what the transition into therapy felt like for him. Although the pandemic was unusual and out of the ordinary, the general experience of a transitionary space is highlighted by its occurrence, allowing us to understand the importance of this for the young people in their experience of psychoanalytic psychotherapy.

I would now like to move onto the observation of some of the participants of the theoretical framework in which their therapists worked. Through the course of their therapy both Aisha and David came to observe the consistent way in which their therapists responded to what they said. Aisha notes:

‘I remember in my first few sessions just the way the therapist would speak was weird to me. Everything is framed, they kind of act like a mirror, everything you say is framed back at you, if that makes sense.’ (p. 2)

Aisha gives an example of asking the therapist about their weekend and how they reframe this as her wondering about being kept in mind over the break. In the interview she did this speaking as the therapist and it bore an uncanny resemblance to a ‘transference interpretation’. This different way of thinking, although initially difficult to understand, made Aisha aware of the experience and stance of the therapist and how this differed from hers, introducing the idea of separation between them, something that will be further explored in the next section, ‘Building a Meaningful Relationship.’

For David, the lack of agency and feeling of passivity in himself appeared to mirror what to him felt lifeless and rote in his relationship with his therapist, and he mentions this in relation to the theoretical framework, noting the repetition in the sessions, ‘things going around in circles’ and that he felt very ‘fatigued’ by it all. He speaks about a wish to be challenged more and says ‘It is really predictable, I can predict every beat of what the therapist is going to say, how they are going to question things that I have said. Sometimes I am caught off guard and that is good. Yeah, like kind of being presented with a way of looking at something I have said from a completely different angle. It can be very refreshing and it gives me a lot of food for thought.’ The predictability that David speaks of is clarified by the following excerpt which illustrates that he is thinking about the theoretical framework that his therapist is using ‘Um, I suppose in therapy there is quite a lot of meta-therapy. Whether it is kind of, everything is taken to be contextualized around the therapy itself. Like, I will be talking about my relationship with my friends or family and that will be turned into a kind of allegory for my relationship with the therapy, um, this is one of the things that could become very predictable.’ For David this reference back to the therapeutic relationship appears to

reinforce his frustration with the lack of connection and liveliness between him and his therapist. Perhaps in a way to counteract this sense of stagnation and lack of agency, David notes that he might well get to the point of 'opting out', making the decision to terminate his therapy (and to him what feels like reclaiming a sense of agency). While David feels that this way of thinking is unhelpful (and painful on a deeper level), Aisha first describes the way of thinking as 'weird' but she then goes on to feel that it enables her to view her therapist as separate and her thinking as valuable. I will now go on to discuss the third GET, Building a meaningful relationship.

4.2.3GET 3:Building a meaningful relationship

This formed the cornerstone of the experience of psychoanalytic psychotherapy and each of the participants spoke about it in their interview, most observing the way in which the relationship developed, Aisha, Batseba, Chloe and Eric while others, David, wondered about why it had felt frustrating and unhelpful (and undeveloped in the sense that he was hoping for). In the development of the relationship Aisha, Batseba and David all observed some form of a power differential in the dynamics, Aisha saying 'Like, who is this person that I am talking to who I know nothing about and who knows pretty much everything about me?' Batseba describes her therapist as 'sort of like the expert' but develops this thought as an expertise that can be challenged and that her views then become as meaningful as that of her therapist.

David's feeling of powerlessness is multi-faceted, beginning with the feeling of being obligated to go to therapy and this further compounded by a sense of exclusion, generated by a conversation held about him by his therapist and members in the multi-disciplinary team from which he is left out 'It just kind of comes back to what I mean about me hoping that it would be more straight forward in that I would be presented with the actual kind of, I would be part of the discussion in place of just kind of the subject.' He is left feeling powerless and exposed and wondering who knows what about him ('..they have this really private information about me') and why his capacity to participate more fully in what he perceives to be an age-appropriate way, is not recognised. For David, establishing the relationship was challenging and he notes that confiding in a person that he did not know was hard 'Um, I suppose getting to know someone new felt difficult. Being not very open about mental health and stuff and having to open up about that to someone new was difficult.' David adds that 'This therapist I have talks quite a lot about establishing a relationship, um, but I don't know, it doesn't seem to have materialised in my mind.' This felt both a frustrated and painful admission of something being regularly spoken about but not fully realised in David's mind, a

tantalizing failure on both their parts perhaps. I wondered how David made sense of this lack of connection in his mind and what he attributed it to.

Like any relationship, the inception begins with communication and Chloe and Eric spoke about their struggle to find the words to communicate with their therapists. Chloe observes that she found it difficult to find the words to communicate with her therapist, and to initiate and develop the relationship further and I had an experience of this in the interview with her too. Chloe requested prompts from me on a number of occasions, seeming to feel that she might be missing something or did not quite have the information to hand to describe her experience of her therapy and she says this in relation to her therapist 'Unless I am prompted I don't, I can't say things…..' I noticed that asking for help in this way was unusual in the cohort. Chloe later goes on to describe both how helpful but also uncomfortable she feels when she is more aware of her feelings (this capacity developing through the therapeutic relationship where she is put in touch with what she refers to as her 'subconscious') and how she can feel left alone with this awareness when she is not in the session with her therapist. Chloe says ''It is challenging when you have that information but you don't really know what to do with it because it is like, ok, I know I think like this and it is not particularly helpful but when it comes to things that you don't do consciously it is really hard to be like, I need to stop thinking like that, because you can't control it anyway.' (p. 5). Coming together with her therapist inevitably involved being aware of their absence when they were apart and this highlighted Chloe's need for the physical presence of someone, and how perhaps she was still developing her internal resources as well as the notion of a more containing internal presence in the absence of her therapist.

Similarly, when Eric began his therapy he found it very difficult to communicate with his therapist, saying that he 'ran into roadblocks' that felt very uncomfortable. He links the feelings in the therapy between himself and his therapist, saying that they were 'heated' and that he had similar occurrences in the rest of his relationships (this can be linked to the idea of the 'transference' in which other relationships are played out in the interaction with the therapist). Eric tries to pre-empt this by writing down what he would like to say and taking this to his therapist, and he says that he appreciates the feeling of authenticity when his therapist refrains from the social niceties of asking him how he is but rather allows him to struggle with where to begin the session and how to begin it too 'I would get so frustrated because they (roadblocks) were sort of there and just like blocking my way, I couldn't think and I just couldn't get passed them. Um, yeah those were the hardest parts.' As the therapy progressed Eric notices a shift in the way that he communicates saying that he and his therapist began to 'chat' more, that it felt more like a 'back and forth' and less of a 'one way'

communication, perhaps a sign of Eric becoming more able to communicate and as a result of this something livening up between the two of them.

Aisha and Batseba spoke about what their expectations of the therapeutic relationship were before they began their therapy and how this differed from the actual experience. Aisha says 'I was told in the assessment that often people relate to their therapist as a sort of surrogate parent. So that was an interesting idea to have in my mind, um because I have a really strange relationship with the idea of any authority figure or a parent at all. So that was a weird expectation to have.' Because her therapist was younger than she expected she likens the relationship to that of an older sibling (which is interesting in itself as Aisha is an only child) yet it still has some element of the power differential described above. She however spoke warmly of the relationship and how it formed the, not uncomplicated, core of the work. For Aisha, there was a yearning for a particular kind of relationship with her therapist, one that she describes as having a shared understanding, 'being on the same page' but as this expectation shifted she goes on to explain that 'More recently I have started to think that there is a limit to how much we can have a shared understanding of something and I guess it is okay if we understand things differently. Whereas for a while I just wanted us to think the same way, like I just wanted a shared understanding, I just wanted to feel like we were on the same page and I guess sometimes we are just not going to be on the same page because she just doesn't think the same thing that I do.' Somewhat painfully Aisha has to adjust her expectations and recognise in a more realistic way the experience of two individuals with separate minds coming together. However, the recognition of a different stance introduces the idea of separation and learning that would not have been possible if they had been more merged. Aisha notices this and says 'Like I could be talking to someone and feel like I had enough space to think at the same time as talking to them and that is not something, I was very good at before. I think that maybe that is partly from accepting that me and my therapist just don't think the same way sometimes.' (p. 10).

Batseba also noticed and spoke about what her idea of the therapeutic relationship was, her expectations prior to embarking on the journey. She begins by saying 'I think at the sort of start I did, knowing the length of time that I had was helpful because I could use a decent chunk of the first sessions to get to know my therapist and for her to get to know me and sort of see what our relationship would be like.' Batseba had previously had CBT and the more directive, short term approach of this modality leaves her feeling intrigued and curious about what her relationship might be like in this more fluid long term intervention. She goes on to say 'I think, it is hard to distinguish whether you genuinely don't get on with your therapist, which obviously can happen. In my case I feel like it was more about what I expected and what I actually got.' For Batseba, like Aisha, the expectation of what the therapist might be

like involves the recognition of there being a person with a separate, and at times contradictory, mind. Batseba recalls her confusion when her view of a situation is challenged by the proposal of a different view from her therapist, 'I went in having read the situation like this and was told, well actually it is something different, it could be read in a different way and I was like, no, it is my way is the right way. And even although it is not explicitly spoken of, having that time to speak about different things, slowly I became more receptive to looking at things in a different way.' (p. 9).

Two features of the relationship seemed important to Batseba, the first being the therapist's separate thinking mind and the other the connections between events that she helped Batseba make. There is a tension in the idea of separation and connection but Batseba felt intrigued by this separate mind as well as the connections made in order for experiences not to feel fragmented. Batseba develops this thinking more when she speaks of her therapist holding onto what has happened and helpfully linking them up with similar situations, holding the separate pieces together, 'In psychotherapy we talk about why the group chat was stressful and then maybe three weeks after I talk about something that happened at work and my therapist makes the link that actually those feelings, even although it is a completely different environment and a completely different situation, the sort of core feelings are the same.' Batseba comments on this when advising other young people of what therapy might be like. She says that it feels very important to pay attention to even the mundane as there is a lot of depth to what her therapist says. She adds that 'I feel sometimes they kind of hold a lot of like, not necessarily advice but good information to reflect on and think about.'

During the course of the interview Batseba described the initial feelings toward her therapist and how she struggles to 'mesh' with her. She puts this down to what has been discussed above-the different stance of the therapist and how this could at times feel challenging. The more time Batseba and her therapist spent together, the more tolerant and robust the relationship became and Batseba says 'Like you can retaliate and discuss and have differing opinions because you know, while she is sort of the expert it's not what she says goes. If you feel differently about something you can talk about that and see where that leaves you and maybe in discussing your different views about the same situation you might be able to unlock more from it, you can get more from it by having that sort of back and forth.' Batseba is able to take this experience back to her relationships and she explains how she is now able to think *in* a situation (Aisha had mentioned this above as feeling that she had enough space to think in social exchanges too) whereas previously she would be reactive and then ruminate, a very unhelpful way of 'thinking'. Batseba ended the interview by saying 'I wasn't entirely sure that I would grow to like my therapist and I have, that's something that is quite special.'

Within this idea of two individuals in the therapy room noted by Aisha, Chloe, David and Eric came the acknowledgement of a variety of feelings towards the therapist and this shift appears to coincide with the more general abandonment of the idea of perfection, the perfect patient, and the perfect therapist. Aisha speaks very movingly of her relationship and how important it is, but she is also able to express anger at her therapist as well as being concerned about her. She says 'I think it is really valid to worry about this person that you are really close to but know nothing about (laughs). It's weird to worry for yourself and to worry about the relationship being quite a fragile thing sometimes.' Finally, Aisha noted 'To have a therapist that I feel comfortable talking to. Yeah, I think that is a pretty big deal.'

With this recognition of the value of being heard by someone, a separate person with a mind of their own, Eric adds that he was very aware of his therapist and her wellbeing. He wondered about her life and difficulties and what it might feel like for her to listen to other people's 'problems' all day. I wondered about this concern for her and whether Eric might also have been worried about whether she would be able to withstand the dark, circular thoughts and to survive them, have the strength and resilience to oppose them by providing an opportunity of a healthier way of relating. The notion of a separate person was alluded to as Eric describes a feeling of something less 'one way' in the relationship with his therapist, two separate people communicating with each other. I will now discuss the fourth GET, Managing Frustration.

4.2.4GET 4:Managing Frustration

'Managing Frustration' has appeared in other PETs briefly, 'Building a meaningful relationship', for example in which the young people speak of the difficulty in finding the right words to communicate with their therapist as well as having to manage expectation, relinquishing their idealistic thoughts of what the relationship might be like for something bearing a closer relation to reality. However, I will now look more in depth at 'Managing frustration' and I noticed how this clustered around three ideas for the young people, the first being what they initially believed therapy would be like, what and how it would change experiences in their lives, some speaking of what they believed would be a profound, watershed moment and this not quite happening in the way that they had anticipated. The second was the length of time that they felt that it was taking to feel better, the idea of what feeling better would be like is closely linked to what they felt therapy would change. The third source of frustration came from the longing for certainty, for some young people this meant the wish for a clinical diagnosis. Before looking at each of these in detail, I want to acknowledge another uncomfortable feeling, mistrust, a feeling that was raised by one of the participants in particular, Aisha.

Aisha spoke of her troubled childhood that resulted in contact with social services, and how this had coloured her engagement with mental health services and her therapist. She says 'I have a tendency to mistrust things that my therapist is saying. Like I will think, 'Why are you saying this? Where is it really coming from?' One of the concerns that Aisha had was whether something really important had been missed in her treatment, a continuation for her of her feelings of an inattentive therapist. She gives the example of a friend who was offered therapy only to find out after quite some time from a second intervention that something had in fact been overlooked. Unfortunately, the feeling of mistrust that Aisha brought with her, was further compounded by the loss of her referral, something more concretely being lost and overlooked and leaving her wondering whether professionals could be trusted at all. Aisha noticed that these feelings of mistrust would often be linked to frustration and would surface when she was feeling 'low'.

Aisha and Chloe both spoke of their expectation of therapy, Aisha being more exuberant initially, she says that she felt that her therapy would be 'Like a kind of re-set, like just feeling born again maybe. Which obviously is not, without being at the stage of finishing therapy I can't say what it will feel like. Maybe I will feel born again in a different way.' (p.7). When she first says this I had the feeling of a religious experience, leaving behind the past altogether and starting afresh. She qualifies this though and amends her original idea, proposing a type of re-birth but different in some way and this refinement conveys something more realistic and attainable. It also appears to recognise that the past is part of her experience, not something that can be discarded but can be integrated. She goes on to say 'You want someone to make everything disappear and you just want to feel reassured and you want to feel that everything is going to be better but I can't tell you how long it is going to take to get there and we also don't know what that really means for you personally and I think before I started therapy I had this maybe idealised view in my mind of what the outcome of therapy would be, which is being completely stable, not experiencing anxiety or depressive feeling at all…… Maybe the change is that going into therapy I had some expectations and now it is like I think those expectations are pointless. It is just going to be what it will be, and that is okay.' Similarly, Chloe notes a more realistic expectation of therapy, although for her this is how she begins her therapy, not having to give up the notion of something more idealistic, 'I have no like notion that everything is going to be better after like six months of therapy, or that I'll be cured. But if it is better, I think that's fine.'

Aisha, Batseba, David and Eric all spoke about the length of their therapy. Both Aisha and Chloe noted that the process felt long and that it could be very challenging to hold progress in mind, Aisha explains, 'I have been doing this for how many months now and I have made progress in all of these areas but why is this stuff happening and when is it going to stop

happening?' Aisha was also the oldest of the participants and was on the cusp of entering employment, something that added an extra element of pressure and the need for improvement before finishing her therapy. Chloe adds that 'I mean I think it is better but I know for a fact that I still have a long way to go. I am emotionally unaware of myself.' Eric noted the importance of being able to manage frustration and to endure and not give up and he says 'Um, and there would be ups and downs, there were times when I did feel that it wasn't working as effectively, um, sometimes. Then that would change and it would come back, and just stick with it. It is supposed to be a slow process it won't be quick but it is absolutely worth it.' (p. 5) For Batseba the length of her treatment was felt to be positive from the beginning, but her being able to hold onto what had happened she found challenging

'Um, and so I think while the length of time has definitely been beneficial to me, I can sort of see where it could be an issue. Where my therapist does that link is helpful because it allows me to remember the sessions.'

The third part of the feeling of frustration developed around the notion of the wish for certainty. Aisha has spoken throughout the interview of clinical diagnosis and the different ways that she has experienced this. In the beginning she is very surprised at how quickly she is given one (when she travels to do a year abroad), subsequently going on to question whether it is the right one and then describing her frustration at not getting a diagnosis in this last intervention 'One thing that I do find really annoying is that I just want to know what is wrong with me, like I would really just like to have a clear diagnosis.' Aisha says that she understands her therapy is for thinking about her experience but it is evident that in moments there appears to be a real draw to the idea of something more concrete. This tension between the wish to know, represented by the medical model of diagnosis and medication, and the ability to bear uncertainty, appears throughout Aisha's narrative. Chloe notes that she thought, based on media representation, that mental health began with a diagnosis and then a treatment, often involving medication. When this is not what she experienced she says that she found it 'surprising'. She felt that as she was 'underage' it would be concerning to both her and her parents if she was medicated with something like an anti-depressant for low mood and her talking therapy was therefore a reassuring way for her to explore and improve her mental health. This concludes the experiences of managing the inevitable frustration generated by the process of therapy and I will now go on to look at the last of the PETs, Benefit and hope.

4.2.5GET 5:Benefit and Hope

All of the young people spoke about whether they felt that therapy had been beneficial to them, some feeling more frustrated with the process as described in the PET above, ‘Managing frustration’ and others, David, unsure of what to credit a shift in his thinking too, was it his therapy or a more developmental progression that would have occurred without his therapeutic input?

Aisha and Batseba recognised a feeling of being able to think in the moment as one of the benefits of therapy. The therapeutic relationship had enabled them to explore what happened when two people came together and for them to then take this understanding back to their friendships and other relationships. Significantly, a break, the Christmas break, generates a feeling of what therapy has done for her Aisha and she says ‘By the time I had the Christmas break and I came back it made me really appreciative of what therapy was giving me because I felt the difference of having therapy there versus not having it and I just kind of thought, even though it is really hard it is just worth it, like I am not going to feel like amazing while I am doing it but I now have more trust that it is doing something because when it isn’t there how much I have to rely on other things to support me.’ There is a sense of something being internalised, a containing presence of her therapist which precludes the need to look for something else to sustain her. Batseba talks about taking something from her therapy back into relationships too and how she is now able to be less reactive and more thoughtful and understanding of herself ‘Even discussing it on the plainest level (in therapy), just having those thoughts in the front of my mind just meant that in turn I could sort of pick up on things and notice them before they, before my anger got to a point of snapping at someone or before my anxiety got to a point of panicking.’

Chloe spoke of the hope of achieving this capacity for thinking and noted that her mental health had an impact on both herself and those around her and she includes this in her hopes for her therapy ‘I just want to get better in the sense that I want to know more about myself so that when I engage in behavioral thoughts that are not good, I can catch myself and stop it and try and minimize the effects of it on me and the people around me because I think that it is why I go to therapy.’ She adds that participating in this project and reflecting on her therapy have made her understand the importance of her therapy and how it has changed some of her thinking, noting ‘Like I don’t really think about it outside of psychotherapy but when I go to therapy it kind of forces me to take stock and think, have I been okay this week, like am I alright, what is happening. I’ll sometimes, because I have really large mood swings, I won’t even realize how much my mood has changed or how I am feeling until I go to therapy and my therapist is like, what’s up? How are you feeling? And

then I'm like, actually ……I think that is good.' Perhaps through the remaining part of her therapy, like Aisha and Batseba, this more reflective capacity will happen without the prompting from her therapist.

Although David's experience of therapy is dominated by feelings of frustration and obligation he does however note a shift in his mental health and how it is difficult to know how this shift came about 'Honestly, I am not sure, when I have been asked whether it has made an impact, I am never really sure of how to answer. I mean on the one hand I still feel the kind of obligation to attend but on the other, um, the kind of emotional problems are still there. I suppose in terms of behaviors there has been a slight change but ah……. well, I haven't self-harmed in quite a while and I do kind of tend to be a bit more firm in avoiding suicidal thoughts, the kind of thoughts that would distress me. But I can't be sure if that is the therapy or me having a long-term experience with those behaviors and they are growing with me.' Similar to Aisha and Batseba, David has also become more aware of what his thoughts are and how he then pre-empts something more destructive happening by 'being firm' with himself. For David his mental health journey has been long and perseverance an important part of overcoming his difficulty, he notes that although he can feel despondent in moments he is 'still willing to put the work in'. Thinking about the rest of his therapy he notes, with a wry laugh, that he hopes that it will be 'good' and he verbalises a real wish for more of the moments that catch him off guard, that run counter to the predictable and challenge him to think in a different way. Although David struggled within his relationship with the therapist and the team, he was able to notice something warm and welcoming in the more benign members of the clinic, the reception staff, which he spoke of as being friendly and helpful.

Eric also noted that the benefit of therapy had come about in the relationship with his therapist and unlike David he had a less complicated relationship with his therapist saying 'Um, obviously I found it very helpful. Like having my own space where I could say anything to another person and I knew that I would be heard and listened to.' The relationship with his therapist provides a deepening of the space that he was afforded, a space in her mind and time with her in which to say the things that 'were in my head and that most people would not have the time for. Um, that helped me a lot.' His incentive for participating in the research project was formed from a feeling of generosity for the help that he had received and that he wished to reciprocate 'I felt so grateful for what they had done for me. Um, and I thought that by doing this it might help someone in the future get over their problems. Yeah, I wanted to feel that I could give something back.' (p.7). At the end of his therapy Eric described a sense of peace or calm after a session, explaining that he had a feeling of breaking himself down during the week and then working with his therapist to put the fragmented pieces together. Through the course of the work Eric felt that his identity changed from that of a 'patient to a

person' and he noticed a re-orientation, away from something more insular towards a feeling of being more interested in others. I want to link this to the way that both Aisha and Batseba noted the taking away from therapy an experience that they then utilised in other relationships, for Aisha and Batseba this was the ability to think and reflect in the moment while for Eric we have him being interested in others just as his therapist was curious about his mind. He says 'I could say anything to another person and I knew that I would be heard and listened to and like someone else was just watching and keeping an eye on me and making sure I was okay.' (p. 3). This concludes the Findings of the project and I will now begin the Discussion, linking theoretical concepts to the findings.

5.Discussion

In this chapter I will consider how the material of my qualitative analysis stands in relationship to the published literature presented in Chapter 3 and the conceptual framework of psychoanalysis that I adopt as a clinical practitioner. I will note points of contact and possible divergence across these realms, drawing out answers to my title question where possible. I will discuss three Group Experiential Themes in detail below, selected as they were strongly represented in the cross-case analysis and had been conveyed to me during interviews in a way that signified these were important and powerful parts of the experience of psychotherapy for the young people who participated in the project. I want to ensure that the participants' voices and experiences are kept in mind during this discussion, so have included brief excerpts from the interviews to make clear links to this central data.

5.1 GET 2: Recognising a firm framework

The idea of the therapeutic framework encompassed two aspects, one external and more concrete, and one more internal, a frame of mind. The concrete elements include matters such as the building of the clinic, the time and duration of the sessions as well as their regularity. These aspects provided a physical containment for the therapeutic work and delineated it from other aspects of the young people's lives. It served to prepare them for what lay ahead in the session as well as providing an opportunity to 're-calibrate' (Batseba) after the session and re-join their everyday activities, taking what they had experienced in their session to the relationships they had in the world.

The second aspect of the framework is provided by the mind of the therapist and her links to her therapeutic modality, how she works clinically (this will be discussed further in GET 2, 'Recognising the importance of the therapeutic relationship.'). I would like to connect this idea of the containing framework to the work of Bick (1968) and her paper *The experience of the skin in early object relations*, in which she describes the function of the skin as an early container for the disparate parts of the self. I wondered whether the physical containment mentioned above as well as the containing mind of the therapist provided the young people with what was a very important function, the initial holding together of different parts of the self and containment of anxiety during the early stages of their therapy. Eric spoke of the importance of knowing when his session was-every Friday- and how this held the function of reassembling the fragmented parts of the self that had occurred during the week: he says 'that (therapy) would always kind of put me back together.'

Aisha uses the word ‘contained’ in her narrative saying that ‘When I was in therapy it sort of felt contained because you go to this building, you are in the same room every time’ and Eric also notes the comfort and reassurance of being in the clinic, taking a moment before the start of his therapy to relax and listen to music. Each young person is assured of the space in the building and the space in the mind of their therapist. In addition to the idea of containment it is important to add the notion of reverie as described by Bion (1967) which allows for the transformation of Beta elements (unprocessed sensory input) into thoughts in the presence of the thinking mind of the therapist. This process allows for the experience to become thinkable and to be put into words in order to communicate this to another, something Chloe, Batseba and David spoke about in their interview, the challenge to find the words to express what they felt and how, at times, it felt very challenging to get a satisfactory fit between words and experience.

I have discussed the containing function of the clinic building, time, and regularity as well as the mind of the therapist but, it feels equally important to mention the minds of the young people, their internal states and how this influenced their perception of containment, something that I noticed shifting and changing through the course of the interviews. In order to do this, I would like to use the concepts of the ‘paranoid-schizoid position’ and the ‘depressive position’ as developed by Melanie Klein (1946). Bott Spillius et al., 2011, in *The new dictionary of kleinian thought* note that the paranoid schizoid position is characterised by a group of anxieties and defences that are present from the very earliest days of the infant’s life. Although they more commonly first transform in the young child and shift to the depressive position, they may be re-visited on occasion well into adolescence and adulthood and make an appearance at any stage of life when in a state of anxiety or distress. Splits between ‘good’ and ‘bad’ are common, and the bad are experienced as hateful and persecutory. I would like to give an example of this state of mind in one of the young people in relation to the framework and have chosen Aisha to do this as she describes both positions clearly. As mentioned previously she initially observes the framework, noting how it is implemented and the words she uses are matter of fact. However, when she talks about the experience of time in the beginning of the work she says that ‘there was literally a clock on the table’ (the words were used to convey a feeling of time as persistent, something that no matter the content of what she was speaking about, held ultimate authority in when the session ended) and that she would be left in a ‘state’ at the end of the session as she had not gathered herself together enough to face the world again. These two examples fit with Klein’s (1946) description of the paranoid-schizoid state of mind, the tendency to feel more persecuted by objects, in this case the clock. Interestingly, at other times there is a feeling of gratitude for the length of time offered to her, time here feeling generous and falling in the

scope of the depressive position. Batseba spoke of the idea of the length of her therapy (psychoanalytic psychotherapy commonly lasting for at least one year) as helpful even before she started, feeling that she had enough time to explore what felt important, she was then able to approach her therapy in a less anxious, defended way, a more depressive stance.

In the paranoid-schizoid position the object can be both idealised and denigrated and we can see this in the wish for the perfect therapist as well as wanting to be the perfect patient (and, perhaps due to being in the training phase, clinicians might too have these feelings of wanting to be the perfect therapist, particularly trainee psychotherapists). Both Batseba and Eric spoke of getting frustrated or angry in their sessions, Batseba saying 'don't feel like you have to be this like, the perfect patient' and Eric noting how things got 'heated' in some of the sessions. One of the young women wondered whether it was in fact very helpful to bring these different parts of the self, allowing herself to be seen in this less than perfect light by her therapist, the notion of the good and bad residing in the same object, her therapist and herself.

Linked to the idea of idealisation and denigration, for some young people, there seemed to be an unrealistic expectation of the outcome of therapy (Aisha expecting to be 'reborn again'). However, to be more in touch with reality and the combination of the loved and hated, perfect and imperfect, however painful is a move to a healthier position as Spillius et al., 2011 explain:

> 'If the confluence of loved and hated figures can be borne, anxiety begins to centre on the welfare and survival of the other as a whole object, eventually giving rise to remorseful guilt and poignant sadness, linked to the deepening of love' (p. 32).

We can see an example of this in two of the participants, Eric and Aisha, who wondered about the lives of their therapists and spoke of a concern for their wellbeing, Eric saying that it must be 'quite hard' to be a therapist and Aisha explaining, 'I think it is really valid to worry about this person that you are really close to but know nothing about.'

Aisha, Batseba and David all noticed and commented on the framework that their therapists appeared to be working in. For Aisha and David they noticed this particularly in the transference interpretations, Aisha giving a verbatim interpretation in the course of the interview. I will discuss transference more in the next GET, 'Recognising the importance of the therapeutic relationship.' For Batseba this new way of thinking in a psychoanalytic framework gave her an opportunity to think together with her therapist in a different way, and although initially challenging, became refreshing and creative. Bion (1961) suggests that in order for thoughts (pre-existing) to become thinkable, they need to do this in the presence of

a containing mind, for Batseba, the mind of her therapist. David however noted the lifeless quality of the way his therapist spoke, the predictability of the transference interpretations shutting thinking off for him. Bion (1967) writes eloquently about the importance of truth in the analytic encounter. He was of the opinion that there are moments in which theory or even supervision could stand in the way of something more direct and spontaneous in an analytic encounter. He adds that it is perhaps when we are confronted with 'not knowing' something that we might draw on theoretical knowledge in a less helpful way. Perhaps just as David's therapist might have drawn too heavily on his theoretical framework, I would also like to explore David's way of experiencing the interpretations more, linking this idea to that of the paternal function, something that I will develop in the next section.

5.2 GET 3:Building a meaningful relationship

In the second Group Experiential Theme, 'Recognising the importance of the therapeutic relationship' I will be discussing aspects of the therapeutic relationship, the cornerstone of the experience of psychoanalytic psychotherapy, and, through the transference and countertransference, where a lot of the work and potential change happens. I hope to discuss the different parts of this relationship, connecting where pertinent to the ideas in the previous GET1 'Recognising a firm framework', and will do so in the following order, a wish to be more merged with the therapist, ideas of separation between the young person and their therapist, the notion of links with people outside of the dyad (triangulation), the paternal function and the transference.

The relationship with the therapist is something that intrigued a number of the young people, Aisha, Batseba, David and Eric mentioning this explicitly. Chloe noticed that she was able to think about her feelings more closely in the company of her therapist, and that it was hard to keep in touch with them in the same way when by herself. Each of the relationships felt important but not without complexity as the young people struggled with the notion of how to connect. This project sought to understand the experience of young people between the ages of sixteen and twenty-five and this developmental period presents very particular ideas of connection and independence. I noted the work of Waddell (2018) in the Introduction (p. 9) and her description of the 'liminal' position of the adolescent and the way in which previous identifications are relinquished as others are explored. A significant part of the work of the adolescent is to change position from the family unit, the more dependent stance, to that of full membership of the peer group accompanied by a sense of developing independence and sexuality (while retaining links with the family).

Noting how the participants in this project explored their relationship with their therapist therefore feels particularly important as some expressed a wish and pull to a more merged relationship with the therapist, something running counter to ordinary adolescence, Aisha saying 'for a while I just wanted us to think the same way', this idea of how to relate perhaps being more typical of a younger child or even an infant. This way of relating precluded the necessity to have to use words to communicate and conveyed a wish to be magically understood. Hopkins (2014) in her book entitled *The dangers and deprivations of too good mothering* speaks of how responding too closely to the needs of an infant (or adolescent in therapy) can arrest development and impair a fully developed sense of self and other. Bronstein and Flanders (1998) note that the management of anxiety in adolescents when they ask for therapeutic help is crucial in allowing this space to think, something that is not possible if the pull to merge with the therapist feels too strong to resist. In the merged state there is also a negation of any difference, complexity in the relationship as well as sexuality and the complications that this might present to the dyad of therapist and patient.

In order to think together in a different way two separate minds have to come together and I would now like to return (see p. 6) to the ideas of Ronald Britton (2004) from his paper *Subjectivity, objectivity and triangular space*. Britton (2004) explores the idea of how a baby begins to relate differently to their objects when a 'third' is introduced. The dyad of mother/carer and baby is extended to include something that occupies the mind of the mother other than the infant. Britton explains:

> 'If the link between the parents perceived in love and hate can be tolerated in the child's mind, it provides him with a prototype for an object relationship of a third kind in which he is a witness and not a participant' (p.48), he continues 'This provides us with a capacity for seeing ourselves in interaction with others and for entertaining another point of view, whilst retaining our own' (p. 49).

While Britton (2004) speaks exclusively about the 'third' being the partner of the mother, we can also think of the theoretical framework and additional clinical supervisors as fulfilling this role for the therapist and her linking up with these, providing an opportunity for the young person to experience and develop the capacity to tolerate a 'third' and therefor a different perspective.

As mentioned above in GET1 'Recognising a firm framework' (p. 59) I would like to think about how David responded to his therapist linking up with the 'mysterious team' and how this feeling influenced his thinking about the transference interpretations. For David the feeling was one of exclusion (from the couple, therapist and team) and wondering what was being said 'behind my back'. Although difficult to identify exactly what was coming from

whom, there appeared to be an uneasiness with the connection between his therapist and the team, something that he experienced as sinister and unhelpful and left him in a position of not being recognised as a capable young person. This is in fact one of the points at which David uses the term ‘infantalised’ to describe how he felt. During the course of the interview David mentions two different connections outside of the one with his therapist, the first being with the assessing clinician, something that he observed as follows:

> ‘The woman that I had who was doing the initial interviews was, I had a very good experience because she was very good at kind of very flatly putting what the consequences of what I was saying were. The kind of logical conclusions and statements. I was hoping for something along those lines, something kind of more analytical, I guess.’ (p.7).

The second connection was with the reception staff in the clinic and he notes how friendly and welcoming they were. Interestingly all are women and I wondered about David wanting me to know that he too could couple up with different people, to the exclusion of his therapist. This clearly represents the Oedipal Complex as first described by Freud (1899) in the book *The interpretation of dreams*.

This leads to the concepts of the ‘paternal function’ which is clarified by Faimberg (2017) who speaks of the trajectory of thinking about the paternal function, the role of the father, from Freud to Winnicott. She notes that ultimately the paternal function is to separate the child from the mother and notes that the ending of the session is one of these separations, the separation from the analytic mother by time. I would like to note the example given in the previous GET, ‘Recognising a firm framework’ and how the perception of time changed, at times reassuring, where the paternal function of delineating structure and boundary is understood as containing and helpful and how at other times it is experienced as cruel and expelling, for example, at the end of the therapy session, or, as in David’s case, expelled from the couple of his therapist and the team.

I noted in the Introduction (p.6) that the manner in which transference is typically taken up in psychoanalytic psychotherapy distinguishes it from other psychodynamic psychotherapies. Freud (1949, p. 26) wrote, ‘The transference, which, whether, affectionate or hostile, seemed in every case to constitute the greatest threat to the treatment, becomes its best tool.’ Klein (1952) continued with this idea and added that ‘It is my experience that in unravelling the details of the transference it is essential to think in terms of total situations transferred from the past into the present, as well as of emotions, defences and object relations.’ (p. 55) In thinking about the transference when working with adolescents in particular Jackson (2017)

writes about the complex nature of sexuality in this population group, the demographic of this project:

> ‘Given the profoundly unsettling nature of this area of work and its capacity to disrupt our thinking and psychic equilibrium, it is easy to underestimate how much we are drawn to avoid, negate and defend ourselves against registering such experiences.’ (p. 6)

As uncomfortable as they are, Jackson (2017) notes the necessity in being able to process and think about them with the adolescent in the room. He adapts a more indirect transference interpretation to include more than just the young patient and himself in the room, wondering whether any of the dynamic happening might also occur with teachers, friends, the therapist, parents etc. Both Aisha and David noted the discomfort they felt when a transference interpretation was made, David wondering why everything was brought back to his (uncomfortable) relationship with his therapist. Jackson (2017) holds the therapeutic frame by working in the transference but does so in a way that is sensitive to the developmental stage of adolescence, the emergence of sexuality and how easily intimacy and sexuality can be confused (p. 7). He observes himself and his countertransference as well as how his patient responds to what he has said as either something settling and thought provoking or exciting in an unhelpful way. Links to his own analysis as well as a clinical supervision group are identified as protective factors in his ability to acknowledge in this difficult area.

For each of the participants in this study there were moments in which they perhaps unknowingly spoke of the transference, how they wished to relate to their therapist in a more infantile way for example, denoting the maternal transference. One of the young people described her relationship with her therapist as an older sibling rather than maternal due to the therapist being younger than she expected. For David (who had a male therapist) there appeared to be a rivalry, in David’s mind each vying for a position with a partner, perhaps something more paternal developing between him and his therapist.

Transference also appeared to occur not only onto the individual therapists, both the maternal and paternal aspects, but also onto the system of mental health provision, which was described as unreliable or inattentive and uncaring, with limited resources, evoking the image of a mother burdened with demand and unable to attend to her child. I wondered about the transference onto me as the interviewer too, sensing at times a feeling of being perceived as part of this system, one young person asking me if I knew how therapists spoke, wanting me to understand the framework and trying to ascertain whether I was part of it or needed to be educated about how it works. I noticed that Aisha used a number of

psychoanalytic terms and concepts when she spoke to me, impressing me with her intelligence but also perhaps wanting very much to be the 'perfect patient' or the 'good girl' with me, something that she felt unable to be with her therapist. On occasion there also seemed to be something more benign, someone with whom the young people could process their experience of their therapy, Chloe saying that she had not thought about how useful her therapy is until thinking through it more in the interview. Four of the participants, all except David, spoke in a way of wanting to reassure and encourage other young people in their therapy, acting in a way similar to a helpful older sibling. I will now turn to the third and last GET to be discussed, 'Managing frustration.'

5.3 GET4: Managing frustration

There appeared to be different sources of frustration for the young people in this project. I would like to describe these further before linking them to the psychoanalytic theory of the paranoid-schizoid and depressive positions as well as to the thinking of Bion (1961) and how he talks about frustration. In his paper *A theory of thinking* Bion (1961) makes a connection between the ability to tolerate frustration and the beginning of thinking. He notes that when expectation, in this case he uses the example of the expectation of the breast when an infant is hungry, is met with the realisation that the breast has in fact not materialised, this produces frustration, 'If the capacity for toleration of frustration is sufficient, the 'no breast' inside becomes a thought and an apparatus for thinking it develops.' (p.179) We can think about Aisha's wish for a merged relationship with her therapist and how this did not happen, leading to an increased separation and ability to think.

In another example of managing frustration Aisha, David and Eric all commented on what getting better might look like, how they initially envisaged this (in a more idealistic way) and how, through the course of their therapy, they amended their thinking to something more in touch with reality, noting feeling more able to manage feelings than not having any challenging feelings at all, for example. They wondered about how much longer the process would be (Aisha, David, Batseba), what they had to manage as they became more aware of their previously unknown feelings (Chloe) and whether they were actually getting better, was their therapy working (David)? Eric grappled with 'roadblocks' in his therapy, and, although frustrating, a learning experience as it mimicked what he was going through in numerous relationships in his life (an example of the transference), allowing him space to think about it differently and shift the way that he managed this. Frustration arose as a result of being more in touch with reality and we can think of this in terms of a move away from the paranoid-schizoid position to the depressive position and, by not evading the inevitable

frustration (Bion, 1961) the capacity to think increasing. I will now turn to the last section in this paper, the conclusion, including the strengths, limitations and recommendations for future research.

6.Conclusion

This ‘experts by experience’ research project sought out and valued the perspective of young people who had experience of undertaking a psychoanalytic psychotherapy treatment. The participants recognised the importance of the framework of the therapy, externally in the form of the building, as well as the day of the week and time of the session delineating the boundary of the therapeutic hour. Predominantly these frameworks were felt to be reassuring and containing, but, on occasion could be experienced as restrictive, for example, when having to end a therapeutic session feeling exposed and vulnerable. Equally important was the recognition of the framework within the mind of each of their therapists, how they worked clinically and held onto their theoretical frame of reference, for example, by the regular use of transference interpretations.

For each young person the relationship with their therapist formed the cornerstone of the experience, encompassing very complex emotions that ranged from anger and frustration to something tender and transformative that challenged previously held beliefs about thinking and ways of relating. The tension between a wish to merge with their therapist gradually being replaced with the idea of two separate people with different, but potentially enriching, perspectives. This separation and thinking in the presence of another facilitated the process of being able to put experiences into words and share them with their therapist (Bion,1962). With the idea of a separation between the therapist and young person, feelings of concern began to emerge about whether the therapist and relationship were robust enough to tolerate difference, as well as anger and frustration. All of the participants spoke of the frustration that they felt at whether therapy was ‘working’, how long it would take and with this they noted the importance of being able to manage their frustration and persevere with the treatment.

As therapy progressed an idealised way of thinking was gradually replaced with thoughts that were more in touch with reality, this included being able to relinquish the notion of being the perfect patient (knowing what to say and being able to communicate this at all times), having the perfect therapist (immediately bonding with an all understanding therapist), and the outcome of therapy defined as making helpful changes and being able to think together with someone rather than expecting a total transformation (one young person initially thinking that engaging in therapy would leave her with a feeling of being ‘born again’). When asked why they participated in the research project they spoke of wanting to give something back as a sign of gratitude for the help that they had received, Klein (1957) explaining this as ‘If this gratitude is deeply felt it includes the wish to return goodness received and is thus the

basis of generosity. (p.24) The participants in the project encouraged other young people to undertake and persevere with their therapy and challenged the stigma of mental health.

6.1 Strengths, limitations and recommendations for future research

6.1.1Strengths

This study has focused on what the experience is like for young people to engage in psychoanalytic psychotherapy, the semi-structured nature of the interview allowing each participant an open forum to speak about their therapy in a way that felt authentic and representative of their experience. This 'experts by experience' viewpoint is rare in the body of research and it allows adolescents, at a time in which there is an increasing sense of autonomy, to communicate what they felt and for this to be heard and valued .

6.1.2Limitations

The richness of the data could be enhanced by increasing the size of the group, this project having five participants. I did wonder whether young people who had a more positive experience of their therapy and who were more engaged could find it easier to agree to participate and how in the future other experiences could be encouraged, could *we* work hard to reach young people who might want to talk about more critical or challenging ideas about their experience and how could we go about recruiting them?

6.1.3Recommendations for future research

As with previous research it would be recommended to build on this body of data and analysis by extending the single format interview to include a follow up interview (this would help to develop the transference more, an important source of information) , as well as to include a group forum to deepen discussion within the group. It would also be helpful to interview young people who have completed their therapy, allowing a period of time for them to process the ending of the work and understanding what internal resources they had developed.

Recommendations for clinicians

This project highlighted the tension between valuing the position of young people in therapy and how their experience is thought about whilst holding the frameworks within which we work as psychoanalytic psychotherapists. Over and above this project in NHS clinics there are various opportunities for young people and their parents to provide feedback on the service as well as service user forums, all important sources of information for clinicians. In

light of this I have noted the way in which adaptations to technique are helpful (p.59) and now want to use the example of transference interpretations further from this project. Participants in this project observed the ways in which their therapists worked through their adherence to a clinical framework, their formulation and delivery of transference interpretations, the cornerstone of our therapeutic work, is perceived differently by young people but there appeared a helpful distinction between interpretations that were felt to be more alive and those given more in the service of the clinical framework lacking the relational aspect, for example, one participant referred to the feeling of a ‘meta therapy’ in which he could predict the response of the clinician, leaving him feeling bored and frustrated. While in contrast another noticed that she was intrigued by a response from her therapist which offered an alternative way of thinking, thinking that offered a different view of a situation, shared between two separate people, coming together in the therapeutic relationship and thinking together, productively. The second experience had a feeling of the generation of something new while the former appeared to end thinking and leave the young person frustrated. In conclusion I would like to link this to the notion of the participants finding the framework reassuring, a firmly delineated place in which to explore challenging experiences.

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8.Appendices

Appendix A:

Ethical TREC Approval

The Tavistock and Portman NHS
NHS Foundation Trust

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

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

Nadine Lewis
By Email

5 December 2019

Re: Trust Research Ethics Application

Title: What is the experience of Adolescents of intensive psychoanalytic psychotherapy

Thank you for submitting your updated Research Ethics documentation. I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee your application has been approved. The assessor had an advisory note to add– the wording of the letter to be sent to participants who do not get to take part due to oversubscription, or if they are deemed high risk, needs revising. Rather than saying 'I will no longer be able to interview you' a softer option might be to say that 'your participation will not now be required'?

You can now proceed with your research.

Please be advised 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.

Best regards,

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

cc. Course Lead, Supervisor, Research Lead

Appendix B

Advert for Participants

Young People's Experience of Psychotherapy

My name is Nadine Lewis and I am a Trainee Psychotherapist at the Tavistock Clinic and I would like to understand what it is like for young people (13-21 years old) to participate in psychotherapy so that we can possibly help future patients. If you agree to participate in this project you will be invited to take part in an interview that will last about one hour. Due to the circumstances that we currently find ourselves in because of the Corona virus, the interview will be conducted either by 'Zoom' or a phone call. All of the information will be confidential and will not be shared with your therapist. If you are interested in participating in the study please can you email me on: nlewis@tavi-port.ac.uk before the 30th of September 2020

Appendix C

Participant Information Pack

Research Project

'What is the experience of psychoanalytic psychotherapy for adolescents and young adults?'

Are you a young person or adult between the ages of thirteen and twenty-five years old who has been in psychotherapy? Would you consider taking part in an interview to help us understand what the experience was like for you so that we may possibly help future patients?

part in a project. This sheet tells you about the study and what will be involved if you decide to take part.

What is the purpose of the study?

In this study I would like to explore the experience of young people and young adults who have been in psychotherapy. You will have an opportunity to express your views and how it has felt being in therapy.

Who is conducting the study?

My name is Nadine Lewis and I am a Research Student at the Tavistock and Portman Clinic. The Tavistock and Portman NHS Foundation Trust are the sponsors of the project and a group of colleagues from the Tavistock and Portman NHS Foundation Trust (TREC) have very carefully studied this project and agreed that it can go ahead.

What will participating in this study involve?

If you agree to participate in the project you will be invited to an interview. Due to the situation we find ourselves in because of the Corona virus the interview will be conducted via 'Zoom' or a phone call and will be a conversation about how it has felt to be in psychotherapy. The interview will last up to one hour and, with your permission will be recorded and written up. I will then identify the main themes of your interview and those that are similar to other participants themes. Because I plan to only interview a small number of people there is a very small chance that you may be recognised

from your direct quotes although every effort will be made to prevent this through anonymisation such as changing names, ages and particular details.

Do I have to take part?

No, it is your choice whether you participate or not. If you do agree to take part you may still decide to leave the study up to a week after the interview. You will have a clear idea by then whether you do wish to continue.

What will be done with the results of the study?

The results of this study will be used in an academic paper and will be discussed with the service that I work for.

What are the benefits of taking part?

You might find it useful to share your experience of psychotherapy with someone else and to have the opportunity to think about what it might have meant to you. In the future it may help to shape and develop the services for young people.

Are there any risks in taking part in this study?

You might find it uncomfortable talking about some parts of your experience and if you have a query about any aspect of the study you could ask to speak to the project leader who will do their best to try and answer your questions.

(nlewis@tavi-port.ac.uk). If you feel that you would like to speak to someone else to help you think further about your concern you could contact Simon Carrington,

(SCarrington@Tavi-Port.ac.uk).

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 1 year 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. The confidentiality of the information you provide is subject to legal limitations in data confidentiality, for example the data may be subject to a subpoena or a freedom of information request. In the event that you, or another person, seems at imminent risk of serious harm, it may be necessary for the researcher to contact senior colleagues to discuss what steps might be needed to address this. 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

Contact details:

Nadine Lewis

nlewis@tavi-port.ac.uk

Tavistock and Portman clinic

120 Belsize Lane, NW35BA

Thank you for considering taking part in this project and reading the information sheet. If you are willing to be interviewed please complete the assent/consent form.

Appendix D

Consent Form

The Tavistock and Portman NHS
NHS Foundation Trust

Consent Form Age 16 and over

Research Project Title: 'What is the experience of adolescents of Psychoanalytic Psychotherapy?'

- I confirm that I have read and understood the information sheet for this research study.
- I understand that my participation in this study is voluntary and that I may still decide to leave the study up to a week after the interview.
- I understand that the interview will be voice recorded in order to ensure accuracy.
- I understand that the information given in this interview could be used for future publication, reports or presentations.
- I understand that any personal data that could be used to identify me will be removed from the transcription and that it will not be used in any publication, report or presentation.
- I understand that the confidentiality of the information I provide is subject to legal limitations, for example the data may be subject to a subpoena or a freedom of information request.
- I understand that because only a small number of people will be interviewed there is a very small chance that I may be recognised from my direct quotes although every

effort will be made to prevent this through anonymisation such as changing names, ages and particular details.

- I understand that in the event that I, or another person, seems at imminent risk of serious harm, it may be necessary for the researcher to contact senior colleagues to discuss what steps might be needed to address this.

Participant's Name (Printed)……

Participant's
Signature……Date……

Researcher's
Signature……..Date…….

Appendix E

Indicative Questionnaire

Participant to be welcomed and thanked. Check that they are comfortable and ready.

Purpose: Trying to understand the big question—what is it like for you to be in psychotherapy? As this is a big question, I have thought up some smaller, more focused ones that will help us to build a picture together.

A little about yourself, and what led you to therapy? Is this your first experience of therapy?

What was it like to be offered therapy? In advance, what did you think might be difficult? Did you have an idea it could be worthwhile? Or even exciting, maybe?

What things have been helpful about your therapy, if there have been some? Were any of these a bit of a surprise? Have these things changed over the weeks?

What things have been hardest about being a patient, if there have been any? Have these things changed over the weeks and months?

What would you tell yourself about this experience of being in therapy, if you could jump back to speak about it with yourself the week before it all started?

I wonder what ideas you might have about how the remaining bit of your therapy might be like.

Can you think about something important, that I've not thought to ask about?

Can you think of something small, maybe even a bit silly? But that *you* know has been a special part of your experience?

Lastly, something about why you agreed to contribute to my study.

Thank you for participating it is very much appreciated.

Appendix F

Example of Interview (David)

David: Um, probably …I don't know. Um, this is a tricky one. I suppose it has been difficult to sacrifice the time.

N: Are you in more than weekly sessions?

David: No, it is only once a week but I live quite far away so it is quite a trip….and it is how I begin every Monday, every week and it is difficult to continue with the day afterwards. I don't know whether to try and brush it off or to spend more time thinking about it which will impact how the rest of the day will go.

N: Are there any other things you would like to add?

David: Um, I guess it is also kind of, I guess it is just a me kind of problem but the infantilizing aspect, um, it does kind of, I don't know how to describe it but it does feel like there is a lot of stuff going on behind the scenes that I am not aware of, a lot of things being spoken about behind my back that I do not have access to. It just kind of comes back to what I mean about me hoping that it would be more straight forward in that I would be presented with the actual kind of, I would be part of the discussion in place of just kind of the subject.

N: When you say that you would like to be part of the discussion, with who do you mean?

David: I mean with the therapist and the team, the mysterious team that works in the offices and has this really private information about me, I would want to know what they talk about, be recognized as someone capable of understanding these things. Um, yeah, I think that is all I have to say.

Appendix G

Example of Tentative Themes (David)