“A transformative journey”

How Child and Adolescent Psychotherapists experience their work with adolescents with depression. An Interpretative Phenomenological Analysis.

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ABSTRACT

This study explores the lived experiences of child and adolescent psychotherapists working with adolescents with depression. In this study, the age group of the adolescents discussed is 13-18 years. In this context, the definition of depression is not limited within psychiatric terms, but includes a variety of presentations, such as long-standing feelings of low mood, hopelessness, lack of motivation, self-harm, and/or suicidal thoughts. Data was collected through semi-structured interviews. Five child and adolescent psychotherapists were interviewed, the experience of whom varied from ten to more than thirty years. Data was analysed using interpretative phenomenological analysis (IPA). Five group experiential themes emerged from the data analysis across five interviews: Losing internal compass; Risk changes it all; Reaching the adolescent; Therapeutic relationship is a personal matter; Another mind to think with. The main findings of the study show that the work with adolescents with depression has a significant impact on the therapist, who experiences feelings of hopelessness, incompetency, guilt, rejection and sadness among other feelings. The results strongly indicate that countertransference is a helpful tool in understanding the young person's internal and external reality. Most therapists talked about needing to adapt their psychoanalytic approach, such as transference interpretations, something that raised dilemmas in some therapists. Links between personal and professional life were also made. Finally, risk was discussed as one of the most impactful factors for the therapist which led to findings about the importance of network in managing risk and supporting the therapist.

Keywords: adolescents, depression, child and adolescent psychotherapists, experience, psychoanalytic psychotherapy, countertransference

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INTRODUCTION

The following study aims to explore child and adolescent psychoanalytic psychotherapists' (CAPTs) lived experience of having worked with adolescents with depression. The focus of the study is on psychoanalytic psychotherapy with adolescences aged 13-18. My interest in this subject developed during the second year my work as a Trainee Child and Adolescent Psychotherapist in a generic CAMHS team and an inpatient adolescent unit. Both services worked with adolescents until the age of 18.

During my work in both services, I worked with adolescents with depression whose presentation ranged from no deliberate self-harm, to deliberate self-harm, and/or suicidal Ideation (among other age groups and/or presentations). In the second year of training, I started to notice the impact this work had on me. I realised that each young person elicited different emotional responses in me. There were times when I felt 'burned out' by the complexity of their presentation and their background, and I often found myself trapped in the wish to 'bring back' the liveliness. I realised that I often 'shared' a space with them, in which no thinking was allowed; both of us stuck in a void. At other times, I felt as if I accompanied them on a roller coaster journey, where the primary aim was to survive and contain the anxiety. I learned how to observe myself from a third position and how to observe my countertransference, which often guided me. I would often feel overwhelmed by the material discussed in the sessions or would be worried about the young people's safety from one session to the next. Bringing my thoughts and concerns into my supervision spaces, I begun to understand what my countertransference feelings informed me about the young person's mind and "object relations" (Klein, 1957). An integral part of our psychoanalytic training has been to learn and understand how countertransference (Heimann,1950) informs us about the internal world of the young person, what the child or young person projects into us (Klein, 1946) and how we work with our understanding.

Therefore, I became interested and curious about how other CAPTs experience the work with

the same population. I was interested in exploring how they managed the strong feelings elicited in them, and how this helped them understand something about the young person.

Did they find a way to help the young person change the way he viewed the self, others, and the world?

LITERATURE REVIEW

I used two methods to identify relevant literature for this project: database searches and citation tracking, also known as "snowballing". Before starting any of this, however, I identified key areas that were relevant to my study. They are:

- Adolescent development
- Adolescent depression
- Risk and suicidality in adolescents
- Working with depression and suicidality in adolescents
- Psychotherapists' experiences of working with adolescents with depression

Literature research strategy

When identifying key areas, I started searching for relevant literature on the databases available through the Tavistock and Portman Library website. These were PsychINFO; PEP Archive (Psychoanalytic Electronic Publishing), and PsychArticles via EBSCO. Together, these hold an extensive collection of psychoanalytical literature.

The first step was to identify key search terms for the concepts mentioned above, and to create a list of synonyms for each key term. I applied an asterisk (*) in place of the word endings in order to broaden possible results. Boolean operators were used to create advanced searches by

combining synonyms with the "OR" function, which I then connected with the next term(s) using the function "AND". I did four different searches, combining different terms each time (see examples below).

Search 1:

adolesc*	AND	**depress***
'young people'		'low mood'
teenag*		'Mood disord*'
'young person'		
youth*		

Search 2:

suicid*	AND	**adolesc***
risk*		'young people'
'suicid* ideat*'		teenag*
'self-harm'		'young person'
		youth*

Search 3:

psychother*	**AND**	**adolesc***	**AND**	**depress***
Psychoanalyt* psychother*'		'young people'		'low-mood'
intervention*		teenag*		'Mood disord*'
therap*		'young person'		suicid*
'psychoanalyt* techniq*'		youth*		risk*
'psychodyn* psychother*'				suicid* ideat*
				'self-harm'

Limitations were applied to ensure the following inclusion criteria for the literature findings: Literature only in English language; year range 1960–2023; peer reviewed; subject major

psychotherapy, and age adolescence 13–18 years.

There exists an array of psychoanalytic literature and research on adolescent development, adolescent depression/suicidality, and psychotherapy with adolescents. However, the main focus of this study is on the psychotherapist's experience of working with this particular group. It is worth noting that a literature search combining the term "experience" and its synonyms in search combination 3 did not yield enough results. Among the very few results, none was a study. The process of narrowing the findings I would use for the literature review was long and sometimes complicated. I had to keep in mind the research question of my study in order to avoid expanding into less relevant topics.

Adolescent development

Blos (1962) describes adolescence as the psychological dimension of puberty. In this context, the term "puberty" signifies the physical changes associated with sexual development, such as the time just before the emergence of primary and secondary sexual characteristics.

The elucidations of early childhood linked adolescence genetically to earlier periods of life; thus, puberty was instated into a continuum of psychological development. We came to recognise adolescence as the terminal stage of the fourth phase of psychosexual development, the genital phase, which had been interrupted by the latency period. (p.1)

Blos conveys that adolescence is not tied to physical growth and timing can vary between individuals, suggesting that each person's experience of adolescence is unique and does not always directly correlate with the physical changes of puberty. Waddell (2002) describes how, "adolescent states of mind may be found in an 8, 18, 80-year-old. The mental or psychological period between childhood and maturity does not necessarily occur at the time traditionally defined as 'youth'" (p. 140). Arnett (2015) adds that although there is a defined start of puberty, there are no definite indicators of the end of adolescence. Adolescence is not a time of turmoil in all cultures, suggesting it is a culture-specific, rather than a universal,

phenomenon (Mead, 1943). Similarly, Briggs (2008) argues that some adolescents succeed in negotiating adolescence, their relationship with their parents is not interrupted, and they do not necessarily experience symptoms of psychological distress. Briggs further argues that it is important to consider the wider social context in which the adolescent belongs, especially in terms of race, class, gender, and sexuality. Moreover, relationships with parents play a significant role in tolerating the conflicts and helping the adolescents make sense of them. As Briggs (2008, p. 7) phrases it: "these relationships are founded on a bedrock of stability throughout childhood and reflect the integral nature of qualities of negotiability and trust on both sides."

It has been widely highlighted that teenagers are faced with a sense of loss of childhood whilst entering the unknowns of adulthood. Waddell (2018) describes adolescence as not only a turbulent period, but a creative stage during which the personality flourishes as one experiments with different interests and relationships, and experiments with dependence and independence. Preoccupations with identity is another central characteristic of this period, which often comes with a strengthening of ties to a specific peer group. This has crucial importance in the development of the adolescent as it allows them to explore different aspects of his personality. Winnicott (1958) talks about the young child's capacity to be alone, which stems from the experience of feeling safe while alone in the presence of their mother. Good (enough) early attachment relationships provide the necessary safety for the adolescent to endeavour new relationships and independence.

Waddell describes the essence of adolescence as follows:

> Although often not recognized as such, the process of adolescence is one of moving into a world where everything is in flux. At a time when bodies, feelings, impulses, familiar selves are all changing, these young people are also having to deal with the social changes and with new, exciting, challenging, and anxiety-provoking responsibilities for organizing their lives and thinking about their futures. They are

> forming new relationships, making friends, facing big decisions. And all this is going on under the sway of the enormous hormonal upheavals of puberty and the resulting intensification of sexual and aggressive urges. The excitement and turbulence are extreme, both thrilling and also by no means always welcome. (p. 35, 2018)

Waddell here highlights that the emotional life of an adolescent is complex due to the intensity of their search for identity, combined with the loss of childhood in their journey towards adulthood. Intense emotional experiences are often characteristic of adolescence, which is now better understood due to research on the brain development of adolescents.

Neurodevelopmental perspective

The neurobiological understanding of the adolescent brain has provided a clearer view of what makes adolescence unique, and show that the emotional experiences and behaviours of adolescents can be explained on a biological basis. Guyer and colleagues (2016) discuss how the emotional experiences and behaviours of adolescents result from a complex interplay of neurobiological mechanisms. They explain how both external environmental factors and neurodevelopmental changes in the brain influence these behaviours. The adolescent brain undergoes rapid developmental changes that impact emotionality. These changes are crucial for emotional regulation, social interactions, and learning. Moreover, these neurodevelopmental changes differ between individuals, and impact on the mental health of the adolescent, such as depression and anxiety. Though Guyer and colleagues' review explores the significant role played by environmental factors, the study could have benefited from including a more diverse cultural perspective. Exploring how different cultural environments and expectations impact neurobiological development could have added great insight into whether these findings could be applied cross-culturally. Additionally, the authors could have explored how these findings could inform therapeutic approaches.

Blakemore and Choudhury (2006) review the neurodevelopmental changes in the adolescent

brain, particularly focusing on the maturation of the prefrontal cortex and amygdala. They explain how these changes contribute to the emotional volatility and risk-taking behaviours characteristic of adolescence. The prefrontal cortex, responsible for cognitive control, develops more slowly than the amygdala, which is involved in emotional processing. This imbalance results in heightened emotional responses and a propensity for risky decisions. The authors emphasize that understanding these brain changes can help explain the emotional and behavioural challenges faced by adolescents. The review offers insight into understanding the adolescent brain, highlighting the need for further research on how genetics and environment influence brain development and behaviour. It also raises questions about the impact of social and cultural contexts on adolescent decision-making and emotional responses.

Music explores the interplay between nurture and nature in his book "Nurturing nature" (2016), which explores how, change can take place despite the effects of experiences of trauma or neglect on brain development and neuronal pathways. Music argues that good parenting can make changes in the brain's pathways possible, as can therapeutic work (p. 94). Patton and Viber (2007) explain that the pubescent brain shows "great neural plasticity" (p.1132), and changes to the brain impact on learning, memory, cognition, and affect regulation. Like Music, they argue that enhanced social and learning experiences can reverse the effects of early experiences. Briggs (2008) suggests that neural plasticity provides what Blos (1967) describes as "a second chance" of development in early adolescence.

Adolescent depression

Until the 1970s, depression was recognised as a disorder only for adults. It was uncommon for young people to be diagnosed with a depressive disorder, as depression was considered inherent to adolescence, which came with "turmoil, adolescent angst, masked depression or depressive equivalents" (Bhardwaj and Goodyer, 2009). Bhardwaj and Goodyer (2009) draw on two studies from the 1970s and 1980s (Pearce, 1978; Puig-Antich, 1982) that show that

depression in adolescents manifests and is experienced in similar ways to adults. The authors also highlight the problem of the disorder not being greatly recognised in the community, resulting in adolescents not accessing treatment. They base this on a study by Rey and colleagues (2001), which also shows that parents and teachers do not easily detect internalised depressive feelings, as opposed to externalised behavioural difficulties. This is also shown by a U.S study by Behrhorst et al. (2023), which focuses on Black youth, and shows that manifestation of early signs of ill mental health, such as depression expressed as anger or aggression, in Black adolescents are not accurately captured by the diagnostic tools, often leading to misdiagnosis or underdiagnosis of mental health needs. They explain that externalised depressive symptoms are associated with stressful life experiences linked to poverty, such as few academic or economic opportunities, but also with parental advice to suppress their feelings in the face of possible discrimination from different racial groups. This underscores the importance of culturally sensitive diagnostic instruments.

In November 2021, the World Health Organisation (WHO) published that one in seven people aged 10–19 suffers from a mental disorder, representing 13% of the total disease burden in this age group. Depression, anxiety, and behavioural disorders are major contributors to illness and disability in adolescents. WHO[1] also identifies that "suicide is the fourth leading cause of death among 15–19-year-olds". It is also estimated that one in seven 10–19-year-olds, that is 14% of this age group, experience mental health conditions globally. WHO also identifies depression as affecting approximately 1.1% of adolescents aged 10–14 years, increasing to 2.8% for 15–19 years.

On the 29th of November 2022, the NHS published a report from their survey on the mental health of children and young people in England 2022, stating that in 2022, 18% of children

[1] https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-healthTrowell and Dowling (2011) reflect on their experience of conducting the Childhood

and young people 7–16 years old had a “probable mental disorder” and 10.8% had a “possible mental disorder”. In 17–24-years-olds, 22.0% had a “probable mental disorder” and 13.6% had a “possible” mental disorder. It is worth noting that for the ages 17–24, young women had higher rates (31.2%) than young men (13.3%). For 17–24-year-olds, an overall rise of rates of “probable mental disorder” was observed between 2017 and 2020, from 10.1% to 17.7%, and no change in rates observed between 2020–2021. However, an increase was detected from 2021 to 2022, from 17.4% to 25.7%. The report also provides statistics on social and economic context, suggested that there is a link between socio-economic factors and the rise of mental health difficulties. However, there was an absence of data on diverse cultural and ethnic groups, raising the question whether the findings give an accurate picture of the mental health disorders across different populations and groups.

Depression Project (Trowell et al., 2007), a randomised controlled trial with particular focus on the family dynamics and patterns observed in the therapies, genetic factors, and individual pathologies in the young people participating in the study. They observe that the majority of children who participated did not manifest their sadness in a straightforward way, but masked it by defiant behaviour or anger outbursts. The authors also express surprise at the difficulties that the families presented with and the intergenerational issues. They found that “the young people were often the recipients of family projections and inappropriate expectations, sometimes related to the past” (p. 243). Similarly, Reiss and colleagues’ 2019 study examines the direct and interactive effects of low socioeconomic status (SES), such as household income and parental education and mental health, as well as stressful life situations on mental health problems in children and adolescents. The findings indicate that children and adolescents from lower SES backgrounds were at higher risk of developing mental health problems.

Understanding depression through a psychoanalytic lens

It lies beyond the scope of this study to present the array of existing psychoanalytic literature on depression and adolescent depression in detail. However, below, I will present some key psychoanalytic ideas on this topic.

In *Mourning and Melancholia* (1917), Freud suggests that both mourning and melancholia are related to the experience of the loss of an important "object". By "object" he means an actual person, an idea, or a relationship. In mourning, there is acknowledgement of loss, which is followed by a period of sadness and bereavement. The lost love object then becomes securely internalised as something with whom the person can identify. In melancholia, by contrast, the feelings towards the lost loved "object" are characterised by ambivalence. Freud suggests that the loss cannot be faced, and the object is internalised and felt as part of the self. In order not to face the anger and guilt that were originally aimed towards the lost figure, the depressive person turns feelings of anger and resentment towards the self. Freud suggests that instead of facing the separation and the consequent feelings of anger and guilt, the depressive person forever "carries" with him the hated object: "the shadow of the object fell upon the ego" (p. 249).

Later, Abraham (1924) would link the vulnerability of some people to depression with hostile components in the infant–mother relationship, as he observed that the way some of his adult patients responded to experiences of loss was an unconscious repetition of early childhood experiences of being narcissistically wounded. Therefore, feelings of hate and aggression are evoked and, unable to face them, the person turns the hate towards the self. Klein (1935; 1940) also links depression with early infant–mother experiences, holding that early experiences of loss, separation, and weaning, among other things, constitute the prototype for the person's response to later changes in life.

Not all adolescents find their transitions from latency to puberty and adolescence to

adulthood hard. However, chances of onset of depression increases at the age of 13 (Lewinsohn et al., 1998; Costello et al., 2006). As Rustin (2009) explains, the adolescent is faced with the loss of childhood and is now called on to become more independent and responsible. The way the adolescent adapts to these developmental tasks might be easier or more painful, especially if there are family difficulties that can become obstacles to their development. Where experiences of trauma exist, this process might become even more complicated and give rise to depressive symptoms. Allen and Sheeber (2009) suggest that lack of emotional involvement and family support increases the chances for adolescent depression. Midgley et al. (2013) similarly suggest that adolescents find the developmental tasks overwhelming when there is insecure attachment with their caregivers and their mentalisation ability is weakened, putting them at risk of a developmental crisis.

Klein (1940; 1946) suggests that the first months of life are marked with "paranoid-schizoid" defences against anxiety, where bad and good parts of the self, split for the survival of the self. In the developmentally subsequent "depressive position", those aspects are integrated, giving rise to feelings of guilt due to hostile feelings towards the loved object. Working through the depressive position resolves the depressive anxieties, as the main worry is the protection of the loved internal and external object. Klein suggests that intolerance of these depressive anxieties might lead to depressive symptoms later in life. The importance of the integration of loving and destructive feelings has been widely recognised within psychoanalytic thinking, as it plays a significant role in one's tolerance of guilt and ambivalence, and aids the development of reparative abilities.

Psychoanalytic theory emphasises the role of the fear of aggression in the formation of depression. Freud's concept of the "death instinct", introduced in his 1920 essay "Beyond the Pleasure Principle", suggests that we have an innate, unconscious drive towards death and self-destruction which operates in opposition to the "life instinct", which is our innate capacity for love. Freud's approach was new, moving beyond the notion that sexual desire is

the main anxiety in the individual's development. Psychoanalytic thinking thus shifted into considering how to tolerate the fear of the consequences of hatred and how to protect both self and loved ones from it. Klein (1932) further develops this idea, and particularly its connection to the early formation of a harsh superego, but it is beyond the scope of this study to expand further on this. Spillius (1994) underlines that analysts trying to distinguish to what extent the self-destructive tendencies are innate or acquired is wrong, as this is not only impossible but might also lead to analysts mistakenly blaming the patient or his objects. She suggests that the focus should be on the "negative tendencies in the present analytic situation" (p. 341), while it is also important for the analyst to monitor whether their behaviour might intensify the patient's tendencies.

A lack of tolerance for aggressive feelings towards a love "object" creates feelings of hopelessness in the depressive person, who turns those feelings inwards. Midgley suggests that adolescents with depression often show difficulties in integrating their aggressive feelings (Midgley et al., 2013). Bion's concept of containment (1962) explores the importance of a mother's, or primary caregiver's, ability to take in feelings and anxieties—he calls this "reverie"—that are difficult for the infant to tolerate, and return them back to her in a way that can be understood and accepted. Infantile anxieties are then modified, and the infant feels protected by her impulses. If this process fails, the infant is left with "nameless dread". Consequently, the greater the lack of internal resources on which the individual can rely, the greater the likelihood for depression to develop. Waddell (2002) points out that the way in which the adolescent manages re-emergent conflicts depends, among other factors, "on the quality of the original containment of infantile impulses" (p. 142). In other words, the adolescent draws on early experiences of being parented and contained.

An integrated psychodynamic formulation of depression is presented in the treatment manual for Short Term Psychoanalytic Psychotherapy (STPP) by Cregeen and colleagues (2017, p18) (which was part of the development of the Improving Mood with Psychoanalytic and

Cognitive Therapies (IMPACT) study (Goodyer et al., 2011) that I will further explain later in this chapter.) The key features as presented in the manual are:

- **Narcissistic vulnerability** i.e. an insecurely founded sense of a separate self

  and heightened sensitivity to perceived or actual losses and rejections, leading to a lowering of self-esteem which in turns triggers depressive affects, existential angst and rage in response to narcissistic injury;

- **Conflicted anger** i.e. anger, blame and envy directed towards others, leading to disruptions in interpersonal relationships, confusion about what the young person is or is not responsible for, and to self-directed anger and subsequent depressive affects; **Severe superego, experience of guilt and shame** i.e. feelings and wishes seen as bad and/or wrong, with doubt about whether the young person's love outweighs aggression, leading to negative self-perceptions and self-criticism and in some cases a confusion between reality and fantasy;

- **Idealized and devalued expectations of self/others** i.e. high self- expectations and/or idealization of others, often switching to sudden de- idealization and devaluation, leading to disappointment, anger at self and others and subsequent lowering of self-esteem;

- **Characteristic means of defending against painful affects** i.e. use of typical defences such as denial, projection, passive aggression and reaction formations leading to increased depression because either the world is seen as hostile or the self is attacked. Splitting would also be a characteristic defence against aggression, which would then not be available to be integrated into the services of personality development.

<u>Risk and suicidality</u>

Suicidality and risk towards the self are often part of the adolescent's depressive presentation.

Laufer (1995) explains the difficult task that adolescents are faced with by looking at the developmental stage they are at. He describes adolescence as marked by significant changes due to factors such as physical sexual maturity, changing relationships, changing expectations, and societal attitudes. These changes can lead to potential trouble areas that were previously balanced during childhood but might fail in adolescence. He further explains that the adolescent must confront the unpleasant realisation that his previous coping mechanisms for stress are now more detrimental than before. For example, a quiet and compliant child reaching adolescence realises that his previous mechanisms are no longer useful to him. Feelings of loneliness, incompetence, or that something is wrong with him arise. Laufer (1995) considers that these are some of the factors that might lead to a psychological breakdown in adolescence, describing it as "a collapse of the earlier ways of meeting various situations of stress" (p. 7). Laufer stresses that the way in which an adolescent manages these difficulties are part of a "continuum" from infancy to adulthood, and that difficulties at each stage can affect the psychological development in later life. Waddell (2018) describes how children who are subjected to neglect, physical violence, sexual abuse, and domestic instability are at a significant disadvantage. According to the Childhood Experiences Study (Felitti et al., 2019), those who have experienced four or more types of adverse experiences during childhood are at four to twelve times higher risk of depression or attempting suicide, as well as other health risks, than those who have not experienced any.

In "The Psychogenesis of a Case of Homosexuality in a Woman" (1920), Freud first described the present dynamics in suicidal behaviour:

> … analysis has explained the enigma of suicide in the following way: probably no one finds the mental energy to kill himself unless, in the first place, in doing so he is at the same time killing an object with whom he has identified himself, and, in the second place, is turning against himself a death-wish which had been directed against

someone else. (p. 147)

Here, suicide is thought of as killing a bad object. Klein (1935) adds that by committing suicide, and killing the bad object, the individual also aims to save the internal or external good object. Anderson et al. (2012) add that suicidal behaviour is dyadic as it represents a relationship between a subject and its object; this relationship entails a loss of the third person. They draw on the Oedipus complex to explain the conflicts of adolescents, and how ambivalent parental attitudes complicate sexual feelings.

Campbell and Hale (1991) made findings that accord with Freud (1920) and Klein (1935) after interviewing 500 adolescents within 24 hours of a suicide attempt, and drawing on their work with suicidal young people. They found that in young people's mind, the body became split off, with one part identifying with the bad object, which is then to be killed off. There is also a phantasy that the surviving part will see what happens after the attempt, or as Robert Hale puts it: "Suicide is an act with meaning and has a purpose, both manifest and unconscious. It takes place in the context of a dyadic relationship, or rather its failure, and the suffering is experienced by the survivors, or rather, part survivors, of the suicide attempt." (Briggs et al., 2009, p. 14)

According to Anderson (2002), male suicides exceed female ones with a ratio of 2:1. This ratio is even higher in adolescents, at 3:1. In Europe, suicide rates among male adolescents aged 15–24 have increased by 75% since the mid-1990s (p. 65). When Anderson's book was first published, suicide constituted the biggest cause of death for adolescents after car accidents. The studies that Anderson draws upon show that risk factors for young men are drug and alcohol misuse, social isolation, bad economic circumstances, history of bullying and sexual abuse, among others. For young women additional factors include difficulties with socialising and sense of self, and family problems. A more recent study (van Velzen et al., 2022) attempts to retrospectively identify risk factors for attempted suicide in outpatient care and predict which young people with severe and complex depression did or did not attempt

suicide. By using sociodemographic, psychosocial, and clinical variables, they found that risk factors were suicidal ideation during outpatient care, suicide attempt prior to receiving care, changes in appetite, parental separation, and parental mental health difficulties.

In a study conducted by Anderson et al. (2012), seven experienced child psychotherapists in a CAMHS team in Essex used a post-Kleinian psychoanalytic approach to make an extended assessment of young people who deliberately self-harmed (DSH) or presented with suicidal behaviour, and their parents/carers. Analysing the data using Grounded Theory and aiming to provide "explanations, interpretations and predictions in relation to the behaviour studies" (2012, p. 131), they endeavoured to refine the risk assessment process and inform the care pathway, drawing on their findings linking family circumstances, suicidal ideation and cognition, and the nature of DSH. They formed four major theoretical findings with regards to the young person's presentation and family circumstances: when the suicidal young person and the family hold different perceptions of reality; when the truth is hidden (e.g. hidden sexual abuse from a family member); when a truth is revealed without a containing environment, and when a truth is revealed but it is possible to be thought about. The findings of the study are extensive and multi-layered, going beyond the scope of the present project, but it is of note that Anderson et al. (2012) here aim to provide a "map of the psychological territory" (p. 142) in order to help clinicians gain further understanding and form the care pathway for a future "life worth living" (p. 142). The study also highlights that current theories and risk factors do not indicate which people are at risk of suicide or deliberate self-harm, and the theoretical links between family relationships and suicidality do not suffice for prediction. They further highlight that only previous attempts of suicide or suicidality, as well as media reports of suicidality are linked to further acts of harm towards the self. This shows the nature and unpredictability of suicidality and the dilemmas and difficult situation the clinicians faced when working with the suicidal adolescent.

Psychoanalytic psychotherapy with adolescents with depression

The National Institute for Health and Clinical Excellence guidelines (NICE, 2019) for the treatment of mild and moderate to severe depression in adolescents suggest a step-by-step approach to treatment. They recommend a careful assessment of the presenting symptoms, while the first- line treatments are Cognitive Behavioural Treatment (CBT) and medication. NICE guidelines recommend psychodynamic psychotherapy if the first-line treatments do not meet the clinical needs of the young person. Additionally, the guidelines recommend time-limited psychoanalytic psychotherapy (maximum 30 weekly sessions) for depression when the combined treatment does not prove to be suitable. The guidance also highlights that when clinicians recommend the most suitable treatment, they should consider the preferences of the service user and their families.

Even though my research does not explicitly investigate suicidality, depression and suicidality are linked concepts. When there is suicidality and self-harm in adolescents, NICE guidelines recommend conducting a thorough risk assessment, considering factors like current suicidal thoughts, past behaviours, and family dynamics. Psychological therapies alongside medication are also recommended in specific cases. However, as Large et al (2017) found in adult suicides, half of the suicides were completed by adults who were assessed as low risk. This opens a question about how do we assess and manage adolescent risk, and rather can we *truly* assess risk? These questions need to be considered carefully when providing treatment to adolescents, and surely psychoanalytic psychotherapy can provide a unique approach when thinking about adolescent turmoil.

Psychodynamic treatment[2] has fallen behind other treatments in developing an evidence base

[2] Here the term "psychodynamic treatment" is used as an umbrella term for psychotherapy treatments informed by psychoanalytic principles. Most research projects prefer the term "psychodynamic" to "psychoanalytic", as the latter is regarded as narrower. Of note, in the UK, Child and Adolescent Psychotherapists are trained to provide psychoanalytic psychotherapy, offering intensive psychoanalytic psychotherapy (thrice-weekly), parent work, brief interventions and assessments, among other things.

(Midgley et al., 2017). However, this has been changing over the last decade. Strong evidence came from a randomised controlled trial (RCT) carried out by Trowell and colleagues (2007), which carried out thirty sessions of individual psychodynamic psychotherapy, in parallel with fortnightly parent sessions, and fifteen family therapy sessions conducted over a nine-month period. From thirty individual sessions, an average of 24.5 session were attended, and out of fifteen family therapy sessions, an average of 11 sessions were attended. Both treatments were found to be equally effective at the end of treatment, with three-quarters of participants no longer meeting the criteria for depression. However, a six-month follow-up measure found that the symptoms of participants who had received individual psychotherapy remained alleviated, while the family therapy participants did not. This outcome might suggest that psychoanalytic psychotherapy might be more effective in the long-term for the treatment of depression in children and adolescents.

Trowell et al.'s (2007) findings paved the way for a large-scale, national multi-site RCT, the Improving Mood with Psychoanalytic and Cognitive Therapies (IMPACT) study (Goodyer et al., 2011). The aim was to explore the efficacy of Short-Term Psychoanalytic Psychotherapy (STPP) in comparison with CBT and Brief Psychosocial Intervention (BPI, provided by a psychiatrist or a mental health nurse) in the treatment of adolescents aged 11–17 years old with moderate to severe depression. STPP is comprised of 28 weekly 50-minute sessions provided by child psychotherapists, in parallel with seven monthly parent sessions provided by a different child psychotherapist. The findings suggest that there is no difference in effectiveness of the three treatment modalities, as they all successfully reduced the depressive symptoms at the end of the treatment. In a year's follow-up, there were no significant differences in the effect of STPP. However, it was found that 85% of the adolescents who had received STPP no longer met the diagnostic criteria for depression, compared to 75% and 73% in the CBT and BPI arms respectively. Even though there is not yet enough empirical research to provide guidance as to which depressed young people will benefit from

psychodynamic treatments, the IMPACT study provides significant data on the matter. Goodyer and colleagues (2017) suggested that all three treatments should be implemented for adolescents with moderate to severe depression in CAMHS.

According to Midgley et al. (2012) clinical experience suggests that psychodynamic therapy is often chosen for adolescents with depression, chronic and severe difficulties, and comorbidity, as this treatment does not focus on the reduction of symptoms, but takes the developmental process of adolescence into consideration.

Midgley et al.'s (2017) study on the evidence base for psychodynamic psychotherapy treatment for children and adolescents with various disorders focused on the research published in the period March 2011 and November 2017. They found that more studies were published during this period, three of which were RCTs. The body of research indicates that there is good evidence for the effect of psychodynamic psychotherapy in the treatment of various mental health disorders, but they highlight that more research needs to be done in the future. Importantly, they suggested that in the future there is strong likelihood that RCTs will focus on *how* psychodynamic treatment works, rather than on *whether* it works.

What is it that we do?

Monica Lanyado and Anne Horne (1999) eloquently describe what lies at the heart of all psychoanalytic work, that is, the "constantly evolving relationship between the therapist and patient" (p. 55). They describe how what happens in the consulting room, in the therapeutic relationship in the "here and now", provides insights that lead to change in the young person's internal world and relationships. The main feature of psychoanalytic work lies on the focus that is placed on the unconscious processes that are observed by the psychoanalytic psychotherapist working with their patients. The therapist's aim is to maintain an openness to her patient's psychic experience as observed in the room, but also to draw on her knowledge

of the patient's external circumstances, while attuned to the defences against anxiety that are beyond their conscious awareness (Freud, 1905b).

Melanie Klein (1957) developed Freud's ideas on the analysis of children. Focusing on the internal world of children as manifested through play, she formed her thinking around what of their early and primary relationships—that is their "object relations"—was internalised.

These principles underlie the focus of child psychotherapy work on the transference relationship. The therapist tries to understand who she is in the patient's mind (Freud, 1905); this gives insight into the patient's internal world and "objects relations". These aspects are believed to be present in the way the young person externalises their picture of the world.

So how would a therapist use her understanding of the patient's unconscious communications? Central to this are the concepts of "projection", "projective identification" (Klein, 1946) and "containment" (Bion, 1962). Bion wrote extensively on the ways in which the patient locates—that is projects—the unwanted feelings and parts of himself into therapist. The therapist is thus identified with these characteristics, and the patient unconsciously feels rid of them as they are now attributed to the therapist. The therapist, through her countertransference (Heimann,1950)—her emotional responses to the transferred elements of the patient's way of relating—is able to think about what belongs to her and what to the patient and tries to help the patient think about and understand what has been projected. In other words, the "transference relationship" becomes a "mirror" to the young person's way of relating to himself (and his internal objects) and those important to him. It is important to note that a young person's response to their therapist can also be a response to the real person of the therapist; to the real relationship with the therapist. For that reason, personal analysis is an integral part of Child Psychotherapy training, enabling the therapist to become aware of which emotional responses belong to him and which are elicited by the transference relationship.

Transference work with adolescents can prove to be particularly challenging for both therapist and young person. Ulberg et al.'s (2021) multicentre, observer-and patient-blind, randomised component study looked at the outcome of the influence of transference work in psychoanalytic psychotherapy with depressed adolescents. They recruited depressed adolescents aged 16–18 in outpatient clinics in two different Norwegian cities, who attended 28 weeks of psychoanalytic psychotherapy with and without transference work. Transference work was delivered to 39 adolescents, while 31 received no transference work. They found that both groups marked significant improvement during the study process, finding no significant differences pre-treatment and up to 12 weeks into treatment, or in the one-year follow up. However, from session 12 to one year post therapy, the level of depression had decreased significantly more among the adolescents receiving transference work than the non-transference work group. They concluded that the symptom measure improved more when the adolescents were encouraged to talk about their feelings and thoughts towards the therapist in the "here and now". The researchers rightly concluded that more empirical studies are needed to know what treatment works best for whom, but also to understand what individual factors interact with the techniques of the treatment.

Krause et al. (2020) analysed interview data originally obtained from the qualitative IMPACT-My Experience (IMPACT-ME) study (Midgley, Ansaldo, and Target, 2014) where they analysed interviews of adolescents, parents and therapist participants of the IMPACT study. The IMPACT-ME study explored the participants' experiences of receiving treatment as part of the IMPACT study. Krause et al. mapped outcomes following psychotherapy for depression (Cognitive-Behavioural Therapy, STPP, or a Brief Psychological Intervention). Importantly, participants received STPP treatment emphasised feeling *seen* and *seeing* differently, while also improvements were noted on their self-esteem and self-confidence, and assertiveness, autonomy and identity.

Therapists' experiences of working with adolescents with depression and the literature gap

In reviewing the literature, I first looked at adolescent development from a psychoanalytic perspective as I felt that this was important for laying the ground for my study. I then drew on neuroscientific research focusing on the impact of trauma, while also looking at socioeconomic factors on the formation of depression in young people through relevant quantitative research studies. I felt that linking psychoanalytic thinking on adolescent development with neuroscientific and socioeconomic factors—that is, bridging the internal and the external—is especially important at the current time. There is a vast number of papers on adolescent depression. I have outlined important psychoanalytic theories on depression and adolescent depression, as this forms one of the backdrops for my research question. I have also given an overview of psychoanalytic theory and the evidence-base for the effects of psychoanalytic psychotherapy with adolescents with depression.

I found only one study that was somewhat relevant to my research question, that is, the therapist's experience of working with adolescents with depression. Jones et al. (2020) investigate the experience of psychotherapists delivering two treatment modes to adolescents with depression: psychodynamic psychotherapy with and without transference interpretations. This is a small study where they interviewed six therapist, who found that transference interpretations are effective in therapy with adolescents with depression, even though they found the experience challenging. They also share that the technique needs to be adapted to the individual young person. In the conclusion they discuss the importance of training and supervision in order for therapists to feel confident to work differently. This brings up the dilemma that many of us experience when working with this demographic: how creative can we be in our work with adolescents without feeling we are losing the psychoanalytic frame? Much of the literature on psychotherapy with adolescents (Briggs, 2002) emphasises the importance of the therapist responding to the developmental and

therapeutic needs of the particular young person, rather than religiously adhering to a particular model of therapy. I found several studies on the experience of adult psychotherapists—not specifically psychoanalytic psychotherapists—working with adult patients with different mental health disorders, such as schizophrenia, but I found that they did not offer much relevant information for my research.

I found one relevant study (Tanzilli et al., 2024) that explores therapists' (psychodynamic psychotherapists and cognitive-behavioural therapists) responses when working with depressed adolescents. It looks at how the specific personality disorders (according to the Psychodynamic Diagnostic Manual, Second Edition (PDM-2) (Lingiardi & McWilliams, 2017)) among adolescents with depression elicit unique countertransference responses in their psychotherapists. They found that specific traits in their personality organisation and mental functioning relate to specific emotional responses in the therapists. The research found that some depressive presentations (anxious-avoidance personality) elicited warm feelings and emotional attunement in the therapists. The research also found that depressed adolescents who presented with narcissistic personality subtype evoked criticism, annoyance and disengagement. The authors suggest that this dynamic of patient-therapist illustrates the severe difficulties of these patients in forming intimate and reciprocal relationships. Adolescents who struggled with integrating different parts of themselves and others, elicited rage, disorganisation, dread, anxiety, concern and sexual tension, while they formed ambivalent and instable relationship with their therapists. Working with this patient population, who often presented with suicidality, therapists also experienced helplessness, worry or confusion.

Some depressive symptoms in the patients were connected with feelings of worthlessness or devaluation of the self or their objects. The conclusion states that "depressive symptomatology is 'nested' in distinct emerging personality syndromes related to specific levels of mental functioning and personality organisation in adolescence" (conclusion, no

page number). The study highlights that it is important for the therapist to monitor their countertransference responses towards their patients as these might give insight into specific psychological and interpersonal characteristics.

A paper (Per-Einar Binder et al., 2008a), which was part of a larger study conducted in Norway, explored how therapists (nine psychotherapists, eight psychologists, and one physician) experience psychotherapy with adolescents and how they establish a therapeutic bond with them. Even though this study did not focus on adolescent depression, I believe it sheds light on the difficulties experienced by therapists when working with adolescents. The paper discussed that the most common challenges therapists faced were: identifying what the adolescent experiences as their problem and finding a way to work together on it, finding an effective therapeutic role, helping the adolescent find motivation to engage in therapy, creating a shared framework for mutual understanding, and managing ambivalence.

From the same large study, they published another paper (Per-Einar Binder et al., 2008b) that explored how psychotherapists experienced and worked through ruptures in the therapeutic alliance (either when adolescents withdrew from therapy or became less active and showed more negativity towards the therapist during sessions). In this study, most participants preferred exploring ruptures in the therapeutic alliance from the adolescent's perspective, although there were differences regarding how much attention should be given to the therapeutic relationship or to the adolescent themselves. Some participants understood ruptures as a mirror of how the adolescent manages relationships outside therapy. The study discussed that if the relationship is the main focus, the therapist typically acknowledges and validates the adolescent's ambivalence toward therapy. Participants who interpreted ruptures as something caused by issues “within” the adolescent viewed ruptures through the lens of the adolescent’s need for autonomy. Therapists who are more relationship-oriented tend to explore how the adolescent might feel their autonomy threatened within the therapeutic relationship, sometimes interpreting the desire to avoid therapy as a sign of underlying

tension between the therapist and the adolescent. Additionally, some therapists noted that being aware of their own emotional reactions and finding a way to communicate them during sessions helped in addressing and managing ruptures effectively. Both papers acknowledge that they have explored only the therapists' perspective, highlighting the need for future research on the adolescents' experience of the therapeutic relationship.

On a similar note, another study (Morán, J., et al., 2019) explored the subjective experience of clinical psychologists when ruptures occur in therapy. The participants identified several causes of ruptures, including the therapist's failure to recognize the adolescent's experience, the adolescent's difficulty in engaging with intense, overwhelming emotions (which in turn elicit similarly intense emotions in the therapists), initial struggles with the therapeutic purpose on the part of the adolescent, how they perceive the role of the therapist, and finally, when the family obstructs the therapeutic process.

From my review of the current literature, it seems apparent that more research into child psychotherapists' experiences of working with adolescents with depression needs to be done, but even more importantly, future research on how adolescents with depression experience psychotherapy is needed. I hope that by exploring psychotherapists' experiences, further insight into the real struggle of the adolescent might be gained.

METHODOLOGY

Overview

In this chapter, I will describe the design of the study, the rationale behind the chosen methodology, and I will reflect on my role in the research process and data analysis.

Design

This research seeks to examine how Child and Adolescent Psychotherapists experience and make sense of their work with adolescents with depression. Quinn Patton (2002) suggests that "in new fields of study where little works has been done, few definitive hypotheses exist and little is known about the nature of the phenomenon, qualitative inquiry is a reasonable beginning point for research" (p. 193). Due to the explorative nature of this study, a qualitative method was considered suitable. Since the aim of the study is to gain deeper understanding of lived experiences, I used IPA (Interpretative Phenomenological Analysis) to analyse the data, which was collected from five semi-structure interviews.

IPA's origins

The methodological approach of IPA is idiographic, hermeneutic, and phenomenological. In philosophy, phenomenology denotes the study of human experiences, and in psychology "it provides us with a rich source of ideas about how to examine and comprehend lived experience" (Smith et al., 2009, p.11).

Hermeneutics, the other important theoretical underpinning of IPA, offers an interpretation, a meaning, to what specific individuals say within their particular contexts. Whilst the IPA-guided researcher seeks to stay as close as possible to the participants' experiences and their own meaning-making, IPA involves a double hermeneutic process: while the participants try to make sense of their lived experiences, the researcher tries to make sense of the participants' sense-making of their experiences (Smith, J. A., & Nizza, I. E., 2022). Thus, the

researcher is “both like and unlike the participant […] So, in that sense the participant’s meaning-making is first order, while the researcher’s sense-making is second order” (Smith et al., 2009, p. 35-36). IPA is also particularly adept at shedding light on the uncertainty and stresses present in individuals’ responses to what is happening to them. The latter is especially important for the current study, owing to the array of emotional responses explored in the interviews.

IPA is idiographic in focus, meaning that it is concerned with the detailed, nuanced, and in-depth analysis of the individual’s experience. IPA aims to understand the experiences of a particular person in a particular context. However, idiography “does not eschew generalisations. It locates them in the particular, and hence develops them more cautiously” (Smith et al., 2009, p. 29)

IPA recognises that the researcher is seeing the participant’s experiences and sense-making through their own experiences. Therefore, the researcher’s own biases and assumptions will influence the data, which needs to be reflected upon. This will be expanded on in more detail below, in the section on reflexivity at the end of this chapter.

Rationale for choosing IPA

Before choosing IPA as the most appropriate methodology for the current study, I considered other qualitative methodologies. Thematic analysis emphasises patterns/similarities across the data, so it would not give as in-depth an analysis of each participant’s unique experiences as IPA. Given that my research inquiry was investigating an experience involving psychoanalytic work, a framework interested in dept of experience, I felt IPA was a better fit. I also considered grounded theory, which aims to develop an explanatory-level account of the matter explored. Creating explanatory accounts may have provided suitable data were the research questions focused on answering a “why” questions, for example. ‘What key aspects of clinical work do CAPTs ascribe to

therapeutic change in their work with depressed adolescents?'. The current research, by contrast, was aimed at capturing unique characteristics of CAPTs' experience, which the idiographic lens within IPA affords.

Ethics and ethical considerations

The study required ethical approval from the Tavistock and Portman Trust Research Ethics Committee (TREC) since I have aimed to solely recruit Child and Adolescent Psychotherapists registered with the Association of Child Psychotherapy.

The study examines the experiences of psychotherapists with a minimum of five years' experience post-qualification, knowing that the interview process might elicit more intense feelings in a newly qualified psychotherapist or a trainee than a more experienced psychotherapist. As it happened, all participants had a minimum of ten years of experience as qualified psychotherapists, so did not expect the interview to evoke unmanageable emotional responses. However, due to the depth of the themes discussed, the participants were made aware that they could contact my supervisor should they needed to speak with someone.

The process of data safety followed the ethics guidelines and the University Data Protection Policy. This is fully described below.

Research sample

IPA research focuses on the detailed examination of individuals' experiences. The sample sizes of an IPA study are therefore usually comparatively small, as it "benefits from a concentrated focus on a small number of cases" (Smith et al., 2009, p.51). Due to its idiographic focus, an IPA study aims towards quality over quantity.

With this in mind, I planned for a sample size of five to six people. Sample homogeneity facilitates in-depth exploration of the psychological differences between participants,

allowing commonalities and differences to be also analysed as appropriate. Another rationale behind this sample size was the limited timescale of the project. The inclusion criteria for participating in the research were the following:

- Being a qualified member of the Association of Child Psychotherapists (ACP).
- Having been qualified for at least five years.
- Have worked in a CAMHS and/or Tier 4 adolescent unit.
- Clinical experience with at least five adolescents (aged 12–18 years old) that conform with the aims of this study, since the beginning of their clinical training.
- Have worked with those adolescents for at least six months for once-weekly or intensive psychotherapy.
- Live and work in London.

Potential participants that met the above criteria were considered eligible, and were excluded if they did not meet all the above criteria, with no additional exclusion criteria.

All participants needed to have worked clinically with adolescents (aged 12–18) who were diagnosed with depression, or presented clinically as such. Here, I did not restrict the definition of depression within psychiatric terms, but included a variety of presentations, such as long-standing feelings of low mood, hopelessness, lack of motivation, self-harm, and/or suicidal thoughts.

Pseudonyms were assigned to each participant to protect their identities. Considering some participants' concerns about confidentiality, specific details such as ethnicity, years of experience, or sector of work were omitted, ensuring the anonymity of all participants. Some participants discussed cases from their work in their NHS service, while others talked about cases in their private practice. Some participants did not wish for this to be clarified

in their narratives in order to protect the confidentiality of their patients and workplace. I understand this to be related to the worries and anxiety that working with this patient population can evoke**.**

Recruitment

I proposed two different recruitment approaches.

- Upon receiving ethical clearance from the Tavistock and Portman Trust Research Ethics Committee (TREC), I emailed the Operations and Membership Officer of the Association of Child Psychotherapists (ACP) with the Participant Information Sheet and Participant Consent Form (see Appendice 1, 2, 3), requesting that they share them with their qualified members. I then received a confirmation email that they would share my research project and Participant Information Sheet in their Chair's Newsletter in September 2022. I would conduct a brief screening contact with any potential participants to ascertain their eligibility, and gather the information needed according to the inclusion criteria. This contact would also give participants the opportunity to ask any questions they might have about the research.

- The second proposed recruitment approach was to e-mail clinicians with a wealth of experience of working with adolescents directly. With the help of my supervisor, I identified clinicians that would be appropriate participants in my research project. "Purposive sampling technique" is widely used in qualitative studies (Patton, 2002). It acquires knowledge from participants with particular expertise, thereby resulting in responses that foster deeper and in-depth exploration of their experiences.

The first recruitment approach did not result in any expressed interest. I therefore turned to the second approach. I sent an "Invitation email" to the previously identified pool of clinicians, as well as to some I myself had identified, where I explained the reason for making contact and provided a brief outline of my research project (see Appendix 4). I also attached

the Participant Information Sheet and Consent Form (see Appendices 2, 3). The Participant Information Sheet contained clear information about the rationale of the study, the researcher, what the participation in the research would involve, as well as information about the interview duration, data protection, and ethical clearance. I maintained the anonymity of the clinicians who responded to my e-mail, even from the pool of clinicians identified by my supervisor. I approached Child and Adolescent Psychotherapists at varying time intervals to prevent over-recruitment. I aimed to approach a similar number of men and women to promote homogeneity, but also because men are quite underrepresented within the profession. A total of eleven Child and Adolescent Psychotherapists were contacted, and five of them expressed an interest in participating.

Participants who expressed their interest in taking part in the research project were given the opportunity to meet with me and further discuss the background and rationale of the study and how the data would be used. Participants who agreed to partake signed and returned the Consent Form, were aware that participation was voluntary and that they may withdraw their participation without providing any reason up to three weeks after the interview. No participant withdrew their consent. The interviews were conducted on a day, time, and place that was convenient to the participants. In the context of the COVID-19 pandemic, the participants were given the option to be interviewed via video conference (by using the Zoom platform). However, I expressed my willingness to be as flexible as possible in order to facilitate in-person interviews. One interview was carried out via Zoom, and four were conducted in person in the participants' work environments/practices.

Data collection

Semi-structured interviews were used to collect the data. This enabled the participants to provide detailed narratives about their experiences of working with adolescents with depression.

Interview design

The interview schedule (see Appendix 5) consisted of seven open questions. My aim was to create a schedule that would facilitate a meaningful and comfortable interaction with the participants, that would allow them to expand on their experience under exploration, but also to ensure that all participants were asked the same core questions. I asked participants to think of a case that had made a significant impact on them. Questions about the emotional impact it had had on them, and implications or dilemmas of technique followed. The final part of the interview schedule comprised reflective questions regarding psychoanalytic psychotherapy and depression. These questions were posed only if time permitted at the end of the interview.

Conducting the interview

When a date had been agreed upon, I asked participants whether they would prefer to receive the interview schedule prior to the interview, clarifying that this was not required. Four participants found this idea helpful, while one participant preferred not to receive the interview schedule before the day of the interview. I emailed the interview schedule to the participants a few days prior to the interview or on the morning of the interview. All participants were aware that the interview would last for roughly one hour. Due to workload, most participants had a maximum of fifty minutes to one hour available.

I related to the scheduled interview slot in a flexible manner, allowing the participants to expand on their thoughts and find their flow. I used prompts where needed.

The interviews lasted between forty-five minutes to one hour. Each interview reached a natural end, at which point I allowed some time for the participants to pose any questions or reflect on the interview process. All participants expressed that the interview was stimulating and allowed them to further reflect on their work.

The interviews were audio-recorded using a mobile phone. The recordings were then transferred and saved on a password-protected laptop, accessible only to me. After the conclusion of each interview, I audio-noted the impression each participant gave, as well as my countertransference feelings throughout the interview.

Data analysis

The data was analysed step-by-step, following the method and terminology laid out by Smith & Nizza (2022).

I transcribed the interviews verbatim and made notes of initial thoughts or countertransference feelings, where different tones of voice or pauses helped me recall my thoughts and feelings. In the initial phase of data analysis, I read the transcriptions along with the audio recordings multiple times. Then, as suggested by Smith & Nizza (2002), I noted down the thoughts that occurred to me in a research diary, so that I did not become overwhelmed by the array of initial responses when reading the interviews. Writing down my personal reflections in a separate document helped me maintain my focus on the data itself, e.g., how I felt as a novice researcher and a trainee interviewing senior psychotherapists with a wealth of experience, and how this affected my responses throughout the interview as well as throughout the data analysis process. I returned to these notes at a later stage of the data analysis.

I then returned to the transcript and divided the document into three columns. The left column was for exploratory notes, the middle for the transcripts, with numbered lines, and the right column was for experiential statements. Rereading each transcription multiple times helped me immerse myself in the participant's world, and began to reveal to me what was important to them. I highlighted words and phrases throughout the documents and made linguistic and descriptive notes in the column for exploratory notes, directly in the electronic document. This process helped me understand, at a basic level, what was conveyed to me. During

subsequent readings I took conceptual notes, e.g. questioning something that did not make sense to me at the time, or when I first came across contradictory statements. I tried to be open to the participant's standpoint, whilst being aware of how my interpretations were influenced by my theoretical frame of reference. Further re-readings helped me gain an overall sense of the data, and some of my early enquiries or gaps in understanding now found meaning.

In the next phase, I formulated experiential statements in the right column of the document. At this stage, I moved away from the participants' claims, moving instead towards a more interpretative account of their experiences. The experiential statements were not merely a summary of the exploratory comments made for each segment of the transcript, but they held an overall conceptual meaning of the participants' experiences.

Throughout the data analysis process I discussed my findings with my supervisor to reassure that I was on the right path and my research followed the IPA methodology. Once the experiential statements were identified, I created a list containing all of them. When each interview had a list of experiential statements, I proceeded to create clusters of "personal experiential themes". I printed and cut out all experiential statements (for each interview) so that each statement was on a separate piece of paper. I then placed them on my desk (see Appendix 6) and moved them around. It was interesting to observe how the data took a different form at this stage, as if they now obtained "a life of their own"; they somehow became more "alive", and different statements were drawn together in clusters. Each cluster, or "personal experiential theme", was titled in a way that conveyed the meaning of all the experiential statements that were brought together. A table of personal experiential themes was created for each interview. Smith and Nizza (2002, p. 43) term this stage of the analysis an "interpretative activity" in itself, as it requires the researcher to continuously keep in mind the research question and the hermeneutic stance of the IPA method.

Once I had completed this process with each interview, I printed out all the experiential

theme tables. I cut out each table, with its respective subthemes (and experiential statements), and placed them on the floor. I then moved them around and started grouping the overlapping themes, moving some experiential statements to different experiential themes or merged them with others. A first formation of superordinate and subordinate themes began to take shape. At this stage, I was surprised by the abundance of data and decided to try something different in order to "map out" the emerging superordinate themes, as the visual stimuli was overwhelming. I collected each table of experiential themes, with its respective experiential statements, in one document and audio-recorded myself reading them. I then listened to the recording a few times and noted down possible groups of experiential themes. Then, looking at the material I had on the floor, I was able to create the final groupings of superordinate and subordinate themes in a clearer way, resulting in a final table of five group experiential themes, each with two or three sub-themes.

Personal Reflexivity

I have kept notes of my reflections in a research diary since the start of this research project, and throughout the process of interviews and data analysis. By engaging in a reflexive process, my aim was not to "neutralise" the impact of my role as researcher, but to acknowledge how my biases—e.g. theoretical background, gender, ethnicity etc.—may affect my role as researcher during interviews, as well as my interpretation of the collected data. As Francisco M. Olmos-Vega et al. (2023) have discussed, the data should be interpreted as a result of the distinct relationship between researcher and participant. Throughout the process I was very aware of the interview dynamics, as the participants were all experienced psychotherapists while I was a trainee. I kept notes of my thoughts and countertransference feelings during the interviews in order to remain fully aware of them during the data analysis. Moreover, given my personal interest in and experience with the research topic, I was mindful that this could affect the way I formed questions during the interview, and how I responded to the participants. Therefore, I kept notes of these thoughts and discussed them in

supervision as well, in an attempt to minimise this influence as much as possible. Lastly, even though all participants were given the same information sheet, with the most recent version of the research question, in one interview I had given by mistake a previous version of the interview schedule where the only difference was that the element of risk/suicidality was in the question. I discussed this with my supervisor and we concluded that this difference didn't compromise the credibility of the final results and analysis.

FINDINGS

Introduction

This chapter presents the findings of the data analysis. These findings are the results of a hermeneutic process that has followed the IPA guidelines, as described in Chapter 3. Five group experiential themes emerged from the data analysis: “Losing the internal compass”; "Risk changes it all”; “Reaching the adolescent”; “The therapeutic relationship is a personal matter”, and “Another mind to think with”. Table 1 shows each group experiential theme with its corresponding subthemes.

Table 1. Group experiential themes and subthemes

Group experiential theme	Subthemes
Theme 1 **Losing the internal compass**	**1a.** Bearing difficult feelings **1b.** “What am I doing?”
Theme 2 **Risk changes it all**	**2a.** Preoccupation with risk **2b.** Contact with one’s wish to die
Theme 3 **Reaching the adolescent**	**3a.** Reflecting one’s own position **3b.** Tailoring the technique **3c.** Finding what is helpful
Theme 4 **Therapeutic relationship is a personal matter**	**4a.** Hope in the therapist **4b.** Tolerating the “gap” **4c.** Thinking about personal experiences
Theme 5 **Another mind to think with**	**5a.** The vital role of the network **5b.** Need for a reflective space

Each group experiential theme will be explored through its subordinate themes. The themes will be presented in a sequence that offers optimal readability. Each subordinate theme will be explored and commented upon interpretively, drawing upon excerpts from the interviews that capture the participants’ experiences and provide context for the findings.

Before presenting the findings, information about the participants and cases presented might help the readability of the findings' narrative. The participants—Charlotte, Robert, Laura, Helena, and Anne—presented cases with female adolescents. All cases presented with depression or depressive symptoms. Suicidal ideation and/or co-morbidity were also part of the young people's presentation.

The participants had a mean age of 55 years, and an average of 20 years of professional experience both in the NHS and in private practice. While some participants identified as White British or Black British, others were from various European countries. Due to concerns about confidentiality, some participants preferred not to have their demographic information explicitly shared and were reluctant for the study to specify whether their work took place in private practice or within the NHS.

Group Experiential Theme 1: Losing the internal compass

This group experiential theme concerns an array of difficult emotions that the therapists had confronted in their work with adolescents with depression. Across all interviews, participants talked about the work with this group of adolescents impacting their sense of professional competency, often leaving them feeling impotent, powerless, and helpless. Most participants expressed that their work with the adolescent often did not progress as expected, leading to feelings of frustration and, subsequently, a sense of being ineffective. Whilst therapists were able to think about the link between these negative responses and their patient's internal world, the intensity of the experience seemed to impact them on a deeper, rather, personal level. One might wonder whether the intensity of the emotional impact suggests a malleability of the boundaries between the professional and personal realms. All participants talked about how the work challenged their sense of who they thought they were as therapists, and what support they were aiming to offer the young people.

Subordinate Theme 1a: Bearing difficult feelings

All participants talked about how the work with this group of adolescents was very difficult and emotionally draining. Interestingly, Charlotte wondered whether it was the personality of the young person that had such an impact on her, or the nature of the depression:

So, this particular young woman was very emotional, would make lots of threats to make me feel, ehm... worried, to make me […] would say things to make me, you know, to make me feel that I should be guilty or should have done more for her, to help her with her depression. But it's hard to disentangle what is called oppression and whether it was to do with the fact that she was so depressed and, and whether that was the depression that had the impact on me, or whether it was the way in which she responded to her depression. p. 5, line 115

Charlotte's use of the word "oppression" conveys her feeling of being emotionally "tortured" by the young person. It was interesting to observe her use of "I should be" or "I should feel" as a linguistic tool, which has an imperative tone, possibly implying that Charlotte felt there was an intention from the patient towards her. I wonder whether the patient might have tried to unconsciously push a specific response from the therapist to test whether she would tolerate her or give up on her. Later in the interview, Charlotte had understood this experience as conveying something very important about the young person's quality of object relations: that is if she did not control her objects, she could not receive the care she needed. It was important for the therapist to bear these difficult emotional experiences so as to gain insight into the young person's internal world.

Helena expressed an experience of feeling unable to help the young person she was working with, as the effect she had on her was almost paralysing:

When I started the sessions with her, I said "Oh my God, oh my God, this is… we are back to the same thing, I will not be able to help her", and the loop is repetitive. Then during the session, not immediately, it takes me… the loop is also very… it

> *bamboozles you. So, then I cannot change gear, to say no, right, let's do some work here.*
>
> P. 3, line 37

Helena conveys a sense of powerlessness, and discomfort, being taken over by the state of mind of the young person. Here, I wonder whether the only way that the therapist could make sense of the young person's difficulties was to allow herself to feel as the young person felt; for both therapist and patient to "inhabit" the same paralysing state.

Laura assigns a different quality to her sense of powerlessness: *"I had to carry also the reality that she may die, that she really could die. She wasn't even that risky in her behaviour, but I knew very well that she could die"* (p. 4, line 75).

Here, Laura relays a feeling of powerlessness in the face of the risk of suicide. This painful emotional experience seems to be a central feature of the work with adolescents at risk of suicide, and what the therapists are faced with. It speaks to the powerful impact that contact with a young person's wish to die has on therapists, and how difficult it is to stay in contact with their psychic pain. The linguistic use "I had to carry", which has an imperative tone, might convey a sense of responsibility having to withstand an emotional "weight", without necessarily having *to do* something about it.

Anne presented a different experience of feeling disoriented when in contact with "not knowing", the "negative capability", explaining that she would sometimes ask the young person too many questions when she could not make sense of what was happening. In the following excerpt, Anne explains that a therapist needs to understand and reflect on what leads (unhelpfully) to too many questions:

> *Irritation or not understanding. So perhaps, not been able to bear the... what's it called... the negative… no? The doubts, Keats. Doubts and not being able to... and*

> *also feeling that "how long shall I be kept in that confusion, these doubts?" And also, I must say from a more benevolent part of myself, also because I hope that at some point, I will finally find something which could put me in the right direction.*

P. 16, line 316

Anne conveys how a state of "not knowing" might leave her not only with frustration, but a sense of discomfort. Anne's statement *"I will find finally something which could put me in the right direction"* speaks of her experience of feeling lost or working in the "dark" for too long. Anne also seems to convey that staying in this state for too long, and in its consequent discomfort, becomes more tolerable by holding on to hope that this will end in the near future. Later in the interview, Anne talks about the importance of the therapist keeping their countertransference feelings in check, in order to keep in check what might be acted out in the treatment, such as asking too many questions out of irritation. The experience of not knowing will be further explored below in Subordinate Theme 1b.

Robert talked about experiencing very difficult feelings due to being racialised by the young person:

> *… all her good aspects were held in her Western side […] and all of her so-called bad stuff was held in her Eastern side and evacuated frequently into me, and that's quite difficult. That's a real kind of pure experience of racism […]. If you are othered in that way. But that was quite hard […]it was really quite hard to be in a position where someone is racializing you.*

p. 8, line 220

Here, Robert talks about the painful experience of being subjected to racism by the young person, the repetition of the word "hard" indicating this. He addresses the powerful projections he received from the young person, as the unwanted, split off parts of herself

were all located into him.

Subordinate Theme 1b: "What am I doing?"

All participants talked about how they often felt that they did not know what they were doing with the case. In line with the theme discussed above, feelings of powerlessness led to the therapists' sense of agency growing precarious.

Anne shares*, "Clearly, I feel quite discomfited by having worked with her for three years and if she goes to an inpatient unit […] I don't understand how, how our relationship can't help her because, I expect, I expect therapy to work."* (p. 10, line 181).

In the above excerpt, we observe how Anne's sense of potency is wavering, rather utterly shocked. Anne's sense of agency appears to have been challenged by the prospect of the young person being admitted to a Tier 4 unit. On a more interpretative level, I am wondering whether Anne's certainty in her conviction that therapy, and the relationship, is expected to work, is her way to manage the anxiety of not knowing, and possibly feeling impotent, deskilled or failing. I wonder whether this might be considered as the patient's own experience of feeling lost, fragile, or impotent, let in the countertransference.

Laura expressed a feeling of entrapment, giving rise to feelings of regret about getting involved with the case: *"what have I got myself into? I can't get out of this because I am her therapist and she relies on me and twice a week she comes and talks about such difficult things, she's been waiting for years to be in therapy and finally we are here"* (p. 16, line 296).

The impact of risk will be explored in the theme below, but in this excerpt, Laura expresses a sense of feeling lost with the case. Laura doubting how she can help the young person in the face of a deep fear of losing her patient. Facing the unimaginable, the therapist does not know what to do, feeling almost paralysed.

Similarly, when thinking about the emotional impact that the work had on her, Charlotte talked about an array of negative emotions. Thinking about the hard work that she had to do for her very difficult case—e.g. long hours of liaison with the network and ensuring that the young person was safe in the community—she expressed feeling drained of internal resources.

> *Well, I can tell you a range of emotions. She sometimes left me very angry. She sometimes left me very frustrated. She sometimes left me feeling that I wanted to shake her and say, "just get a grip, do something". I, I at times felt… I wish I just could give her away to another, I had enough. I cannot bear it anymore. I, I don't want her as a patient. […]if I have to give so much to you, I've got nothing left for [laughs]… she drained me, and it's just someone else's turn. You know what I mean?"* P. 13, line 308

In the above vignette Charlotte emphasised the negative feelings she experienced towards her patient resulting from the significant work she dedicated to the patient beyond the clinical hours of her sessions. I wonder whether this aggravated her frustration, letting her feel that she had nothing else to offer, which in turn might have risen questions in her whether she was doing anything right. I wonder how Charlotte had felt sharing those feelings with a clinician; did her laughter indicate a discomfort in sharing her negative feelings towards her patient with me? Her laughter might also evidence a relief talking about the pressure and strain she was under, the experience of the interview being an unburdening process for her. Helena conveyed that she felt in despair by the lack of development in the young person, but also from the repetitiveness of her negative thinking to the extent that she felt deskilled and unimpactful: *"I was kind of slightly despairing because the loop is back, and I don't seem to be able to help her. So, it was very debilitating to the point that I am thinking maybe she needs a different person."* (p. 2, line 24).

Later in the interview, Helena talked about losing her sense of agency: "*I think it's part of the, in a*

way, nullification of my power, power is not the word, but my agency" (p. 15, line 271).

Helena's experience with this young person utterly challenged her sense of agency and professional competency. The choice of the word "power"—quickly retracted—is interesting, here, as it communicates a potential unconscious fear of losing control or a wish to maintain control by holding on to the certainty of what works and for whom. I believe her experience of lack of control and "what am I doing here?" was then experienced by me in the process of the interview, as at this point, I remember feeling that I had no control over the pace of the interview, the order, or the topics discussed.

Group Experiential Theme 2: Risk changes it all

This group experiential theme constitutes one of the core findings of the current research project. Although the research question did not specifically focus on adolescents who present with risk, it became apparent that risk held significant importance in the therapists' experiences of working with adolescents with depression. Three participants discussed one case, respectively, and two participants discussed two cases each, in which depression had manifested differently. Four out of five participants brought up the concept of risk in our conversation, as it appeared to have the most significant impact on a personal and professional level. In the context of the interviews, "risk" specifically pertained to suicidality and a severe eating-disorder that may necessitate hospitalisation.

Subordinate Theme 2a: Preoccupation with risk

A preoccupation with the young person's safety was a recurrent theme for Laura, Charlotte, and Helena:

> *It's very strange, even the way I talk about it, it's not clear, it's not clear because it's not clear, sometimes I wake at night with terror for one of my patients, sometimes they come in my dreams, but actually in the large part I do put it aside because you*

do learn how to do that. You have to work on it.

Laura, p. 25, line 465

I could really text [the psychiatrist] and say "look, this is serious, and do I tell the parents?" The risk, of course, because at that point the parents were still almost negating the depression. Not, not, not as they were at the beginning, but you know, if you tell the parents, then do you increase the risk?

Helena, p. 20, line 356

I think because there was so much risk involved. And that's usually why the cases have an impact on me. […] But I think it is what it feels the case leaves you with… […] it's the fact that when they leave, you worry about whether they're going to be safe, you worry about whether they're going to self-harm, whether they may attempt suicide, whether they may do something.

Charlotte, p. 2, line 35

The therapists vividly described how they became preoccupied with risk, keeping the patient in mind beyond the boundaries of the session. Laura showed how preoccupation with a young person's safety can be so intense that can slip into her dreams, showing how the mind cannot rest. She also conveyed the need for the therapist to learn how to protect her mind from being intruded upon by preoccupations about the patient.

Charlotte and Helena talked about the uncertainty the risk left them with. Helena talked about her conflict on how to manage the risk, between contacting parents or holding it between her and her colleague. They both conveyed how difficult it can be to know how to manage those situations, with Charlotte illustrating that risk can create room for uncertainty, to be filled with various fantasies about what can potentially go wrong in the absence of knowing what the patients will do after they leave the consulting room. The

therapists feeling preoccupied with worry made me wonder whether this might reflect the patients' unconscious wish to be held in mind and experience their therapists tolerating the frustration.

Charlotte's excerpt below adds a different experience related to preoccupation with risk: *"That patient encroached on my, the work that I would have, should have done with other patients because it took much more time, of my thinking time, but also actually of my physical time in terms of follow up and linking up and so on"* (p. 4, line 93).

Here she reveals an experience of boundaries being crossed when risk dominates the work. This is exemplified by her use of the word "encroached", indicating that she perceives the young person to have not only intruded on her personal space by occupying her mind, but also that this experience is possibly felt as a violation. The therapist feeling exasperated might be indicative, as noticed above, of the young person's experience of her objects. Moreover, the use of phrases "would have" and "should have" may suggest a potential sense of guilt towards her other cases.

Subordinate Theme 2b: Contact with one's wish to die

This subordinate theme illustrates how the therapists experienced the young persons' suicidal thoughts, with one therapist sharing the impact of a completed suicide.

> *I remember the sessions with her were really difficult. I mean, you know, you go to a very bad, very bad place and to make sense of the very bad place and to see how to*
>
> *be… well with her for a while I was really worried that she actually… She said that it is like being put in a, in a, in a, in a cell in prison, and I don't have the key out of this prison […] and then when you realise that when she's in that prison, she does have suicidal thoughts and there was one suicidal action, which is very serious […] very disturbing, very unsettling.*

Helena, p. 19, line 340

Here, Helena describes suicide being a possibility. Helena illustrates navigating through a very difficult path alongside the young person, where contact with suicidality was very hard to make sense of, but also to be in contact with. Even though Helena vividly depicts the young person's experience—painting a rather claustrophobic picture—she may also be revealing her own emotional experience: feeling trapped, unable to help herself and the girl out. This might be portrayed by the repetition of the words "in a", possibly indicating how hard it was to find the right words to describe the "internal prison". Also, the shift in pronouns "She [said]" to "I [don't have the key]", might also be the participant's unconscious communication of her feeling of imprisonment.

Laura presented a similar experience:

> *What am I doing with this treatment? How can I get out of this? What am I supposed to do, I am so close to this girl I'm trying to help her, […] and then she might die.*
>
> *How to work with somebody and be alongside them, and really be alongside them, when you wish for them to live, and they wish to die.*

p. 6, line 110

Here, Laura illustrates a painful emotional experience of despair, fear, and entrapment. She poses the rhetorical question "how do I work with someone I feel so close with when they wish to die?" I have interpreted that as her questioning how one *bears* the emotional pain, reinforced by the way she phrased "and then she might die", as opposed to "commit suicide", making the act of suicide something less violent, possibly distancing herself from the experience. Laura's, possible, unconscious wish to distance herself from very painful feelings aroused in her, along with her earlier statement "I feel so close with [the patient]", highlights her emotional closeness with her patient, the importance she attributes to their

relationship and feelings of sorrow at the possibility of the patient committing suicide.

Charlotte described the impact of the completed suicide of a young person with whom she had ended her work a year prior to the incident.

> *[…] when you had a case where something really did happen, I think it changes it. […] about a year after he moved away, his mother let me know that he's committed suicide. […] there was something about this that, it can really happen. A patient can really take their own life because of the state of depression they can get into and, I think THAT subsequently made it very hard for me to work with adolescents who are so depressed that they are acting out at the same time at times, and where that is very much on their mind.*
>
> p. 3, line 50

Charlotte presents the impact of the experience of a suicide as a crucial moment in her work. Like Helena and Laura, she expresses the realisation that suicide can indeed be a possibility. Her vocal emphasis on the word “that” made me think that this experience was life-changing for her. Charlotte also shared that, after this experience, her resilience on tolerating risk changed.

Laura brought another theme in relation to high risk:

> *I think to work with very depressed young people the therapist has to have a certain liveliness. But the trap of that is that if you allow that to be, that you actually are sure that you're gonna save them, it's an illusion. It's not, it's just a tendency within you that you have to have. But actually, you have to be open to the fact that none of it might work.*
>
> Laura, p. 30, line 559

Laura describes the difficulty of facing her own limitations. Laura discusses the importance of the therapist holding on to liveliness, almost as a conscious decision against the possibility of a suicide. Laura talks about a "liveliness" that a therapist has to have, the imperative tone of the words "you have to have" possibly indicating that this might be pivotal for the therapist's, and patient's, emotional survival. Her reiterating that there are limitations in the work made me wonder whether this is something Laura tries to come to terms within herself, as she previously expressed, almost like a conscious decision to defend against a fear of loss. At the same time, what Laura discusses here, is a new idea; it is the idea of being open to uncertainty, which is a particular challenge when working with suicidality.

Group Experiential Theme 3: Reaching the adolescent

This group experiential theme describes how the therapists reached their adolescent cases, most of whom were difficult to reach at the start of treatment. All participants drew attention to a need to adapt the psychoanalytic technique, most of them conveying that they moved slightly away from "classic psychoanalytic technique", that is the use of transference interpretations.

All participants discussed complex cases, where there was a history of significant trauma or transgenerational trauma. Therefore, intimacy in the therapeutic relationship was either experienced as dangerous for the young people, as it would increase the emotional temperature in the room or in different cases, there was a fear that transference interpretations would be perceived too concretely. All therapists talked about gradually and slowly finding their way to the adolescent, with some preparatory work being required prior to interpretation of the transference.

Subordinate theme 3a: Reflecting one's own position

When discussing what helped them reach the adolescent, most of the participants first talked about what *did not* help them. This may speak to the impact that the work has on their sense

of agency, as explored above. This might also illustrate how introspection and self-reflection might be the starting points of reaching the person in the room.

Robert reflected on his initial struggle to connect with the adolescent and spoke openly about acting in the transference in different ways and on various levels at the start of the treatment:

> *One was a colonial way of relating, a bit superior "I know ideas of self and other" and I was somewhat denigrating, […] about her experiences of self and other […] I think initially I was very dubious, wary, denigratory. I think this is because of the racism that I've internalised over the years, actually […] And I think*
>
> *that's precisely what I did do technically, I think I was erm, not collaborative. I think I was authoritative, without realising it. And I think being authoritative closed down space as opposed opening it up.*
>
> P. 12, line 310

In the above vignette, Robert reflects on him unconsciously acting in the transference by becoming superior or denigrating towards his patient. He understands this as a resulting from his internalised racism. This might suggest that Robert's experience of the work had such an impact on him on an emotional, personal level, that reflection became possible only later. As he indicates, his own experiences of racism potentially played a role in him acting in the transference, not helping him to assume an open stance. Robert's example shows how the personal meets the "technical".

Similarly, Laura answered the question by naming what was not helpful:

> *One of the biggest traps is when you become the one holding all the activity and the hope and the wish for them to live and the wish for them to find meaning, and the trap is that if you as a therapist do that a lot and want that too much, they will become*

either passive or aggressive.

P. 7, line 131

What Laura describes here makes me think about how common it can be for adolescents with depression to project their drive for life into the therapist, and the danger there being that the more active the therapist is, the more unhelpful they become. The use of word "trap" is interesting here, and it makes me wonder whether she experiences falling into the traps the patients unconsciously lay. Also, the generic "you", which has a didactic tone, might suggest that she distances herself from this personal experience that might be a struggle for her.

Conversely, Helena talked about being more active as something helpful, but expresses later that her intervention did not last:

I think it's very boring […]I could just switch off and it would be the same session. So, I have to actively intervene, and in a way I have to somehow stop

her talking […] So, in a way my intervention seems to interrupt the loop […] There is a sense of "okay, we're going somewhere" and then...

p. 7, line 121

In this vignette, Helena conveys the state in which she finds herself, feeling uncertain on what might work or not. On a more interpretative level, Helena's narrative conveys that her being active possibly served as a defence against boredom or mindlessness. Being more active might have helped the young person momentarily, while it helped Helena to not "switch off".

Helena also talked about how this case challenged her psychoanalytic frame:

I feel that I have to go slightly out of my way of working, I mean it's not that mentalisation is miles away but, you know certainly working in the transference or

> *long silences, all that is, you know, I have to somehow activate her mind in a very simple… Which is something that probably this girl didn't have in spite of all the care and the attention and the nice schools and… but something like that didn't quite happen. So, I feel that I have to do that.*
>
> P. 15, line 265

Here, Helena gives a different perspective than Robert, Laura. Rather than focusing on what she feels is not "technically correct", she focuses on having to adapt her technique, which may have impacted on her sense of professional identity. The above excerpt makes me wonder whether the work created feelings of powerlessness—"nothing works"—which made her feel that she had to do something different than the psychoanalytic frame she was trained in. Helena's antithesis between the "good" external care and its lack of impact on the internal, together with the expression "I have to", might suggest that she felt she *needed to* change her approach. This might suggest a lack of choice. However, the vignette also illustrates her sensitivity to becoming as flexible as needed. In a more interpretative level, and as excerpt is from a later point in the interview, I wonder whether she has developed more of a sense of agency in technique though reflecting on her work with me.

Anne talked about having to check within herself whether her irritation or anger might lead to asking too many questions: *"The more internal certainly I find myself, for instance, when I am so, again, irritated, to ask too many questions […] It wasn't helpful"* (p. 15, line 309). As explored in subtheme 1a, Anne's experience of feeling lost and in a position of "not knowing" propelled anger in her that consequently led her asking too many questions.

Subordinate theme 3b: Tailoring the technique

All participants talked about having to tailor their technique and more specifically the transference interpretations.

Charlotte shared:

> *I had to be very careful in how I interpreted it and at the pace I did it. In the beginning, she wouldn't accept any transference interpretations […] But over time I would bit by bit interpret what I thought in a much more direct way, although I would never use the word "mother" because I thought there was such a danger of her hearing it as me accused her real mother of being that. So, I, I very much kept the, the interpretations very much in the transference.*
>
> P. 8, line 185

Here Charlotte talks about transference interpretations being very difficult at the start of treatment, possibly feeling "too close" for the young person. The therapist is describing a very tactful way of working, with sensitivity to pace and temperature. At a later point in the interview, Charlotte talks about having to withstand projections and attacks without interpreting them. The meaning behind the difficulty in transference interpretations might be twofold: the young person perceives them in a literal way, as an attack on them or their objects, while the therapist feels wary of being thus perceived. This might be suggested by Charlotte's use of the word "never", which can also convey her clarity on a way she absolutely could not work. I also wonder if transference interpretations offered too early might be experienced as intrusive, and the therapist may thus also feel intrusive. On the contrary, Helena found that using her countertransference feelings, and interpreting the transference, was unhelpful: *"What I found was more helpful is, you know, to try and help them mentalise […] And that is the only thing that seems to work a little bit when we get hold of a specific example"* (p.11, line 144).

Helena expresses that what helped more than transference interpretations was helping the young person develop her thinking capacity (mentalise). Later in the interview she explains that the young person found it hard to process her feelings and thoughts, as she was drawn into repetitive thinking that would often distort reality. Helena's narrative might suggest that transference interpretations might need "preparatory" work—a basic mental process, as it

were—for the patient to be ready to receive them.

Robert brought a similar experience with Charlotte and Helena, with additional meanings:

> *She couldn't take a direct transference interpretation. So, we thought about erm, say her erotic transference, how it got played out with male teachers at school.*
>
> Interviewer: But never with you?
>
> *No, not until right at the end, which enabled her to kind of manage indirect interpretation in that way. […]. I think also that got to do with the culture side […] this idea that it's kind of forbidden to have particular thoughts or behaviours towards someone that's older than you […] using lots of interest in literature and film, to think about her thoughts and feelings, […] It just felt an easier way to explore the transference really, to explore herself how she projected into these characters*.
>
> P. 13, line 350

In Robert's—the only male participant's—excerpt, what is illustrated and differentiates from the other accounts, is the difficulty of a male therapist working in the erotic transference with a female adolescent. Robert sensitively considered the young person's religion and what it postulates for women around men. What is also suggested, as observed in a previous theme, is that, as a male therapist, Robert might have found it challenging to work with erotic transference. On a more interpretative level, I think that working on displacement might have helped the therapist as well.

Anne explained that she used her countertransference feelings and interpreted on the transference since the very beginning of the treatment: *"Well, I think since the very beginning, because she made it very clear that she was using me as a container of her feelings"* (p. 10, line 189).

Anne is the most senior of all the participants, with more than 30 years of experience. One could wonder whether the difference in psychoanalytic technique, rather than confidence in sticking with one's frame, is linked with the generation of therapists they belong to, or simply the confidence of what works after so many years of experience.

Subordinate theme 3c: Finding what is helpful

The therapists talked about how they found their way in the work with the adolescent in discussion. Robert was still in training when he worked with the adolescent girl. In his reflective account, he is open about initially maintaining a more "traditional" psychoanalytic technique to then realise this did not help the adolescent. He talked about maintaining silences for longer than the young person could tolerate, given her experiences with other minds who had harboured different intentions. The excerpt below illustrates how Robert worked through this:

> *I think she became very persecuted in silences and was worried what was inside my mind. […] So, I was kind of more active initially, and later on I think she could tolerate [it].. […] What was really helpful, was being more explicit about my thoughts and feelings about relationships, about her. I think that she really felt again quite suspicious by virtue of all her experience, what was in my mind, and I found myself reflecting aloud quite a lot. And there's something about this being really upfront and you know, erm congruent about how I felt and then how I conveyed it into words. And I think that really helped her actually, in terms of getting to know actually what's in a man's mind.*
>
> P. 14, line 390

Robert taking the young person's experiences into consideration helped him work sensitively with her. Reflecting on how she might experience the silences and how these could be experienced as threatening, he maintained a more open stance, providing a sense of safety to

her by being more “active” in the first period of treatment.

Before this part of Robert’s narrative, he talks about aspects of race and culture having been an integral part of the therapy, while these had not been adequately thought about in the training. The repetition of the words “really” and “actually” may be significant in that they suggest that Robert struggled to find what worked for this particular young person, and what ultimately worked for him as a male therapist in a room with a female patient.

It makes me wonder if he found it difficult to challenge ideas from his supervision. Robert's openness likely reduced the young person's sense of threat while also he suggests that being more active at the start of treatment helped him feel less threatening and more comfortable in the young person’s presence.

Laura talked also about silences, but she attributed a different meaning to them than Robert who talked about silences becoming persecutory. Laura talked about silences becoming deadly.Laura contending that silences can acquire a “deadly” essence, possibly reflect the internal world and psychological state of the young person. One can question whether deadly silences are as difficult for the therapist as for the young person, and also how long one should allow silences to go on. Laura illustrates a delicate balancing act between interrupting the silence, thus being more proactive, and inviting the young person into the thinking process by handing the dilemma back to them.

Interestingly, when I asked Laura what she thought the young person was communicating when all the thinking or will was placed in the therapist, Laura explored what *she* aimed to communicate by being open and curious with the young person:

> *But I also think what I was communicating to her because I think it's a two-way street […] I think she had a huge terror of the other's mind and an experience of being*
>
> *overwhelmed by the other’s mind and when I say the other's mind, I actually mean*

> *mainly the real person of her mother […] What I want to hold onto is the confusion, the idea of the other person's mind is either not understood or has nothing understanding. […] So, I think being an alive person in the room and that's why I was very transparent always or I explained to her if I had a dilemma.*
>
> P. 22, line 411

Laura here illustrates the co-existence of two minds—the communication between therapist and young person—as a "two-way street". The choice of metaphor "two-way street" conveys a dynamic relationship, contrasting with the experience of "deadness" in the silences previously mentioned. In my question about what the young person might unconsciously communicate with her when she positions her into becoming more "active", she first chooses to highlight the importance of her communication towards the young person, that is that she is in the presence of a mind who is transparent in her thinking and emotionally available. Laura actively invites the young person into thinking with her about the dilemma, which in turn, results in the young person experiencing her as a different object who is lively and thinks *with* her, as opposed to a mother who is overwhelming and does not understand her.

From the above vignettes, the danger of a therapist failing to consider the young persons' external reality e.g relationship with real, as opposed to internal, parents, transpires as important, as this can lead to the therapist creating an environment that feels unsafe.

On that note, thinking about the external reality, both Helena and Anne talked about bringing the external reality into the thinking as something helpful:

> *When she goes into what I call a psychotic state. Because then I am also confused. And this is really difficult to, to relate to my countertransference feelings […] certainly I can't speak about madness. So, I speak a lot about reality. I noticed that recently I've been much more in touch with my reality inside […] I also tried to*

understand a bit about the external life by inviting the parents with her presence and this helped me.

Anne, p. 11, line 210

She doesn't know what she feels because she gets into this tangle. And that is the only thing, the only thing that seems to work a little bit when we get hold of a specific example. And that in itself is already a way of stopping the loop because we are with reality […] really help her to think because the loop is anti-thinking.

Helena, p. 11, line 196

These excerpts reveal therapists' reliance on reality, external and internal, as a way to guide themselves through states of confusion. Anne brings up the importance of relying on her "internal reality" to anchor herself in moments of confusion. Similarly, Helena talks about how bringing reality into the thinking stopped the young person's repetitive states of mindlessness, which seemed to have made a powerful impact on the therapist's thinking.

On a different note, Anne spoke about the helpfulness of putting boundaries in place:

At some point I said "okay, if you don't involve yourself more we will end up by Christmas, so we have a long period in front of us to think about the ending but I don't want to continue because it's not good for me, it's not good for you" […] and she agreed. And since then she never missed one session [laughs].

P. 5, line 93

Anne found that setting boundaries for the young person aided her sense of responsibility for her treatment and improved her engagement. Another observation is that perhaps Anne feeling messed about sparked anger in her, which then prompted her to set boundaries. Her laughter might indicate that Anne was surprised by the outcome of setting limitations,

possibly expecting a different result.

Group Experiential Theme 4: Therapeutic relationship is a personal matter

One finding across all interviews has been that the therapeutic relationship is a personal matter. All participants conveyed their emotional investment and dedication to the work,

while connections with personal experiences or characteristics emerged through the interview process. Upon reflection, I wonder whether the process of the interview provided a containing space for the participants that enabled them to think about their work on a more personal level.

Subordinate Theme 4a: Hope in the therapist

Most therapists shared the significant meaning they devoted to the therapeutic relationship through which they found hope.

Below, Robert reflects upon the therapeutic relationship and himself within it:

> *I found myself feeling a bit hopeless and a bit frustrated and a bit rejected actually… and following that I thought much more hopeful… I suppose thinking that the unbearable could be tolerated by myself and this patient [...] I found myself being very interested in her and I think maybe, now we are talking about it, I think my*
>
> *interest in understanding her depression, maybe let me not… something that was more lively in some way, instead of something that was dead and unworkable. We were both interested to understand what it is that is depressing her.*
>
> P. 3, line 62

Here, Robert expresses how he shifted from feeling hopeless to finding hope through the therapeutic relationship. He conveys how his interest in understanding the young person's depression created a vital sense of liveliness that seemed to impact her as well. Robert vividly

illustrates how a reciprocal interest in understanding transformed something unbearable into something bearable. On a more interpretative level, I wonder about Robert's lack of symbolic thinking in this vignette, as he did not think about the transference and what his emotional responses might reveal about his patient's experience. I wonder whether the absence of symbolic thinking sometimes can be seen in our work with this particular presentation in young people.

On a similar note, Laura shared:

> *It took a lot of processing, to think that if our relationship has the capacity to grow and within this, hopefully she can grow and I can believe in that, even when I don't see it yet, and seeing all that pain, that helped me. So, I think for her, I actually have been a person for her […] and our relationship, not me, our relationship, has been a transformative relationship for her. […] that in a relationship we can work towards feeling safe and we can feel understood, and we can figure things out together, we can get our mind together, because she didn't feel understood by anybody in the world.*
>
> P. 19, line 343

Laura talks about the difficult emotional experience of seeing the young person's psyche, while this seems to have been the only way to make true contact with her patient. She conveys that she found hope in her trust that the therapeutic relationship is a space where growth can take place, and that the young person will be helped within it. She highlights that it is not her that will be impactful, but rather the relationship itself: the therapist and the young person *together.* On a deeper level, Laura's narrative brings to my mind the experience of a baby discovering the world through her mother's eyes. This conveys the therapist's strong feelings for and investment in the case.

Thinking about the therapeutic relationship, Anne discussed parental feelings in the

countertransference:

> *The "caring for" made me think about the beginning of our relationship in which clearly she had hoped to find a person who was caring for her […] I am certainly fond of this girl in spite of the way she treated me these three years. I am fond of her because I can feel that deep down there is a baby; a baby who had for a moment a feeling that there was a good mother and then she lost this feeling [...] So, my feeling was "what can I do in order to restore these good feelings"?*
>
> Anne, p. 12, line 140

Anne conveys her maternal countertransference feelings towards the young person, speaking about warm feelings lasting through a turbulent relationship. It seems that it was the baby part of the young person that elicited these feelings in the therapist, who then hoped to restore the young person's internal object relations. I would be curious to further explore how Anne's warm maternal feelings withstood the attacks of the young person. This can be partly understood through Subordinate Theme 4c, concerning connections with personal experiences.

Laura and Robert explicitly discussed their maternal/parental feelings:

> *I really had to remind myself continuously that I am not her saviour, her mother, even though I was like her mother in the therapy because she actually hadn't been mothered this girl.*
>
> Laura, p. 10, line 181

> *I really enjoyed the journey with her. And I was so pleased how things turned out for her. So, I felt really quite sad (...) I mean I felt really pleased actually in a very paternal way actually, really, really pleased.*

Robert, p. 10, line 273

The therapists use the words “actually” and “really” when they talk about their parental countertransference which may convey the intensity of their emotional experience. I remember that during the interview, I felt that in these moments the therapists did not only talk about unconscious communication; rather, they talked about how they felt towards the young person, on a personal level, the work really impacting them.

Subordinate Theme 4b: Tolerating the “gap”

This theme explores the participants’ discomfort at being positioned in an uncomfortable role. They discuss how difficult they found the discrepancy between who they thought they were for the young people, and who they were positioned to be in the transference.

Helena discusses how she was positioned to feel like a “useless mother” in the transference:

> *I think that I’m […] maybe a bit like her mother who is very well meaning, a good mother, but fundamentally useless. Can’t really help, can give some soothing, sometimes she calls the mother, and the mother has a chat with her, and my patient feels better but then it’s gone. So, I’m a bit like that kind of figure.*

P. 12, line 204

Helena conveys that, like the patient’s real mother, no matter how “well meaning” she was, she essentially could not help her, possibly this being her way to convey she felt impotent or deskilled.

Similarly, Charlotte discusses the young person’s relationship with the external and internal mother figure:

> *I think also that was an internal dynamic between her internal object and herself. I*

> *understood it that she was really feeling internally that there was a mother who didn't do enough for her and that there was a mother […] who wasn't in tune enough with her, who didn't fulfil her emotional needs, […] and that she was making me feel what that is like.*
>
> P. 7, line 155

Charlotte, being positioned in the transference as a mother who was not good enough for the young person, found this difficult to endure. Reflecting on who she was in the transference helped her gain insight into the young person's object relations.

Anne discusses the different positions she held in the transference:

> *Sometimes I felt there was a container, she wanted me to understand, she wanted me to be on her side. And at other times I felt she was attacking me […] it's an unconscious attack on her baby self because she doesn't allow me to look after her baby self. She kidnaps the baby self from me.*
>
> P. 10, line 192

Earlier in the interview, Anne talks about the patient's baby-self eliciting warm maternal feelings in her. Acting as a good maternal figure, Anne hoped for the therapeutic relationship to "restore" the internal object relationships. In the above excerpt she shares a different experience, one of feeling attacked and possibly left out, positioned as a mother-figure who cannot reach her "baby".

Laura, having discussed her sensitive work of trying to understand the young person by creating a new language with her, presents her dismay when the young person expresses not feeling understood: *"She said to me she hasn't felt understood by me at some point, and I felt profound sadness when I heard that. I felt, 'oh my God what's going on?'"*

P. 20, line 365

Laura conveys the shock of realising the gap between who she felt she was in the transference, that is someone who understood the young person, and how she was perceived by the young person. On a more interpretative level, I wonder whether Laura felt disappointed and rejected, rather like the misunderstanding object she mentioned earlier in the interview. The question at the end of her sentence possibly highlights that she was entirely unaware of being perceived as misunderstanding.

Along related lines, Robert discusses his experience of being seen in the transference both as a benign parental figure and as a dangerous male. This makes me wonder how challenging it was for him, as a male therapist, to endure those feelings and find a way to work through them with the young person.

> *[…] now and again it would oscillate, only occasionally, between [being experienced as parental and paternal] and then me being othered by her and seen as someone dangerous, (…) I became someone that would pose her some kind of risk [...] But again, that was more tolerated, we could think about it together.*

P. 4, line 126

All participants conveyed the difficulty of withstanding being the "bad object" in the transference, while working towards repairing the internal "parent–child" relationship.

Subordinate Theme 4c: Thinking of personal experiences

When thinking about the therapists' emotional responses, one finding that seems to be important is therapists discussing some connection between the work and their personal experiences.

Robert discusses the similar experiences in his and his patient's adolescence:

> *[…] we had lots of parallels actually. Erm, we were both second generation immigrants, we both kind of, you know, aspired to go off and do something kind of educationally and we both had an experience of kind of racism, […] a lot of what she talked to resonated with me. Erm, one could argue whether that was helpful or not. I mean, I think it was helpful. That I could really kind of be in this girl's shoes [….] So, I think you know, and especially when she was trying to other me through projective identification, because I think she racialised herself quite a lot […].*
>
> P. 8, line 201

Here Robert talked about him having similar experiences in his adolescence helped him better understand his patient, giving him the sense of knowing *how* it felt like for her. Robert talked about his patient having gotten rid of unwanted parts of herself and locating them in him. This seems to have been particularly painful for Robert who had experienced racism in his life. On a more interpretative level, I wonder whether Robert counter-projected parts of his adolescent part in her, possibly creating blurry boundaries between them. On the other hand, the link between their life experiences, helped him understand part of herself that she was possibly finding hard to accept and form into words.

Conversely, Charlotte discovered a link as the interview progressed:

> *You know [surprised laugh] when you asked I was thinking "Gosh, I'm so unsympathetic". Of course, I did feel quite depressed at the age of 18 now that you mention that [laughs again with surprise] I didn't make that connection while I saw… I mean, of course I took it to my analysis and there was a lot, but funnily enough I didn't make that connection with that patient. So that's a good, that's a good question. […] That was the exact age that I was quite depressed, and I suppose in a funny way, I mean must have an impact on me eventually, you know, becoming a Child and Adolescent Psychotherapist but not in such a direct way that I, that I would make that, that I would make that connection with that girl […] But maybe, I think*

> *something about the dislike of myself and of my feelings, and of having those feelings that I didn't… that she had, might have also… [long pause] Stirred something up in myself.*
>
> P. 14, line 343

Charlotte realises with surprise, her laughter possibly emphasising not just her surprise but also her sense of exposure in discussing this with me, that she was the exact same age as her patient when she was depressed. Charlotte takes time to think and acknowledge that this is an interesting link, speaking of how she possibly, unconsciously, saw in her patient parts of her 18-year-old self that she did not like. This makes me wonder whether her negative feelings towards her patient and the extent to which the the case had an impact on her is related with this experience. It was also very interesting to see that sympathy towards the young person was created by making this link with her own 18-year-old self.

It is interesting to observe how, in Robert's and Charlotte's experiences, the similarities between adolescent self of the therapist and the patient enhanced understanding in one case and created distance in the other.

Similarly, Helena shared: *"I think probably it activates my negative loop. I mean, she has it in a very big, big way. […]I have to fight my own depression, if you want, my own negative loop. […] probably it does also, you know it helps if you had moments of depression in life. So that you, you can reflect, you know, you kind of know"* (p. 13, line 235).

Here, Helena talks about how contact with her patient activates her own depression. Although she doesn't clarify what she means by this, or the meaning she attributes to her depression, it seems that she experiences it as an intrusion that she feels she must 'fight,' as she describes. Again, we see the therapist, consciously, in contact with a personal experience that becomes part of the work. On one hand, Helena finds this helpful, as it gives her insight into the patient—similar to Robert's experience. On the other hand, this same factor might be

why Helena finds her work with this girl so difficult—similar to Charlotte's experience.

Group experiential Theme 5: Another mind to think with

All participants explicitly discussed the importance of receiving support throughout the treatment period. The network's support was paramount in risk management and decision-making, but also as a space where the therapist felt supported. Supervision and other reflective spaces were also important for the therapist's containment and for clinical understanding.

Subtheme 5a: The vital role of the network

The participants shared that the network provided a space to *think with* when there were concerns around the young person's safety:

> *I could really text the psychiatrist and say "look, this is serious, do I tell the parents?" […] because at that point the parents were still almost negating the depression. […] if you tell the parents, then do you increase the risk? But, also*
>
> *professionally. You know, I also had to protect my, cover my back. So, it can be very, it can be very unsettling.*
>
> Helena, p. 20, line 356

> *[…] thinking of solutions in the network in order to think with others how to... I guess... well, how to keep her alive really.*
>
> Laura, p. 4, line 68

In the above excerpts, Helena and Laura discuss the role of the network in assisting with risk management and safety planning, but also in thinking with them. Both conveyed how challenging it was to feel secure in their decisions in the face of risk. This suggests a strong

sense of responsibility that the therapists held, and perhaps sharing the responsibility with the network provided a sense of containment. On a more interpretative level, I wonder whether Laura's "we had to think how to keep her alive", highlights her sense of responsibility as if they were solely responsible for her safety or *could* keep her safe. Later in her interview, Laura reflected that this can be a trap for the therapist, who needs to recognize that they cannot be the only ones responsible for keeping the young person safe

I also wonder whether we can also observe a sense of threat perceived by Helena in the context of risk—risk becoming persecutory for the therapist, as her statement 'I had to protect my back' might suggest.

Similarly, Charlotte discussed the importance of a robust network surrounding the young person, adding how important it was for her to be able to rely on the network:

> *It was helpful also that she, that there were other services involved, so it was my discipline, multidisciplinary team, but there was also a crisis team that was not always actively involved, and a family GP that knew the mum and the family very well that I felt was, you know… if I went, if there was a break you know, they know what's going on.*
>
> *P. 19, line 463*

On an interpretative level, I wonder if Charlotte is conveying finding it difficult to take a break from work without being preoccupied with the young person's safety. Reliance on the network possibly enabled her to take care of herself. Laura also shared a similar view that a therapist must keep themselves well and have trust on the network. As we explored in the second theme, preoccupation with risk can be very difficult to manage, and the boundaries between professional and personal life can easily get blurred.

Anne shared:

> *Her eating disorders deteriorated to the point that I called the parents and say that they should do something because I couldn't continue to see her without medical help because her GP didn't do anything. And finally, the GP referred her to an eating disorder unit. And now she's going to this eating disorder as an inp... as an outpatient.*
>
> P. 7, line 123

The implication here is twofold: the importance of the network, and Anne's frustration when she could not rely on it. The word "finally" and the false start "inp…" may suggest that Anne had been waiting for the network to respond for too long, feeling that the risk was too high to be borne solely by her. Her narrative also conveys that she felt like "the voice of one calling into the wilderness"—a very lonely and frustrating place to be.

Helena, Laura, and Charlotte also discussed the important role of the network in containing their anxieties. This makes me think of "the container's need for containment".

> *[…] therapy within a framework of other people caring for her and caring for me. And that's what helped, otherwise there's no way it would be possible.[…] There was the collaboration of people in the network when her own parents had never collaborated […]. So, she had the experience of us working together.*
>
> Laura, p. 11, lines 204

> *I just felt I needed something very robust around her, to feel less anxious around the work or the possibilities of what she might do.*
>
> Charlotte, p. 18, line 445

> *I don't think I could have done it on my own. It was vital that I have a psychiatrist*

who is very accessible.

Helena, p. 20, line 352

All three participants communicate that the work could not be accomplished alone, highlighting the importance of the network for the therapists' psychic survival. Additionally, Helena presents another interesting role of the network as a “parental couple” for the young person. This makes me wonder whether Helena unconsciously conveys that she also felt “parented” by the network, which could contain all her fears, freeing mental space for the therapeutic work.

Robert—possibly due to being a trainee when working with the presented case—does not discuss the importance of the network. This made me reflect on the difference between the difference of the experience of a trainee when holding clinical responsibility and a qualified psychotherapist, as the level of responsibilities and the liaison with the network, usually, are very different responsibilities post-qualification. From my experience as a trainee CAPT and later as a qualified CAPT, I realised how protected trainees are by their senior colleagues and supervisors who, ideally, hold the clinical responsibility for the trainees’ psychotherapy cases. This dramatically changes as one transitions to a role as a qualified CAPT working either in the NHS or in private practice, as the caseload is bigger, and the clinical responsibility changes form. As the participants discussed, they relied on the network and other colleagues to think and take decisions for a case.

Subordinate Theme 5b: Need for a reflective space

In all interviews, apart from Anne’s, the need for a reflective space and support on a more personal level was discussed as important. I understand this difference to lie in Anne’s seniority—having, I believe, over 30 years of experience. However, this raises a questions in my mind: doesn’t everyone need, or at least wish to have, a reflective space for their work, irrespective of their years of experience?

I kind of constantly bring this case to supervision.

Helena, p. 9, line 149

Supervision helps hugely and even to just hold me emotionally together with it, but also just technically as well. […] and also, my colleagues, the ones that I was able to talk to. So, I didn't feel I needed that third space in my mind.

Laura, p. 7, line 128

I did take it to the team meetings because she had such an impact on me and what I was helped to think about was a very early relationship with her maternal object.

Charlotte, p. 6, line 148

Here, Helena, Laura, and Charlotte convey the need of a thinking space held in supervision, group supervision, or team meetings. All of them speak about the need for the therapeutic work to be thought about and reflected on outside of session time. Their excerpts convey the challenges of the work and how, at times, thinking during the session can be difficult. Laura discusses the importance of her colleagues doing the thinking for and with her, taking on a 'third position,' which may allow her to feel freer and more in contact with the 'here and now' with her patient."

Charlotte's example illustrates how the team helped her to think beyond the boundaries of the therapeutic relationship. This might indicate an intense emotional experience that made it difficult for her to think outside of the dyadic relationship.

In the excerpts that follow, Laura and Charlotte illustrate the negative impact of the absence of time or space to reflect:

I don't leave enough space to process the work, and I do think this has an impact in many ways. So, I find myself getting more overwhelmed or stressed sometimes […]

> *this work needs a lot of space and time to be able to process and to think.*
>
> Laura, p. 28, line 514

> *[…] feeling overly busy, not having enough time to think about it properly or to write it up in a certain way or even think about the links that got missing that one could have made at this stage.*
>
> Charlotte, p. 20, line 475

Laura indicates that it is not only the work that is impactful, but also the lack of a space to reflect and contain her worries. Charlotte's narrative might also indicate a feeling of regret as opportunities to make links were missed due to a busy schedule. On a more interpretative level, I wonder whether therapists not allowing enough time to pause and reflect, unconsciously serves as a disconnection with painful feelings or a, necessary distance from patient's psychic pain.

Robert expressed a different experience, one that the reflective space provided to him could not capture the difficulties he experienced:

> *I just felt very isolated in the work, even though I was very well supported, I just felt that for the issues it brought up for me and the patient I just didn't feel equipped, the training didn't equip me for it. I just felt a bit sad actually*

Robert felt that supervision was not a place to which he could bring his emotional experiences of his work with the adolescent, and the issues of race and culture that were central to his work, but neither could it capture the young person's experiences. This might indicate that Robert felt excluded, "parked aside" as he worded in a later part of the interview. Robert talked about being able to truly reflect on the work in his personal analysis. This makes me wonder whether differences (cultural, racial, or class) between supervisor and supervisee might limit opportunities for reflection and deeper understanding, as Robert

shared that even though he was supported, he felt isolated and unable to discuss in supervision how the work impacted him personally.

DISCUSSION

This chapter discusses each group experiential theme in greater detail in connection with the literature review, and how the findings relate to my clinical experience. Additional literature is presented to address some of the findings. At the end of the chapter, I address limitations of the study, suggestions for future research, and clinical implications.

Losing the internal compass

A common finding across all interviews was the difficult emotions stirred up at different stages of therapy with their adolescent patients. Participants talked about an array of emotions, from feeling hopeless, emotionally drained, and confused, to feeling trapped, controlled, and attacked. I believe this to be an intrinsic part of the work with adolescents who, as discussed in the literature review (Blakemore & Choudhury, 2006; Guyer et al., 2016), undergo rapid developmental and emotional changes, and therefore finding it difficult to manage their emotional experiences, who as the findings suggest (Morán, J., et al., 2019) are in turn experienced by the therapists. The participants seemed to understand these experiences not only as their countertransference response, but as the work having impacted them on a personal level. Most of the therapists talked about often feeling impotent, questioning their agency as therapists, whether their approach was good enough, or even whether child psychotherapy can offer valuable support to the cases discussed. The intensity of the emotional impact on the therapists might indicate that the boundaries between the professional and the personal can often become rather pliable, highlighting that countertransference and personal feelings of the therapist are not mutually excluded. As discussed in the literature review, fundamental part of our psychoanalytic thinking is to be able to hold a “third” space in our mind that allows us to differentiate what belongs to us and what to our patients.

Hopelessness was another common finding shared among most of the therapists, who often

felt that they did not know what they were doing when, for instance, there was an increase in risk. This is in line with the findings of Tanzilli et al. (2024), who have found that hopelessness and negative feelings in the therapist are often connected with a particular depressive presentation and personality characteristics. This was enquired by one therapist as to whether it was her patient's personality responding to her depression or her depression that what such an impact on her.

Feelings of hopelessness, confusion, and impotence—along with a sense of being controlled or stuck—reflect my own experiences during my doctoral training and as a qualified CAPT, working with adolescents struggling with depression. In many cases, their treatment seemed to be stagnant or not progressing. These exact emotional challenges inspired my doctoral thesis as I became curious about the experiences of more experienced psychotherapists. I wondered if these feelings were unique to my time as a trainee or if they were more commonly shared within our profession. When I discovered that participants, with varying levels of experience, voiced similar sentiments, it provided me with a sense of containment and sparked my curiosity about the underlying meaning of these experiences.

One therapist openly talked about feeling manipulated and controlled, describing the young person's depression almost as something "contagious", which she had to protect herself and move away from. She seemed to empathise with the young person's mother who similarly seemed to perceive her daughter's depression as dangerous (according to the therapist's narrative). This reminds me of Winnicott's (1949) concept of "hate in the countertransference", and how this participant was able to think about—as opposed to act out—her negative feelings, while it provided her with insight about her patient's relationship with her real and internal mother. The same participant brought a question into our thinking, of whether it was the depression or her personality's response to depression that made such an impact on her, and talked about how, through feeling manipulated, she gained an

understanding of the young person's "object relations". This is also in line with Tanzilli et al.'s (2024) discussion on how specific personality characteristics elicit particular countertransference responses in the therapist. I will explore this further in my discussion on the fourth group experiential theme below.

Anne talked about feeling irritated by the young person when feeling confused, or finding it hard to bear "not knowing". Even though being able to tolerate not knowing—or "the negative capability" (Bion, 1967)—is one of the fundamental teachings in psychoanalytic training and work, Anne shared that this can be very difficult in practice. She noted the importance of checking her countertransference feelings to see whether she is acting out those feelings in the therapy. This finding is also in line with those of Tanzilli et al. (2024), that is, that the therapist needs to monitor their countertransference feelings in order not to act on them, but also—as mentioned above—in order to gain further insight into the young person's way of relating, both interpersonally and intrapersonally.

Robert brought his experience of being attacked and othered by the young person, but also the way in which he reflected on his countertransference experience to understand the young person's internal reality, but also cultural self which was kept outside the therapy room. He talked about feeling sad for who he was in the transference for his patient but was then able to understand how this girl related to men, specifically older men, in the context of her culture. Here, we saw how Robert's attunement with his own emotional experiences bridged his connection with the young person who had split off her unwanted parts into him (Bion, 1962). He openly shared feelings of sadness as a result of being racialised and othered by her, but throughout the interview he reflected on being able to make sense of these feelings within himself before trying to invite the young person into the thinking.

It was interesting to observe that Robert, the only participant of colour, was the only one who brought issues of difference, race and culture and explored the cultural differences on countertransference dynamics among the participants. I reflected on why the other

participants —who were white British or white European —did not raise sociocultural issues. Could it be that, as individuals from the dominant racial and cultural group in this setting, might have felt less aware or comfortable of contemplating issues of race and culture in the therapeutic relationship?

On the hindsight, I also question why I, a white European woman, did not inquiry these issues myself. I wonder whether I felt like I assumed the same perspective with the other participants who did not readily articulate differences on culture, race, or class.

Thinking about the therapists' experiences of almost having a professional identity "crisis" feeling lost, hopeless and impotent—makes me think of the way Waddell (2018) describes the process of adolescence as "moving into a world where everything is in flux" (p. 35). It seemed to me that all therapists shared a similar experience with their adolescent, not knowing where they are going, who they are, and what their value is, being in contact with loss and vulnerability, often feeling at the edge of giving up. No matter how painful this is, it seems an integral part of the work to think about the meaning behind these emotional experiences, as it might be the only way to truly make contact with the young people.

On a more reflective note, it was interesting to observe how difficult it was for some participants to think more symbolically on the negative transference. I remember that in some interviews, it was hard to understand what the therapists' sense-making of their countertransference and the unconscious communication of the young person was, as I had to repeat the question about the symbolic meaning several times. This makes me wonder whether this difficulty on the part of the therapists might mirror the difficulty of the adolescent in accessing and reflecting on their emotional experiences. This was also experienced by me in the process of analysing the data, as, at times, I found it hard to think symbolically.

Risk changes it all

Four participants discussed the impact that suicidality and risk towards the self (in one case the risk was anorexia) had on them. They described very painful experiences of feeling frightened, rather terrified with the idea of the patient committing suicide, preoccupied with the risk of the young person outside of sessions, feeling solely responsible and full of doubt about whether they had made the right decisions in regard to their response to possible risk. The uncertainty between sessions, the sense of responsibility, but also the raw truth they were in contact with—the young person's wish to die—filled their minds with fears about the young person's safety. One therapist talked about how she would sometimes wake up in the middle of the night with terror about whether her patient was safe. This makes me think about mothers waking up in the middle of the night checking whether their newborn baby is breathing. I wonder whether the patient inhabiting in therapist's mind, apart from being experienced as an intrusion, as discussed in the interview, is a communication of them *needing* to be held in someone's mind, and to for the therapist to tolerate the frustration. For example, the therapist who talked about waking up in the night with terror about her patient's safety explained that this young person was never thought about by her mother, on the contrary, she was abused by her. It seems to me that the therapist was very open to her patient's need of mental holding, in the way that Winnicott (1971) describes the "holding environment".

The therapists' experience of feeling utterly frightened also makes me think of Bion's (1962) connection between countertransference and projective identification. Bion talks about the psychoanalyst not only becoming the unwanted parts of the patient in the patient's mind, but in the psychoanalyst's mind too. The worry, fears, and self-doubts, among other intense feelings described by the therapists, might well be the projected parts of the young people that the *therapists* identified with too. All therapists described how mobilised they felt when faced with dilemmas like "Do I let the parents know or will the risk be increased?" or "Did I

make a good safety plan?", i.e., thinking versus action. On the one hand, these dilemmas highlight the challenge of balancing the safeguarding of adolescents while also maintaining a trusting relationship with them. On the other hand, as Anderson (2002) describes, some young people manage to mobilise other people as a way of communication and enactment of unresolved conflicts, but only towards the people who are available to listen. Anderson gives a parallel of risk and what is mobilised in the therapist with the mother's capacity for reverie (Bion, 1962), and how this gives the baby the sense that she got rid of something dangerous and "is now safely outside" (Anderson, 2002, p. 74). It is no longer a threat to the self.

Two participants vividly described experiences of being in contact with their patients' wish to die. They talked about "accompanying" the patients in a very dark, rather claustrophobic, and nightmarish place. This makes me think of how Briggs (2009) describes the dyadic relationship in suicide and the underlying meaning. This part of the work seems to me enormously meaningful for the young people, as the therapists were available to see *how* it feels to inhabit such a place: possibly one has to be "in" there before trying to get the young person "out".

The therapists also talked about the risk experienced as a real threat which they had to deal with and work though, especially when decisions needed to be made around the safety of the patients. One therapist explicitly talked about her experience of suicide of a previous patient, which impacted her tolerance of risk in the cases she worked with at a later stage in her career. I wonder whether this experience had made her more sensitive to feeling anxiety, solely responsible, or being very active in regard to writing reports or liaising with other professionals to ensure the safety of the adolescent. I wonder whether "action", that is writing reports, professionals' liaison etc, can also provide the therapist with a sense of psychological safety, feeling that they *did* whatever was possible. This opens up a broader question about risk management and safety plans, and whether they can *actually* prevent a young person from harming themselves, as discussed in the literature review (Large et al (2017). How can we use our psychoanalytic thinking and understanding of risk when

making meaningful safety plans with risky patients and their families? Anderson and colleague's study (2012) seems to be a useful guide on this respect. This dilemma mostly applies to work in NHS services, where time for reflection and thinking can, at times, be a luxury. It also brings us in contact with the reality that we, as clinicians, have limitations.

Two participants talked about coming to terms with their limitations from different perspectives. One spoke about the reality being that nobody can really prevent the unimaginable, as therapists and clinicians we have limitations, stating "*if you actually think you are going to save them, it's an illusion"*. The same therapist insightfully added that hope is something that sustains the therapist to keep working and thinking *with* the patient to help her/him understand. This comment still resonates with me, and I often turn to it in my mind when working with adolescents, whose hopelessness and risk are very present in the work, and in my mind, often beyond the session time. Thinking about limitations, another therapist expressed feeling perturbed when the adolescent had nearly been admitted to an inpatient unit. In this case, facing her limitations possibly led to the therapist's sense of agency being shaken.

Reaching the adolescent

This finding addresses some important considerations about psychoanalytic technique with adolescents with depression, who often were difficult to reach. All therapists talked about finding their way to the adolescent, in most cases by first discovering what does *not* work. All of them were very open in their accounts of what they felt was happening in their minds during the session, who they felt they were in the transference, how they responded to this, and how these brought insight into what the patient was ready to hear and at what pace. This is in line with the study presented in the literature review (Binder et al.,2008a) which showed that therapists created a therapeutic bond by, among others, trying to assume an effective therapeutic role, help the adolescent find motivation to engage in therapy, and importantly, create a safe framework of mutual understanding.

Robert linked his personal experiences of racism, and how his patient's projections into him reactivated some of these experiences. He talked about initially holding onto the role of the one who "knew", which possibly limited the space for thinking with the young person. I wonder what was possibly re-enacted in his relationship with the patient, and whether he acted in the transference at this stage of therapy (Joseph, 1978). Robert raised a topic that was distinct from the rest of the findings. He reflected on race and internalised colonial ways of thinking (Fanon, 1952) and how they played a significant part in him providing therapy to this adolescent. This is also in line with Briggs (2008). Later in his narrative he expanded on the role of his training regarding the ideas he formed as what he referred to as "good" and "accepted" in relation to ideas about "the self and other".

One therapist talked about facing and having to reflect on her wish for the patient to feel better, realising that this increased the patient's passivity as all the wish for life was located into her. This makes me think of Bion's (1967) expression "without memory, desire or understanding" and how difficult this can be in practice. It also brings to mind Ogden's (1979) idea that, through projective identification, the patient might project her wishes for recover into the therapist, so that these wishes are protected from the destructive parts of herself. On the other hand, I think that this therapist conveyed her wish to help the young person find a wish for a "life worth living". This is in line with Anderson's (2012) recommendation that clinicians working with adolescents at risk of suicide will hopefully be able to help the young people not reach a point of finding themselves at a "dead end" (p. 148), but a life worth living.

Another common theme across the interviews was adaptation of psychoanalytic technique. One participant brought her dilemma in thinking about how she *had to* find a different way of working with the young person, which made me wonder whether this conveyed that she felt that this went "against" the psychoanalytic frame she trained into. I consider this to raise a central question for our profession: how often do we feel we are "tied" to the way of working

we have been trained in, that when we find more flexible ways, we feel that we are doing something wrong? Can we allow ourselves to be open to meeting the patient at their level (Alvarez, 2012) and learn from them? Many child and adult psychotherapists have written extensively about technique. Horne (2007) highlights the importance of the therapist finding the right pace with the adolescent and comments—like the participants—on how the adolescent can experience silences as very difficult, as they might bring fears of an absent object. As discussed in the literature review, this is in line also with Briggs (2002) emphasising the importance of the therapist addressing the specific developmental and therapeutic needs of the young person, rather than rigidly following a particular therapy model.

One participant made an interesting comment on having to adjust the transference interpretations since, if given prematurely, they might be experienced as intrusive. Casement (1985) vividly describes that some transference interpretations might be experienced as "being pushed down the patient's throat". These issues were brought up in the study of Jones (2020), as discussed in the literature review, where they discussed that therapists conveyed that they found transference interpretations to be helpful, but challenging for the therapists.

Similarly, a study showed that transference work is beneficial for adolescents with depression (Ulberg et al., 2021), but it proved difficult for both therapists and adolescents. The participants of the study shared that at the start of the treatment they had to do "preparatory work" before being able to interpret the transference. For example, one therapist talked about using mentalisation, another about exploring transference phenomena via books or movies, while another talked about carefully wording what she felt was communicated.

Another important element of this finding is that some therapists talked about the young people having experienced trauma in their childhood. They worked very carefully to help

them feel safe in the room. One way they did this was to be transparent with their thoughts and bring their dilemmas into the room. In these cases, silences do not bring fears of an absent object, as described above, but of present abusive or benevolent objects. Emanuel (2021) explains about our work with patients who have experienced trauma: "Before someone can approach the deepest traumatic pain or phantasy, they need to feel they have some resources to manage their anxieties, and this is not based on insight […] The essential starting point has to be to enable the patient to feel they are safe" (p.3 94). The way the therapists talked about the young people having a fear of the other person's mind makes me wonder about their early object relations (Klein, 1957), the infant's lack of a sense of herself and what is in her mind due to the absence of receptivity in the parents' mind.

The essence of *how* we work with adolescents with depression would be unfairly described as merely "technical considerations", as it involves sensitivity, attunement, and deep engagement of the therapist in the work; it involves the therapist's presence and thinking, and this, I believe, cannot be thought of simply as a technical consideration.

Therapeutic relationship is a personal matter

Participants' narratives of their work and emotional journey showed that the therapeutic relationship is a personal matter not only for the young person, but for the therapist too. This was seen in the ways in which they talked about their thoughts on the therapeutic relationship and the meaning they placed on it. Some therapists made links between their own experiences in adolescence and the experiences of their adolescent patients. One therapist made an unexpected link between her 18-year-old self and her patient. All therapists talked about having learned and developed greatly from the case they presented.

Two therapists talked powerfully about the therapeutic relationship. One talked about transforming feelings of rejection into hope when his interest in the young person's experience made something unbearable tolerable. He talked about finding hope within the

relationship helping him overcome his difficult emotions and through that he invited the young person's interest in understanding. Similarly, another therapist placed the meaning not in her role as a therapist, but in the therapeutic relationship. Bollas (1979) writes about the role of the primary caregiver in shaping the infant's internal world, and how this relationship informs the way in which the infant relates to the world. In a different part of the interview the same therapist talked about helping the young person learn about the world, as if she was viewing the world through the therapist's eyes. This is in line with what the literature presented about the importance of the first experiences of the infant–caregiver relationship, which is somehow represented here in the therapeutic relationship.

Thinking about parental feelings being stirred up in the therapists, one therapist talked about the aim, in psychotherapy, of restoring the internal relationship with the mother. Similarly, most of the therapists talked about their caring, parental feelings. However, most of them talked about the disappointment and sadness they felt when realising that they represented something different in the young person's mind, e.g., a non-understanding object or a dangerous other. As Casement (1985) suggests, analysts do not only represent the "good parent", but may well represent a "bad object"; this will then give the patient an opportunity to get in touch with the feelings that could be expressed and worked through with the original object. This makes me think about how painful it was for the therapists to be seen as a "bad" figure when they were trying to restore the internal object relations. This should be particularly difficult when the therapist represents an abuser.

The interview process became a reflective space in which some of the participants made personal links between their adolescent self and the patient. Robert talked about painful personal experiences as a young person of colour in this country. He talked about feeling non- belonging in society, wanting to study, but how his experience—and reality, too—was that people did not have equal access to the educational system. Robert's narrative speaks of how the external, raw reality of being racialised and marginalised impacts the internal. He

talked about *knowing* what the experiences of the young person were, as he had been through the similar experiences. This makes me think that the boundaries between external and internal are thin and in constant interaction. As child psychotherapists we need to think about the realities we and our patients live, and the realities we share, and find ways to bridge those we do not. Culture, race, religion, and class are all aspects that we need to include in our work and find ways to think about with young people. This accords with Behrhorst et al. (2023), who found that depressive symptoms in Black youths can manifest differently as a result of having to protect against discrimination by different racial groups.

Another participant realised that she had been depressed at the same age as the young person she presented. She met this discovery with positive surprise, and it seemed to be that the link between her vulnerable adolescent self and her patient was unconscious and inaccessible to her during the treatment and her personal analysis. This makes me think that links can be made when one has achieved a distance from the work and have time to reflect. The therapist was able to realise something about the young person, and possibly develop sympathy, only when she openly reflected on her own difficulties with separation and early adulthood. Bonovitz (2009) talks about this in his paper on how the analyst's childhood inevitably emerges in child psychotherapy. He notes that, through countertransference feelings, the therapist might not only understand something about the young person's mental life, but also her own. The author highlights the importance of reflecting on the countertransference responses in order to avoid enactments. It was surprising also for me to witness the discovery in the above-mentioned interview. I wondered how she, a very experienced CAPT, had felt sharing this with me, a trainee CAPT at the time. I vividly remember this moment in the interview, where I, as. the interviewer, felt that we had a moment of connectedness with the participant, in a rather personal level. I felt grateful for the participant sharing this personal experience with me, and at the same time greatly responsible for holding this precious insight. I also wonder whether the therapist would have felt differently towards the young

person if she had made the link earlier.

The therapist also made a different comment, indicating that one might become a Child Psychotherapist by virtue of difficult experiences early in life. This made me curious: How do our early experiences inform our decision to study in this field?

Another mind to think with

Four therapists shared the view that the network's involvement was vital for the patient, the continuation of therapy, as well as for the therapists themselves. In the risky cases that were presented, the shared responsibility with the network was of paramount importance for the therapists to feel that they did not hold the risk on their own. The therapists felt a great sense of responsibility and that their role, and therapy, was important for the young person's life. Therefore, the network (psychiatrist, school, or other professionals) seemed to provide "containment" to the "container". All participants expressed that sharing the risk and thinking with other professionals freed mental space and effectively helped the process of the treatment. This is in line with Midgley et al. (2012) highlighting the importance of multidisciplinary teams in providing integrated care to adolescents whose depression is often multiply determined.

Some participants also talked about the importance of supervision, peer group supervisions, multidisciplinary team meetings, and personal analysis, when thinking about the cases. However, two participants talked about having few spaces for reflection due to work demands, in their NHS or private work, leaving little time to pause, think, and make links. On the one hand, I wonder whether too much work—too much action, as it were—restricts space for contact to be made with the psychic pain of the young people we work with. On the other hand, it is concerning how much stress many CAMHS services are currently under, with a steady increase in referrals. This raises a question in my mind: what are the implications of the absence of time to reflect on the treatment and care provided by professionals? This is a question is often raised in my mind as a qualified CAPT working in two

very busy clinics, one of which is in the NHS, as I understand even more now the importance of available time to think within myself, but also with colleagues and supervisors. Our work, especially with complex presentations, demands thinking spaces beyond the clinical session time.

On that note, I wonder whether the interview process served as a unique reflective space for some of the participants. It was interesting to observe the eagerness with which some wanted to reflect about their cases, especially those where there was risk involved. All participants found the interview process interesting, noting that it helped them think. This highlights the importance for therapists to secure spaces to think about the therapy they offer, how it affects them emotionally, what this means, and what links can be made between therapists' own feelings and young persons' mental experiences.

CONCLUSION

Summary of findings

This study has explored the lived experiences of Child and Adolescent Psychotherapists who have worked with adolescents with depression. The findings highlight the multilayered complexity that work with adolescents with depression can entail, especially when there is an element of risk, the emotional impact that the work has on the therapists, and the individual experiences of the therapists linked with the experiences of the adolescent.

Exploring therapists' emotional experiences of the work has revealed the impact of this work on the therapists' sense of professional identity and agency, and how it affects them on a more personal level, creating intense emotional responses. Countertransference has strongly emerged as a particularly useful tool for work with adolescents with depression, who typically do not easily engage in treatment or are difficult to reach. The findings have illustrated ways in which insights from the therapists' countertransference brought better understanding about the external reality of the young person, and vice versa. For example, one participant spoke about how his countertransference, e.g feeling that the adolescent did not bring her emotional experiences into the therapy, helped him understand about the ways with which this young person related with older people within her culture. Equally, by exploring the cultural self of the young person, he better understood his own emotional responses (that is who he was in the transference), towards the young person. Aso, being able to reflect on their intense emotional experiences, such as strong dislike or parental feelings, therapists understood the complexity of the young people's object relations.

The findings brought important considerations about the way CAPTs think about and use their psychoanalytic technique in the room with adolescents with depression, highlighting how difficult it can be to reach these adolescents, and how the therapists' attunement, sensitivity, and creativity help in reaching the adolescent.

Furthermore, this study has underscored the impact of risk and suicidality on the therapist, The findings evidence the importance of the therapists' containment in order for the treatment to be sustained and protected from feelings of anxiety in the therapist. Robust MDT around the case also seemed to be of paramount importance, as depression is often one part of a more complicated picture.

The study also found that the boundaries between the professional and the personal can be malleable. Some cases might unconsciously reactivate child psychotherapists' early personal experiences which, if not thought and reflected about, can affect the way in which they relate to the adolescent patient. This again highlights the need for thinking time, as its absence might have clinical implication.

Limitations

This study has a small sample size, with five participants interviewed through semi-structured interviews. Even though there was relevant homogeneity in participant responses, due to the small sample size, this does not indicate that all CAPTs share the same views and have the same experiences when working with this patient population. Therefore, the study does not provide generalisability.

I analysed the data working and thinking within a psychoanalytic framework. This means that the questions in these semi-structured interviews were formed through my psychoanalytic thinking. Similarly, the data were analysed through psychoanalytic lens, and it is likely that a researcher from a different theoretical background or discipline would produce different findings.

Due to the fact that there was no significantly relevant existing research on my study question at the time of conducting the literature review, I initially aimed to cover the main areas of exploration, that is, adolescence and adolescent depression. However, in discovering the findings, important areas of exploration emerged that may have created gaps in the literature

review. I found that the data led to new lines of enquiry that I had not previously thought about. These are the links/similarities between the personal experiences of the CAPTs in their own adolescence or personal life and the experiences of the adolescent in treatment -and how the work might reactivate some of those experiences, and why do we train as CAPTs-what are the links with our own childhood experiences?

Future research

This study has provided interesting and stimulating results for the profession of child psychotherapy, and particularly with the work with adolescents with depression. However, as mentioned above, the data cannot be generalised due to the small sample size.

A larger sample size would provide a more in-depth understanding of the qualities of CAPTs' work with adolescents with depression. It could also contribute to further development and understanding of how psychotherapy works, and help clarify what it is that CAPTs do that impacts specific young people, while not having the same effect on others. During both the design and implementation of the project, I became particularly interested in understanding how adolescents with depression experience psychoanalytic psychotherapy and how it helps (or doesn’t help) them. This would provide rich material and significant findings for the profession of child psychotherapy.

The findings of the study suggest that depression and risk often present together, and this was identified as the most challenging aspect of the therapists' work. We observed how CAPTs think about and respond to risk. Large-scale research could explore how CAPTs and clinicians from different theoretical backgrounds or disciplines approach and respond to depression and risk in adolescents. This would provide valuable insights into what helps the adolescent, their families, and even the therapists, whether in an NHS service or in the private sector.

One participant discussed the role of culture and race and how these factors influenced the therapist-adolescent relationship and the treatment of depression. Further research into how culture, race, and socioeconomic factors contribute to adolescent development and the onset of depression could offer different perspectives on how we think about depression and its treatment in child psychotherapy, particularly in the context of the current socio-economic climate.

Clinical implications

Adolescent depression is a vast topic of exploration within the psychoanalytic thinking and research, and the evidence in support of psychoanalytic psychotherapy for adolescent depression has been growing since the publication of the IMPACT study (Goodyer et al., 2011). This research project has several important implications for clinical practice:

- It can support CAPTs feel that their experience of working with this particular patient population can be a shared experience within CAPTs, and therefore it can help them feel less isolated, especially when they are under strain or experiencing negative feelings towards their case.

- It suggests that exploring new approaches to working with adolescents with depression within the psychoanalytic framework may be helpful. For example, countertransference interpretations might require some "preparatory" work to help the patient develop the capacity for reflection, or feel safe in the therapeutic relationship. This could involve therapists being transparent in their thinking, especially with patients who have experienced trauma, deprivation, or difficult attachments. Thinking creatively might be challenging for some therapists, who may worry that it deviates from the framework they were trained in.

- It highlights the importance of a robust support network around the

adolescent, from which the therapist can receive support in their thinking and decision-making, as well as feel containment. This relieves the therapist from bearing sole responsibility and enhances their sense of security in the therapeutic work they provide.

- It highlights the importance of providing thinking spaces for the therapist, which are equally crucial to the clinical work they provide. The participants discussed how, in the absence of thinking spaces, they may miss opportunities to make important clinical connections, gain further insights, and explore how the work impacts them emotionally, thus preventing enactments in the therapy.

REFERENCES

Abraham, K. (1924). A short study of the development of the libido in the light of mental disorders. I. Melancholia and obsessional neurosis. *Selected papers*, 422-33.

Allen , N. B. & Sheeber , L. B. (2009). The importance of affective development for the emergence of depressive disorders during adolescence. In N.B. Allen & L.N. Sheeber

(Eds.), *Adolescent emotional development and the emergence of depressive disorders* (pp. 1–11). New York, NY: Cambridge University Press .

Alvarez, A. (1997). Projective identification as a communication its grammar in borderline psychotic children. *Psychoanalytic Dialogues*, *7*(6), 753-768.

Alvarez, A. (2012). *The thinking heart: Three levels of psychoanalytic therapy with disturbed children*. Routledge.

Anderson, J., Hurst, M., Marques, A., Millar, D., Moya, S., Pover, L., & Stewart, S. (2012). Understanding suicidal behaviour in young people referred to specialist CAMHS: A qualitative psychoanalytic clinical research project. *Journal of Child Psychotherapy*, *38*(2), 130-153.

Anderson, R., & Dartington, A. (Eds.). (1998). *Facing it out: Clinical perspectives on adolescent disturbance*. Taylor & Francis.

Anderson, R., & Dartington, A. (Eds.). (1998). *Facing it out: Clinical perspectives on adolescent disturbance*. Taylor & Francis.

Arnett, J. J. (2023). *Emerging adulthood: The winding road from the late teens through the twenties*. Oxford University Press.

Behrhorst, K. L., Sullivan, T. N., & Jones, H. A. (2023). Comorbidity in context: patterns of

depressive and anxious symptoms in black adolescents. *Journal of Child and Family Studies*, *32*(11), 3312-3326.

Bhardwaj, A., & Goodyer, I. M. (2009). Depression and allied illness in children and adolescents: Basic facts. *Psychoanalytic Psychotherapy*, *23*(3), 176-184.

Bhardwaj, A., & Goodyer, I. M. (2009). Depression and allied illness in children and adolescents: Basic facts. *Psychoanalytic Psychotherapy*, *23*(3), 176-184.

Bhardwaj, A., & Goodyer, I. M. (2009). Depression and allied illness in children and adolescents: Basic facts. *Psychoanalytic Psychotherapy*, *23*(3), 176-184.

Bion, W. (2023). *Learning from experience*. Taylor & Francis.

Binder, P. E., Holgersen, H., & Nielsen, G. H. (2008). Establishing a bond that works: A qualitative study of how psychotherapists make contact with adolescent patients. *European Journal of psychotherapy and counselling*, *10*(1), 55-69.

Binder, P. E., Holgersen, H., & H∅ stmark Nielsen, G. (2008). Re-establishing contact: A qualitative exploration of how therapists work with alliance ruptures in adolescent psychotherapy. *Counselling and Psychotherapy Research*, *8*(4), 239-245.

Bion, W. R. (1967). Notes on memory and desire. *Classics in psychoanalytic technique*, 259-260.

Blakemore, S. J., & Choudhury, S. (2006). Development of the adolescent brain: Implications for emotion and regulation of behaviour.

Blos, P. (1962). *On adolescence: A psychoanalytic interpretation* (Vol. 90433). Simon and Schuster.

Blos, P. (1967). The second individuation process of adolescence. *The psychoanalytic study*

of the child, *22*(1), 162-186.

Bollas, C. (1979). The transformational object. *The International journal of psycho-analysis*, *60*, 97.

Bonovitz, C. (2009). Countertransference in child psychoanalytic psychotherapy: The emergence of the analyst's childhood. *Psychoanalytic Psychology*, *26*(3), 235.

Briggs, S., Lemma, A., & Crouch, W. (Eds.). (2009). *Relating to self-harm and suicide: Psychoanalytic perspectives on practice, theory and prevention*. Routledge.

Briggs, S. (2002). *Working with adolescents: A contemporary psychodynamic approach.*

Basingstoke, UK: Palgrave.

Briggs, S. (2008). *Working with adolescents and young adults: A contemporary psychodynamic approach*. Bloomsbury Publishing.

Campbell, D., & Hale, R. (1991). Suicidal acts. *Textbook of psychotherapy in psychiatric practice*, 287-306.

Casement, P. (1985). *On learning from the patient*. Routledge.

Cregeen, S., Hughes, C., Midgley, N., Rhode, M., Rustin, R. ed J Catty. (2017). Short-term

Psychoanalytic Psychotherapy for Adolescents with Depression: A Treatment Manual.

London: Karnac.

Emanuel, R. (2021). Changing minds and evolving views: a bio-psycho-social model of the impact of trauma and its implications for clinical work. *Journal of Child Psychotherapy*, *47*(3), 376-401.

Felitti, V. J. (2019). Health appraisal and the adverse childhood experiences study: national

implications for health care, cost, and utilization. *The Permanente Journal*, *23*.

Freud, S. (1905a). Fragment of an analysis of a case of hysteria ('Dora'). In A. Richards (Ed.), *Case Histories I.* Pelican Books, 1977.

Freud, S. (1905b). Three essays on the theory of sexuality. In A. Richards (Ed.), *On sexuality.*

Freud, S. (1917). Mourning and melancholia. *The standard edition of the complete psychological works of Sigmund Freud*, *14*(1914-1916), 237-258.

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

Freud, S. (1974). A case of homosexuality in a woman. *The standard edition of the complete psychological works of Sigmund Freud*, 147-172.

Goodyer, I. M., Tsancheva, S., Byford, S., Dubicka, B., Hill, J., Kelvin, R., ... & Fonagy, P. (2011). Improving mood with psychoanalytic and cognitive therapies (IMPACT): a pragmatic effectiveness superiority trial to investigate whether specialised psychological treatment reduces the risk for relapse in adolescents with moderate to severe unipolar depression: study protocol for a randomised controlled trial. *Trials*, *12*, 1-12.

Guillemin, M., & Gillam, L. (2004). Ethics, reflexivity, and "ethically important moments" in research. *Qualitative inquiry*, *10*(2), 261-280.

Guyer, A. E., Silk, J. S., & Nelson, E. E. (2016). The neurobiology of the emotional adolescent: From the inside out. *Neuroscience & Biobehavioral Reviews*, *70*, 74-85.

Heimann, P. (1950). On counter-transference. *International Journal of Psycho-Analysis*, 31, *81-84.*

Horne, A. (2007). The Independent position in psychoanalytic psychotherapy with children

and adolescents. *A Question of Technique: Independent Psychoanalytic Approaches with Children and Adolescents*, 15.

Jane Costello, E., Erkanli, A., & Angold, A. (2006). Is there an epidemic of child or adolescent depression?. *Journal of child psychology and psychiatry*, *47*(12), 1263-1271.

Joseph, B. (1978). Different types of anxiety and their handling in the analytic situation. *The International Journal of Psycho-Analysis*, *59*, 223.

Klein, M. (1935). A contribution to the psychogenesis of manic-depressive states. *The International Journal of Psycho-Analysis*, *16*, 145.

Klein, M. (1940). Mourning and its relation to manic-depressive states. *The international journal of psycho-analysis*, *21*, 125.

Klein, M. (1946). Notes on some schizoid mechanisms. Envy and gratitude and other works 1946–1963. *Int Psychoanal Lib*, *104*, 1-346.

Klein, M. (1997). *Envy and gratitude and other works 1946-1963*. Random House.

Klein, M. (2018). Early stages of the Oedipus conflict. In *Female Sexuality* (pp. 146-158). Routledge.

Krause, K., Midgley, N., Edbrooke-Childs, J., & Wolpert, M. (2021). A comprehensive mapping of outcomes following psychotherapy for adolescent depression: The perspectives of young people, their parents and therapists. *European Child & Adolescent Psychiatry*, *30*, 1779-1791.

Lanyado, M., & Horne, A. (Eds.). (1999). *The handbook of child and adolescent psychotherapy: psychoanalytic approaches*. Psychology Press.

Laufer, M. (1981). The psychoanalyst and the adolescent's sexual development. *The*

Psychoanalytic Study of the Child, *36*(1), 181-191.

Laufer, M. (2018). Psychological development in adolescence:“danger signs”. In *The Suicidal Adolescent* (pp. 3-20). Routledge.

Lewinsohn, P. M., Rohde, P., & Seeley, J. R. (1998). Major depressive disorder in older adolescents: prevalence, risk factors, and clinical implications. *Clinical psychology review*, *18*(7), 765-794.

Large, M., Ryan, C. and Carter, G. (2017) Can we usefully stratify patients according to suicide risk? *British Medical Journal.* 359 pp. J4627.

McWilliams, N., & Lingiardi, V. (2017). *Psychodynamic Diagnostic Manual:: PDM-2*. Guilford Publications

Mead, M. (1943). *Coming of age in Samoa.* London: Penguin Books. In Music, G. (2016). *Nurturing natures: Attachment and children's emotional, sociocultural and brain development*. Routledge.

Meltzer, D. (1994). Temperature and distance as technical dimensions of interpretation: 1976. In *Sincerity and other works: Collected papers of Donald Meltzer* (pp. 374-86).

Midgley, N., Ansaldo, F., & Target, M. (2014). The meaningful assessment of therapy outcomes: Incorporating a qualitative study into a randomized controlled trial evaluating the treatment of adolescent depression. *Psychotherapy*, *51*(1), 128.

Midgley, N., Cregeen, S., Hughes, C., & Rustin, M. (2013). Psychodynamic psychotherapy as treatment for depression in adolescence. *Child and Adolescent Psychiatric Clinics*, *22*(1), 67-82.

Midgley, N., O’Keeffe, S., French, L., & Kennedy, E. (2017). Psychodynamic psychotherapy for children and adolescents: an updated narrative review of the evidence base. *Journal of*

Child Psychotherapy, *43*(3), 307-329.

Morán, J., Díaz, M. F., Martínez, C., Varas, C., & Sepúlveda, R. P. (2019). The subjective experience of psychotherapists during moments of rupture in psychotherapy with adolescents. *Research in Psychotherapy: Psychopathology, Process, and Outcome*, *22*(1), 346.

NICE (2019) NICE guideline [NG134] Depression in children and young people: identification and management, available at: https://www.nice.org.uk/guidance/ng134/chapter/Recommendations)

Ogden, T. H. (1979). On projective identification. *International journal of psychoanalysis*, *60*(3), 357-373.

Patton, G. C., & Viner, R. (2007). Pubertal transitions in health. *The lancet*, *369*(9567), 1130-1139

Patton, M. Q. (2002). *Qualitative research & evaluation methods*. sage.

Pearce, J. B. (1978). The recognition of depressive disorder in children. *Journal of the Royal Society of Medicine*, *71*(7), 494-500.

Puig-Antich, J. (1982). Major depression and conduct disorder in prepuberty. *Journal of the American Academy of Child Psychiatry*, *21*(2), 118-128.

Reiss, F., Meyrose, A. K., Otto, C., Lampert, T., Klasen, F., & Ravens-Sieberer, U. (2019). Socioeconomic status, stressful life situations and mental health problems in children and adolescents: Results of the German BELLA cohort-study. *PloS one*, *14*(3), e0213700.

Rey, J. M., Sawyer, M. G., Clark, J. J., & Baghurst, P. A. (2001). Depression among Australian adolescents. *Medical Journal of Australia*, *175*(1), 19-23.

Rustin, M. (2009). The psychology of depression in young adolescents: A psychoanalytic

view of origins, inner workings and implications. *Psychoanalytic Psychotherapy*, *23*(3), 213-224.

Smith, J. A., & Nizza, I. E. (2022). *Essentials of interpretative phenomenological analysis*. American Psychological Association.

Smith, J. A., & Nizza, I. E. (2022). *Essentials of interpretative phenomenological analysis*. American Psychological Association.

Spillius, E. (2007). Kleinian thought: overview and personal view. *Encounters with Melanie Klein: Selected Papers of Elizabeth Spillius*.

Tanzilli, A., Fiorentino, F., Liotti, M., Buglio, G. L., Gualco, I., Lingiardi, V., ... & Williams,R. (2024). Patient personality and therapist responses in the psychotherapy of adolescents with depressive disorders: toward the Psychodynamic Diagnostic Manual. *Research in Psychotherapy: Psychopathology, Process and Outcome*. *Three essays on the theory of sexuality and other works.* Pelican Books, 1977.

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

Trowell, Judith, Ilan Joffe, Jesse Campbell, Carmen Clemente, Fredrik Almqvist, Mika Soininen, Ulla Koskenranta-Aalto et al. "Childhood depression: a place for psychotherapy: an outcome study comparing individual psychodynamic psychotherapy and family therapy." *European child & adolescent psychiatry* 16 (2007): 157-167.

Ulberg, R., Hummelen, B., Hersoug, A. G., Midgley, N., Høglend, P. A., & Dahl, H. S. J. (2021). The first experimental study of transference work–in teenagers (FEST–IT): A multicentre, observer-and patient-blind, randomised controlled component study. *BMC psychiatry*, *21*, 1-10.

van Velzen, L. S., Toenders, Y. J., Kottaram, A., Youzchalveen, B., Pilkington, V., Cotton, S. M., ... & Schmaal, L. (2022). Risk factors for suicide attempt during outpatient care in adolescents with severe and complex depression. *Crisis*.

Waddell, M. (2018). *Inside lives: Psychoanalysis and the growth of the personality*. Routledge.

Winnicott, D. W. (1949). Hate in the countertransference. *International journal of psychoanalysis*, *30*(2), 69-74.

Winnicott, D. W. (1958). The capacity to be alone. *The International Journal of Psycho-Analysis*, *39*, 416.

Winnicott, D. W. (2018). Mirror-role of mother and family in child development 1. In *Parent-infant psychodynamics* (pp. 18-24). Routledge.

APPENDICES

Appendix 1: Email to ACP

Date:

To whom it may concern,

My name is Lina (Stavroula) Stavrakaki and I am a Child and Adolescent Psychotherapist in Doctoral training at the Tavistock and Portman NHS Trust on my third year of training. My clinical placements are North Camden Community Team and Simmons House, inpatient adolescent unit.

I am contacting the ACP as a trainee member, hoping that I will recruit respondents from its qualified members for my qualitative research project. The title of my ProfDoc is: How do Child and Adolescent Psychotherapists experience their work with depressed adolescents? An interpretative Phenomenological Analysis.

The purpose of this project is to explore Child and Adolescent Psychotherapists' lived experiences of working therapeutically with depressed adolescents. It aims to understand more about the ways in which the work with these adolescents affects the Child and Adolescent Psychotherapists' countertransference, thinking, understanding and technique. I am hoping this may also provide clinicians with a space to reflect on what it is like to work with these adolescents and learn from this for their own practise.

This research study has been formally approved by the sponsor and host of the research, the Tavistock and Portman Trust Ethics Committee (TREC).

I aim to interview clinicians with at least three years of experience after qualification with this group of adolescents. The interviews will be semi-structured and will last approximately one hour. They will take place at a day and time convenient to the clinicians. I aim to interview up to five clinicians.

It would be much appreciated if you could kindly share the attached Participant Information Sheet and Participant Consent From with your qualified members. Please do not hesitate to contact me should you require further information about the project or would like to discuss it further.

Contact details:
E-mail: sstavrakaki@tavi-port.nhs.uk Telephone: X

With kind regards,

Lina (Stavroula) Stavrakaki

Appendix 2: Participants Information Sheet

The Tavistock and Portman NHS Foundation Trust

Participant Information Sheet

Professional Doctorate Research Project title : How do Child and Adolescent Psychotherapists experience their work with depressed adolescents? An interpretative Phenomenological Analysis.

Researcher: Stavroula Stavrakaki

Thank you for expressing an interest in participating in this qualitative research study which will form part of my professional doctorate. This information sheet describes more about the research and what taking part would involve.

What is the purpose of this project? The purpose of this project is to explore Child and Adolescent Psychotherapists' experiences of working therapeutically with depressed adolescents. It aims to understand more about the ways in which the work with this group of adolescents affects the Child and Adolescent Psychotherapists' countertransference, thinking, understanding and technique.

Who is conducting this research?

My name is Stavroula (Lina) Stavrakaki. I am a Child and Adolescent Psychotherapist in Doctoral training at the Tavistock and Portman NHS Foundation Trust. I am working in a CAMHS service and in an inpatient adolescent unit. I am the principal investigator of this

study , I have designed the research study and will conduct the interview and data analysis under the supervision of Dr Danny Isaacs. This project is being sponsored and supported by the Tavistock and Portman NHS Foundation Trust and has been through all relevant ethics approval. This course is overseen and certified by Essex University.

What will participating in the research involve?

If you agree to participate you will be invited to participate in an individual interview lasting approximately one hour. The interview will take place at a time and day convenient to you. The interview will be audio recorded. During the interview I will ask you to identify two cases with the presentation described above and to speak about how it felt working with them in a clinical context. The interview will be semi-scheduled, so that you will be able to freely speak about your experience(s) with my prompts.

I aim to conduct the interviews in person, when possible, but in the context of the COVID-19 crisis, it may be necessary that they are conducted via Zoom video conference at a time that is convenient for you.

I will also provide you with a Post-interview Confidentiality Form and Debrief Letter which will provide specific information and serve to secure your privacy.

Who can take part in the study?

All participants will be expected to be qualified Child and Adolescents Psychotherapists for at least three years and have work experience either in a CAMHS service and/or Tier 4 Adolescent Units. The participants of the interview must have worked with the cases discussed for at least six months. The adolescents do not have to necessarily be given a psychatric diagnosis of depression, even though this could be the case for some of the cases. The adolescents discussed should have had presented with very low mood and suicidal ideation. The age group of the young people will vary from twelve to eighteen years old. The

CPTs must have worked with at least five adolescents since the start of their clinical training. The participants will be prompted to think of two cases that they have worked with for at least six months and discuss their experience when working with them. CPTs with working experience that does not meet the above criteria will be excluded from selection.

Do I have to take part?

No, it is your decision about whether you would like to be involved in this research. Although your contribution would be valuable, in case you agree to take part in the study but then change your mind, you can withdraw your data up to three weeks after the interview, without giving a reason to me. In that case, all data collected from you will be permanently destroyed and not used in the data analysis.

How will you use the recorded data?

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 3-5 years after the study has finished. The interview will be audio recorded and transcribed by myself.

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.

All electronic data will be stored on a password protected computer. Any paper copies will be

kept in a locked filing cabinet. All audio recordings will be destroyed after completion of the project. Data from the study will be retained, in a secure location, for 7 years. Electronic data will e password protected and any physical copies will be stored in a lockable filing cabinet. If you would like more information on the Tavistock and Portman and GHC privacy policies please follow these links:
https://tavistockandportman.nhs.uk/about-us/contact-us/about-this-website/your-privacy/

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.

What will happen to the information I give?

The interviews will be audio-recorded using a voice recorder. I will transcribe and analyse the recorded interviews that will form the data for my doctoral thesis. It may be used in future academic publications or/and presentations. All audio recordings from the interviews will be destroyed by the time of the completion of the project. The transcript of the interviews will be anonymised in order to maintain confidentiality and any personal details which would identify you or your patients will be removed from the transcript. Therefore, any all the information you give me will be anonymised in the final doctoral thesis or any future publication of the work. Please note that I will strictly adhere to the above assurances about confidentiality unless disclosure of imminent harm to self and/or others may occur. In such cases I, The Tavistock and Portman NHS Foundation Trust or the University of Essex may be obliged to contact relevant statutory bodies/agencies.

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

destroyed no later than X years after the study has been written up for academic submission.

What will happen to the results of the project?

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

What are the possible benefits of taking part in this research?

The interview will offer you the opportunity to reflect on your clinical experience, past or current, and it may help you further develop your interest, curiosity and thinking. The results of the study also aim to contribute to psychoanalytic thought and discipline in this area.

What are the possible risks?

There are no direct risks to taking part in this study. However, since the subject of this study is of personal relevance there is a risk that strong feelings will be stirred up. You can stop the interview at any time and I aim to conduct the interview with the utmost sensitivity and respect for the strong feelings that can be stirred up. Therefore, I will be sending a debrief email to all participants after the interview in which I will provide the details of sources of support.

Contact details:

I am the main contact for this project. My contact details are:

Stavroula (Lina) Stavrakaki

E-mail: sstavrakaki@tavi-port.nhs.uk

Telephone: X

Should you have any concerns or further questions about this study you can also contact my supervisor:

Dr Danny Isaacs

E-mail: disaacs@tavi-port.nhs.uk

- If you have any concerns or queries regarding this study, please contact Beverly Roberts, Interim Head of Academic Governance, Quality Assurance and Registry, email: BRoberts@tavi-port.nhs.uk

Thank you for considering taking part in this study and taking time to read this information.

If you are will to participate, please complete the consent form provided.

Appendix 3: Consent Form

The Tavistock and Portman
NHS Foundation Trust

Participant Consent Form

ProfDoc research project title: How do Child and Adolsencent Psychotherapists experience their work with complex and high risky adolescents? An interpretative Phenomenological Analysis.

Name of Researcher: Stavroula (Lina) Stavrakaki

Please put your initials in the boxes on the right below to all that apply.

1. I confirm that I have read and understood the Participant Information Sheet, I have had the opportunity to consider this information and ask any questions I may have, and these have been answered satisfactorily.	
2. I understand that my interview will be audio-recorded, transcribed and analysed by the researcher for the purposes of this study as described in the Participant Information Sheet.	
3. I understand that my participation in this study is voluntary and I am free to withdraw it or any unprocessed data at any time up to three weeks after the interview has taken place.	
4. I understand that my name and personal information linked to my participation in this project will be anonymised and held securely by the researcher.	

5. I understand that the information I give in the interviews will be kept confidential by the researcher unless I or anyone else is known to be at risk.	
6. I understand that vignettes from the interviews may be used in the final doctoral thesis but will be anonymised and held securely by the researcher.	
7. I understand that all data which I contribute will be destroyed not later than X years after the study has been written up.	

8. I understand that the results of this research will be published as part of my Doctoral thesis and may form part of future publications and/or presentations.	
9. I understand that the interview may stir up strong feelings or discomfort, that I can stop the interview at any point and that I will be offered a chance to debrief after end of the interview.	
10. I confirm that I _____(Participant's name) have understood all of the above and what is required of me. I consent to participate in this study.	

Contact details:

Date:

Researcher: Stavroula (Lina) Stavrakaki

Participant's name (printed): _____

Participant's signature:

Date:

Thank you for agreeing to take part in this study. Your contribution is very much appreciated.

This research project has been formally approved by the Tavistock Research Ethics Committee.

Appendix 4: Invitation email

Dear…

My name is Lina (Stavroula) Stavrakaki and I am a Child and Adolescent Psychotherapist in Doctoral training at the Tavistock and Portman NHS Trust in my third year of training. My clinical placements are a CAMHS Community Team and an inpatient adolescent unit.

I am contacting you to ask you whether you would be interested in participating in my research project. The title of my ProfDoc is: How do Child and Adolescent Psychotherapists experience their work with depressed adolescents? An interpretative Phenomenological Analysis.

The purpose of this project is to explore Child and Adolescent Psychotherapists' lived experiences of working therapeutically with depressed adolescents. It aims to understand more about the ways in which the work with these adolescents affects the Child and Adolescent Psychotherapists' countertransference, thinking, understanding and technique. I am hoping this may also provide clinicians with a space to reflect on what it is like to work with these adolescents and learn from this for their own practise.

This research study has been formally approved by the sponsor and host of the research, the Tavistock and Portman Trust Ethics Committee (TREC).

I aim to interview clinicians with at least three years of experience after qualification with this group of adolescents. The interviews will be semi-structured and will last approximately

one hour. They will take place at a day and time convenient to you.

If you would be interested and considering to take part, please find attached the Participant Information Sheet and Participant Consent Form. Please do not hesitate to contact me should you require further information about the project or would like to discuss it further.

Contact details:

E-mail: sstavrakaki@tavi-port.nhs.uk

Telephone: X

Thank you very much for your time.

With kind regards,

Lina (Stavroula) Stavrakaki

Appendix 5: Indicative interview schedule

The Tavistock and Portman NHS
NHS Foundation Trust

Date:

Indicative interview schedule

ProfDoc research project title: How do Child and Adolescent Psychotherapists experience their work with adolescents with depression. An Interpretative Phenomenological Analysis.

Researcher: Lina Stavrakaki

Semi-structured interview schedule for qualified Child and Adolescent Psychotherapists exploring their work with high risky and/or depressed adolescents.

Research question: How do Child and Adolescent Psychotherapists experience their work with adolescents with depression?

Questions and prompts

Example of a case

- Can you think of a case of psychoanalytic psychotherapy work with an adolescent with depression of significant impact on you?

The use of countertransference

- What was the impact of their struggles in you? (During the session, after or even before you started the session)
- How did you understand your own feelings? What do you think was the unconscious communication?
- How did you make use of your understanding on the transference and the feelings activated in you? (For example, *who* do you think you were for them, and how did you use your countertransference?)

- Did you feel that any of your personal unresolved conflicts became reactivated?

Some considerations on technique

- Did you come across any technical dilemmas, or considerations? (For example, did you act in instead of interpreting?)
- What techniques were helpful over the course of the treatment? Did you try anything that on reflection you felt was not helpful? (What did you learn?)

Reflections

- How do you believe that working with adolescents with depression is different to other examples of psychotherapy work?
- How do you believe that psychoanalytic psychotherapy help adolescents with depression?
- How did this experience inform your thinking on adolescent depression?

Appendix 6: Indicative picture of experiential statements spread on the desk