‘Finding a room of one’s own’: exploring therapists’ understanding of adolescents’ experiences of beginning and settling into intensive psychoanalytic psychotherapy.

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A thesis submitted for the Professional Doctorate in

Child and Adolescent Psychoanalytic Psychotherapy

Tavistock and Portman NHS Trust

and

University of Essex

October 2024

Abstract

This qualitative study uses Interpretative Phenomenological Analysis (IPA) to explore trainee psychoanalytic psychotherapists' understanding of adolescent patients' experiences at the beginning stages of intensive psychotherapy. Focusing on the conscious and unconscious expectations, anxieties, and phantasies that emerge, as well as the role of transference, countertransference, and the adolescent's use of creative mediums such as the arts and dreams.

The findings reveal a complex atmosphere characterised by a flood of feelings, discomfort, and initial mismatches between therapist and patient as they navigate the beginnings of the therapeutic relationship. Adolescents bring fears of being overwhelmed and phantasies of the therapist as a passive receptacle, alongside hopes for containment and deeper self-understanding. Transference and countertransference dynamics are prominent, with early infantile transference re-emerging and challenges related to dependency and independence surfacing in the therapeutic dynamic.

The arts and dreams serve as vital tools for adolescents to express repressed aspects of their inner world, object relations, and anxieties about therapy. These creative modalities also provide a 'transitional space' for exploration within the therapy. The intensive frequency provides a space for confronting previously unbearable aspects of the self, fostering growth, and supporting processes of separation and individuation.

These findings highlight the non-linear nature of beginning psychotherapy with adolescents, marked by shifts in emotional states and unconscious dynamics. The research underscores the importance of frequency in therapy, enabling emergence of infantile transference and exploration of negative transference. The study emphasises the significant learning experience that intensive therapy offers for trainee therapists. Clinical implications suggest that the beginning stages are uniquely intense, requiring therapists to navigate oscillations between dependency and autonomy, which are crucial for the adolescents' reworking of their internal psychic landscape. The study advocates for the continued availability of intensive therapy in the NHS, emphasising its value in addressing adolescents' unique therapeutic needs, particularly as resources increasingly shift toward shorter treatments.

Declaration

I hereby declare that this thesis is entirely my own work, and that the ideas and written work of others have been identified and correctly referenced. This project has received full ethical approval from the Tavistock Research Ethics Committee (TREC). I confirm that I have taken all reasonable measures to ensure anonymity of the participants, their clients, and institutions.

Acknowledgements

I would like to thank the participants of this research project for sharing their experiences with me for the purpose of this project. I am very grateful to my research supervisor, Dr Margaret Lush, for her ongoing encouragement with this project and generosity in sharing her time, wisdom, and thoughts. And I am most grateful to my family, partner, and friends, all of whom have supported me throughout this journey.

Contents

Introduction

Adolescence is a critical developmental period, marked by intense psychological and emotional changes. Within psychoanalytic literature, there is a rich tradition of exploring this phase of life, yet working therapeutically with adolescents remains challenging. Anna Freud (1958, p.261) described adolescence as a 'neglected period' in psychoanalysis, cautioning that treating adolescents psychoanalytically is "a hazardous venture from beginning to end". Flanders and Bronstein (1998) emphasise the difficulties clinicians face in engaging adolescents in psychotherapy, let alone sustaining it. Given these challenges, the notion of adolescents participating in intensive psychoanalytic treatment raises further complexities due to its structured nature, which contrasts with the transitional aspects of this developmental stage. Adolescents are tasked with the process of separation and individuation – tasks which could be complicated by the dependency inherent in intensive therapy.

Nevertheless, a systematic literature review by Midgley et al. (2021) indicates that intensive psychotherapy may yield greater treatment gains, particularly for adolescents facing complex difficulties. This is especially pertinent as the demand for adolescent mental health services grows, yet individuals over 18 remain underserved, often falling between Child and Adolescent Mental Health Services (CAMHS) and adult services. Additionally, as Jones et al. (2020) point out, much existing research neglects clinician perspectives, highlighting the need for qualitative studies that capture the therapeutic encounter from the clinician's viewpoint.

My research seeks to contribute to the psychoanalytic literature by exploring child and adolescent psychotherapy trainees' understanding of adolescents' experiences of beginning and settling into intensive psychotherapy. This study fills a gap by focusing on the initial treatment stages, where unconscious anxieties, phantasies, and internal conflicts are particularly pronounced. Rather than adopting an evaluative or outcome-focused approach, my goal is to provide rich, descriptive accounts of the beginning stages, illuminating how adolescents engage with and utilise intensive psychoanalytic treatment. As Midgley (2009) argues, descriptive research can challenge our assumptions and reinvigorate clinical practice, benefiting both practitioners and patients. This exploration may challenge assumptions about the compatibility of adolescence and psychoanalytic treatments.

This research interest arises from my clinical experience as a trainee psychotherapist in an NHS service providing psychoanalytic treatment for adolescents and young adults up to age 25. Despite resource limitations, intensive psychotherapy is highly sought after, reflecting its perceived value. Reflecting on my own experience, psychotherapy with adolescents is often fraught with complexities and contradictions. This group may use and engage with this rare and valuable treatment in distinct and fluctuating ways. The patient that I have in the room today might present completely differently tomorrow; with engagement fluctuating from session to session and within the session hour. Additionally, within my team, I have observed that clinicians often bring their adolescent cases for discussion, seeking support in managing the confusion, anxiety, ambivalence, and uncertainty stirred up by their patients' inner worlds. This turbulence, while challenging, also invites further exploration of the unique ways in which adolescents use intensive psychoanalytic therapy.

My interest centres on understanding trainee therapists' perceptions of adolescent patients' experiences at the onset of intensive psychotherapy. Specifically, I aim to explore the unconscious anxieties, phantasies, and conflicts that arise during this initial phase, which can provoke hesitation and alarm. Waddell (1999, p.215) highlights this struggle, noting "beginning to think can itself be an alarming process" as it necessitates self-exploration. This anxiety is often vividly expressed by adolescents in phrases such as 'opening a can of worms' when starting therapy.

I will also investigate how adolescents use the arts and dreams to express their inner experiences. In my clinical practice, creative outlets like music, films, and literature serve as indirect means of communication. Understanding how therapists perceive and engage with these forms of expression is a key area of inquiry. Additionally, I aim to explore transference and countertransference dynamics and how unconscious and dream lives emerge in therapy's early stages. This raises the question: what occurs when an adolescent finds a listener, and how does it influence their engagement with their internal world? I am interested in what it means for adolescents to 'find a room of one's own' in therapy – whether it serves as a space for self-discovery, creativity, and identity formation, or a site for navigating separation and individuation challenges.

Focusing on the phase of beginning has a rich tradition within psychoanalysis. Beginnings – whether of therapy, sessions, or life itself – are thought to reveal significant aspects of one's

internal world and object relations. Through this research, I aim to better understand not only the experience of beginning, but how adolescents use intensive psychotherapy and what internal conflicts they bring to the therapeutic space during this critical developmental stage, where so much is in flux.

In this small-scale research project, I am interested in capturing the individual, specific details of beginning psychoanalytic work with adolescents. My aim is to bring into sharp focus the inside stories of what happens in the consulting room, in the hope that it can expand our thinking about the nuances and complexities of psychoanalytic work with adolescents, and perhaps trace the unfolding development of finding a space for oneself within the psychoanalytic encounter.

Literature review

This chapter aims to outline the field of interest of which this study forms a part. I identified key areas relevant to explore as part of the literature review process:

1) Psychoanalytic study of adolescence

2) Beginnings in psychoanalytic psychotherapy – transference and countertransference

3) Psychotherapy with adolescents

4) Adolescents use of dreams and the arts in the early stages of therapy

Literature review strategy

This literature review draws primarily on a narrative and purposive approach, with some supplementary systematic elements, to explore and contextualise the key themes of this research. The aim was to identify psychoanalytic and empirical literature relevant to the experience of beginning intensive psychotherapy, but also to set the broader theoretical and clinical understanding of adolescence and adolescent's use of psychoanalytic psychotherapy, and the use of dreams and the arts in therapy.

The process began by identifying four key thematic areas: (1) psychoanalytic study of adolescence, (2) beginnings in psychoanalytic psychotherapy – with a focus on transference

and countertransference, (3) psychotherapy with adolescents, and (4) adolescents use of dreams and the arts in the early stages of therapy. These were chosen purposefully, based on their relevance to the research aims and on the availability of literature. In this way, the review strategy was driven by both the conceptual framework of the study and the existing literature in the field.

A core element of the review involved drawing on psychoanalytic texts, clinical papers, and seminar readings from my training as a Child and Adolescent Psychotherapist, particularly the Adolescence workshop and Journals such as the Journal of Child Psychotherapy, International Journal of Psychoanalysis, and EBSCO archives were central to developing a contextual and theoretical foundation. I also reviewed the reference lists of relevant articles to identify additional sources. This narrative phase enabled me to structure the literature thematically and to contextualise psychoanalytic thinking on adolescence and the early stages of treatment.

To complement this narrative review, I conducted a structured search using the EBSCOhost platform, drawing on PsycINFO and PEP Archive. This structured search was used to primarily address thematic areas #2 and #3. Key search terms included: 'initial', 'start', 'beginning', 'adolescent/s', 'young adults', 'young adulthood', '18–25 year olds', 'psychotherapy', 'psychoanalysis', and 'psychoanalytic psychotherapy'. Boolean operators (AND, OR, NOT) were used to refine searches and focus on literature that addressed beginnings in treatment and adolescent psychotherapy. The inclusion criteria were limited to English-language publications, reflecting both practical accessibility and a focus on Western psychoanalytic traditions, particularly those from the UK and Europe.

The process involved significant sifting through results and refining search terms to yield the most pertinent studies. While the structured searches generated a range of studies, there was a notable gap of empirical or theoretical literature specifically addressing the beginnings of intensive psychoanalytic psychotherapy with adolescents. Much of the literature identified was either focused on adult treatment or on broader developmental aspects of adolescence or therapy with adolescents. Given the limited research directly addressing my question, I organised the findings into related areas and consequently, I included relevant literature on adult treatment beginnings, where theoretical insights were transferable, and selected studies that explored adolescent engagement more generally in therapy as well as studies related to adolescents' expectations at the onset of treatment. In this way, the review reflects a pragmatic

and purposive selection of areas where literature could be found, while still attending to the research focus.

This combination of narrative breadth and targeted searching allowed me to structure a literature review that both situates the current study and highlights a significant gap in the field. This gap around the experience of adolescents as they begin intensive psychoanalytic treatment is one that this research seeks to contribute to, by offering new clinical insights into a scarcely explored phase of intensive psychotherapy with adolescents.

Psychoanalytic study of adolescence

Freud first addressed adolescence in his 1905 paper *Three Essays on Sexuality,* framing it as a developmental stage where final changes in infantile sexuality occur. This focus shifted in 1922 with Ernest Jones's contribution in *Some Problems of Adolescence*, where he stated that "at puberty a regression takes place in the direction of infancy" allowing individuals to recapitulate and expand on their early development (pp. 39-40). Waddell highlights Jones's emphasis on the "infantile components of the adolescent psychic make-up", suggesting a shift in psychoanalytic understanding towards adolescence as a crucial period for restructuring and organising personality (2018, p. 5).

While I will not provide a detailed chronology of psychoanalytic explorations of adolescence – covered in Anna Freud's *Adolescence* (1958) and Waddell's chapter on *Historical Context* (2018) – I aim to present key contemporary psychoanalytic ideas on adolescent development, primarily from a Kleinian perspective. My focus will be on the developmental tasks of adolescence and the accompanying atmosphere and emotions, setting the scene for my research. I will emphasise internal processes over external ones, focusing on what might be understood as constituting 'ordinary' development.

Search for identity and becoming a separate person, separation and individuation

Psychoanalytic literature is rich with descriptions of adolescence: Waddell (2018), quoting DH Lawrence, calls this period "the hour of the stranger", or in her own words "the age of experimentation" and a move into a "world where everything is in flux". While adolescence is often chronologically placed between the early teens and twenties, Waddell, building on Klein and Bion, highlights the fluidity of developmental phases, noting that states of mind can

oscillate regardless of age "the adult may be found in the baby; the infant in the adolescent; the young child in the old man; the middle aged man in the 7 year old boy*"* (p.11). This constant shift, or what Meltzer (1967) describes as a psychic experience of a continually shifting 'centre of gravity' in relation to identity, is particularly characteristic of adolescent functioning.

The adolescent may feel that he is inhabiting a contradictory internal landscape, no one clear position is available, feeling like a stranger to self and others. Amidst this turmoil the adolescent is often searching for a deeper meaning and purpose in life, alongside a quest in terms of their own identity and the struggle to discover and answer the question of 'Who am I?' (Waddell p. 34). Summarising her chapter on adolescence Waddell describes it as a process of interrogation, self-definition, a "process of becoming", and one which is not without mental pain and frustration (p.45).

Adolescence is a pivotal time for identity formation. As Dartington and Anderson (1998) succinctly put it, the task is to "move towards becoming an independent person, both internally and externally" (p. 2). Waddell (2018) emphasises the destabilising, in-between nature of this phase, where past identities dissolve before new ones are formed (p. 172). The adolescent has a double task of letting go, like shedding old skin, whilst also finding a way of allowing something new to develop within oneself and in one's life, this "metamorphosis" requires significant psychic effort (Anderson, 1998, p.3).

Wittenberg (1979) likens adolescence to other critical transitions, such as birth or entering school, requiring re-adjustment. Similarly, Waddell (2002) sees it as a process of adaptation to the emotional and physical changes of puberty. Meltzer (1973) describes adolescence as inhabiting a "third space", distinct from childhood and adulthood, where the adolescent resents both adults and children, experiencing a crisis of identity – pulled between independence and dependence. These changes are experienced as disturbing due to the inherent losses they carry. From a psychoanalytic perspective, adolescence demands a new way of relating to internal and external parental figures, which involves a greater degree of independence and separation.

<u>Mourning and re-negotiation</u>

The thread that runs through the papers mentioned above is the experience of loss as the adolescent moves towards separation and independence from childhood. Although this is a

natural development, it involves sadness and pain. Anderson and Dartington liken this adolescent process to Freud's (1915) "work of mourning", where the ego must revisit and relinquish each aspect of lost relationships to move forward. They write: "The ego is required to examine every aspect of the lost object - the lost relationship – to pick up each particular aspect of the relationship, explore it, remember it and face the loss in order to let it go*"* (1998, p.3). To progress with development, the adolescent must face the loss, re-negotiate their relationship with themselves and their internal and external objects, akin to reviewing the life lived so far.

The question of whether these tasks can be experienced as manageable and how any adolescent might deal with these will according to Wittenberg (1979) greatly depend on "the kind of internal stability he has earlier achieved, the way he has dealt with conflicts in his past, in infancy and childhood". The quality of the early object relations is therefore tested in the new context of intense adolescent drives. She argues that the *"*adolescent brings to his new situation the feelings and phantasies which he carried over from early childhood" (p.1).

Therefore, if what gets re-awakened in the adolescent is the feelings and phantasies of early childhood, it might be helpful to recall this state: the helplessness, dependency and terror of loss. Without the parents the infant cannot survive and sustain himself, and so the unconscious fear of death is part of the infant's experience. For the adolescent, the fear of any loss at its deepest might bring him closer to an unconscious terror of complete loss of life. It might be particularly hard when infantile anxieties and longings are stirred up in the adolescent and they are put in touch with the "dangerous internal situations, terrors of something unmanageable or uncontrollable, anxieties" which were kept at bay in latency (Waddell, 1998, p.83). This can leave the adolescent feeling as if "they have lost their often fragile grip on adulthood and collapsed back into a child world from which they will never escape*"* (Anderson, 1998, p.4).

The adolescent, facing the pressures of growing up, may resort to defences like avoidance, omnipotence, or oversimplification to manage feelings of inadequacy (Waddell, 1998). To overcome confusion, the adolescent must turn to the internal object, which Meltzer (1973) frames in physical terms, drawing on Klein's (1953) idea that the mother's body, in fantasy, holds all knowledge. He writes about the need of turning to "the mother's body, where the truth of all things is originally contained*"* and that "this knowledge is felt as though contained, quite concretely, in the mother's breasts*"* (p.23). Meltzer emphasises that adolescents are not only

preoccupied with sexuality but also deeply concerned with understanding and knowledge, which they seek from their internal objects. This is supported by Bion's (1962) theory of learning through experience, where confusion and distress can only be resolved by turning to the internal object for emotional clarity.

Meltzer states that only through acknowledging dependency and facing distress the adolescent can rediscover the internal object's capacity to clear confusion, provided they can endure the pain of feeling dependent once more. This aligns with the shift from the paranoid-schizoid closer towards the depressive position, where denial and splitting give way to introjection and greater emotional maturity. As Harris (1976) puts it the adolescent needs to "proceed through a disintegration to a new integration as an independent adult*"* (p.83).

Therefore, the process of development during adolescence involves reaching a more mature position where one is less entirely dependent like in infancy but remaining in touch with one's own continuing need and dependency on an internal object. Perhaps as Anderson and Dartington (1998) point out part of the task of adolescence is to face reality and the "facts of life" – that becoming an independent person with greater responsibility for one self might involve a realisation of one's own continuing dependency, like Riviere suggests, "absolute individual independence*"* is fiction, a denial which one may cling to – like the adolescent who thinks that he has 'made himself' in resistance against the notion "of the extent to which our lives and our being are interwoven with those of others*"* in a both internal and external way (1952, p. 359).

<u>Beginning psychoanalytic psychotherapy – transference and countertransference</u>

Wittenberg, in her seminal book *Experiencing Endings and Beginnings* (2022) explores the deep and often underestimated emotions stirred by new beginnings, linking them to the very start of life. She describes the newborn's first encounter with the world as both "terrifyingly unfamiliar" and "full of wonder" (p.12). Beginnings, according to her, involve conflicting emotions—hope, excitement, fear, and dread—as they are intrinsically tied to endings, with every new experience involving loss of some sort. Wittenberg emphasises that embarking on a new experience requires "faith, hope, and courage" to embrace the unknown and relinquish the comfort of familiarity (p.2). There is an emotional risk in allowing oneself to get deeply

involved in an endeavour such as intensive psychotherapy, knowing that there will be an ending, as well as not knowing what this journey may entail.

"Every ending, every beginning, therefore, arouses, to a greater or lesser extent, the physical, emotional, mental states that we experienced at the beginning of our life*"* (p.15). Wittenberg compares the feelings aroused in beginnings to those of the beginning of life outside the womb, leaving one feeling lost, helpless and disorientated in a completely new and unfamiliar environment. If helplessness and a fear and worry about survival is a commonality of the human new-born, one might imagine that beginnings, including the beginning of psychotherapy, may involve a worry about one's ability to manage and survive. The baby's experience in utero as well as the nature of the birth are experiences which one may carry within themselves influencing their expectations of the world and those around them. Therefore, our patients in their first encounters with us, in the analytic new beginning, may convey something specific and individual of their very early experiences (object relating and environmental), what Klein called "memories in feelings" (1957).

Reflecting on the early phase of psychoanalytic work, Wittenberg (1970) notes that both patient and therapist bring expectations and hopes. For therapists, there is a desire to be helpful, alongside fears of being intrusive or doing harm. Patients may have idealised expectations to be provided with everything they have "ever longed for", longing for the therapist to alleviate all their pain or act as a "dustbin" for their burdens without the patient taking any responsibility for understanding or thinking (p.11). More realistically, they may hope for a therapist who helps carry their emotional load. These unconscious phantasies and expectations link to early infantile wishes, described by Wittenberg as "phantasy expectations" (p.23) which colour patients' perceptions of reality and the therapeutic encounter.

Therefore, as Ogden notes in the analytic encounter we can experience the patient's "living past" (1992, p.193), the way unconscious phantasies and object relations which constitute part of the patient's internal world are lived out in the analytic encounter. These rather than being represented verbally by the patient are conveyed through the transference- countertransference experience, which allows the opportunity for something yet unexpressed and inexpressible to be directly experienced.

Ogden (1992) also highlights that transference-countertransference feelings are active even before the first meeting, with both patient and therapist forming phantasies about the other. He writes that the "*interpersonal drama"* of therapy has many prewritten scripts but for this encounter to have analytic significance one must be open to a new experience, "a drama never before imagined*"* yet to be created between the analytic couple (p.172). Ogden emphasises that patients introduce analysts to an array of figures within their internal world, including unconscious resistances – "cautionary tales"– which warn against delving into the unconscious mind. This is a warning based on transference anxieties and resistances, and according to Ogden "it is always dangerous business to stir up the depths of the unconscious mind" (p.172), and so the cautionary tale is a warning that it would be best not to engage in such a dangerous liaison. What the patient and the analyst fear the most, according to Ogden, is not that the patient will leave, although the anxiety may be disguised as such, but that the patient will stay and that the internal world of the individual and that of the other might be encountered anew as a "living intersubjective drama on the analytic stage" *(ibidem)*.

Ogden believes that, from the beginning of the initial meeting, there is an expansion of the "psychological space" by entering the analytic experience. In his view patient and therapist engage in creating a shared "analytic space", which he calls the "matrix of the mind"—a third, intersubjective space where the patient's unconscious internal drama can unfold (p.188). This space is unique to each therapeutic dyad, and parallels the space co-created by mother and infant. He writes:

> In the same way that each infant's unique character draws upon and brings to life specific aspects of the mother's emotional potential, the analyst must allow himself to be created/ moulded by his patient in reality as well as in fantasy. Since the infant has a role in creating his mother no two infants ever have the same mother. Similarly, no two patients ever have the same analyst. (p. 198)

In *The Psychoanalytical Process* (1967) Meltzer addresses the initiation of psychoanalytic treatment with children and adolescents. In the paper, Meltzer writes about an introductory period in which "gathering of the transference processes" takes place. He highlights that while children's lives are rich with transference processes, engaging adolescents poses greater

challenges. In his view this difficulty arises from adolescents' tendencies to split off parts of themselves and engage in narcissistic acting out externally, rather than object-related behaviours within therapy. Meltzer suggests that child patients experience a pull in different directions during the initial phase. On one hand, there is hope for relief from distress; on the other, anxiety may inhibit their progress. Children may desire to "engulf every new object" while simultaneously fearing they might "get lost", leading to ambivalence.

Central to Meltzer's concept of gathering is the analyst's ability to receive projective identification and accompanying emotions. He emphasises the importance of receptivity and understanding, noting that this may occur even before verbalisation is possible. The gathering process is akin to capturing snapshots of the patient's inner world, as transference processes seek "expression where their anxieties can find relief" (p.7). This suggests that the patient's transference is also shaped by an unconscious awareness of the analyst's capacities for containment.

Meltzer points out a few aspects of beginning of treatment with adolescents. In terms of behaviour in the room, the adolescent "may want to talk but be unable to accept the dependence and loss of anchorage to reality on the couch*"* (p.8). Therefore, adolescents may hold contradictory impulses of wanting to make use of and depend on the analyst but really struggling to allow the dependency and vulnerability of lying on the couch, which symbolically could be seen as an extension of the analyst.

He characterises the initial process as confusing and "haphazard", where material shifts in response to the analyst's behaviour and external factors like weekend separations. Meltzer argues that transference material in these early sessions is novel, arising from the analyst's presence rather than prior experiences, though it may resonate with existing phantasies. This emphasis on new experiences highlights the potential for understanding transference feelings within the unique context of the analytic relationship in the *here and now*. As Ogden (1992) articulates:

> The patients' thoughts and feelings, his past and present have a new significance… a form of significance that he has never held before. For the analysand the consulting room is a

> profoundly quiet place as he realises that he must find a voice to tell his story. This voice is the sound of his thoughts that he may never have heard before. (p.170)

Ogden emphasises that the patient, together with the analyst, may discover aspects of himself which he has not been acquainted with before.

A notable recent addition on beginning psychoanalytic work is the book *Beginning Analysis* (Reith et al., 2018), which explores the crucial processes and challenges of initiating analysis or intensive psychoanalytic psychotherapy. This book is unique as it stems from a research project conducted between 2004 and 2016, focusing on the analyst's experiences and the "intensity of the unconscious dynamics invading the initial encounter" (p. 11). The researchers examined 28 case studies, seeking to understand what occurs when therapist and patient first meet. Their findings led them to adopt Bion's (1979) term "storm" to encapsulate the intense unconscious dynamics of these early encounters. They poetically describe this experience:

> The unconscious expands into this uncharted territory, revealing both the possibilities and limits of psychoanalytic understanding. A whole life and mind are suddenly unveiled, giving even the reader of such an account the feeling that it is impossible to take it all in at once. A potent and enigmatic transference and countertransference scene of wishes, expectations and fears is immediately set up and can be very disturbing. (p.13)

This illustrates the emotional storm faced by the analyst, emphasising the challenge of maintaining a reflective mindset amid the transference and countertransference that unfolds. The depth of the psychoanalytic encounter hinges on the therapist's ability to remain receptive to emerging meanings, as Ferro (2012) notes, allowing for 'open exploratory interventions' to access hidden aspects of the patient's mind (p. 262). Therefore, does the therapist dare to be open and receptive to a new experience which is yet unknown? How much do we allow ourselves to be affected by our patients and the experiences they bring?

The researchers argue that an 'unconscious storm' invariably manifests in initial encounters, often hidden beneath the surface. They state:

> The metaphor of an ‘unconscious storm’, with its image of disorder and turbulence, seems a good way to describe the multiple and simultaneous forms of communication, levels of mental functioning, and intense intersubjective phenomena including projective identification and identity confusion, role responsiveness and mutual enactment. (p.76)

This storm creates an internal tension filled with both dread and hopeful anticipation as the patient seeks repair through the therapeutic relationship.

According to Ferro (2012), the analyst's role involves opening ‘psychoanalytic space’, a task complicated by the storm of the initial encounter. This requires engagement with the storm's sensations and affects before digesting the experience using internal resources, such as negative capability and reverie. Reith and colleagues found that in every encounter there are ‘storms’ that are either avoided or confronted. Their examination revealed moments of ‘elaboration, defence, and enactment’, akin to a dance of closeness and distance. The authors argue this is the norm rather than exception, but that what counts is the analytic couple’s ability to make use of these necessary parts of the process to engage with unconscious dynamics.

Further metaphors encountered by the research team include “ballet dancing on a minefield” and Freud's (1915a) “explosive chemical laboratory” conveying the anticipatory fear surrounding unconscious forces. These metaphors dramatize the initial encounter, where the patient unconsciously presents their central problem, ‘acting out’ their issues as if on stage (Elzer & Gerlach, 2014, p. 145).

To illustrate these dynamics, the case of Ms. D is explored through process notes and discussion. Ms. D makes the unusual choice to leave her car near the analyst’s building before their meeting, expressing worry about feeling confused after the interview. The researchers hypothesise about her ambivalence, fearing the need for a ‘getaway car’ while also viewing the analyst's location as a potential container for her experiences. Ms. D’s chaotic arrival—her car towed overnight – enacts a sense of ‘irreparable loss’. The opening scene serves as a metaphorical stage, reflecting both her history and the potential for future collaboration with the analyst. The analyst's instinct to rescue her and indicating where the car can be found highlights a moment of relief, suggesting that “you can find your lost objects” (p.93) and not all is lost.

The researchers conclude that Ms. D's opening scene signals her deep fears about object relations and identity loss. They emphasise that beginnings are diverse and depend on the unique characteristics of both participants and the analyst's ability to contain and metabolise these dynamics. The process is often nonlinear, characterised by oscillation between understanding and distancing. In summary, the powerful opening scenes of psychoanalytic encounters can reveal significant aspects of patients' dynamics. These beginnings "open the possibility of finding new perspectives, new understanding in the presence of someone who could potentially receive and contain the unmanageable" (p. 105).

Psychotherapy with adolescents

Research on psychotherapy with children and adolescents is expanding (Midgley & Kennedy, 2011; Midgley, 2021), yet studies focusing on older adolescents and young adults remain limited. Additionally, intensive psychoanalytic psychotherapy for both children and adolescents is under-researched, with more emphasis placed on psychodynamic and weekly therapies. This creates a significant gap in understanding adolescents within the context of intensive psychotherapy.

A literature search on the beginnings of intensive psychotherapy with adolescents yielded no relevant studies. While papers exist discussing challenges in engaging adolescents and conducting assessments, none specifically address the initiation of intensive psychoanalytic therapy for this age group. This gap indicates that the current study could contribute significantly to understanding this process.

Despite the scarcity of evaluative research, numerous single case studies within psychoanalytic literature provide insights into intensive work with adolescents. Journals like the *Journal of Child Psychotherapy* showcase many individual intensive cases reflecting the "consulting room [being used] as the psychoanalytic laboratory" (Rustin, 2019). However, these studies often do not focus specifically on the beginning phase, and as the beginning was not the main emphasis of such the papers they were not included in this study.

To address the gap in literature on the beginnings of intensive therapy with adolescents, we will examine three key areas which are related:

1. Intensive psychoanalytic psychotherapy with adolescents

2. Therapist accounts of psychoanalytic work with adolescents

3. Adolescents' expectations of psychotherapy at the onset of treatment

The frequency and structure of intensive work implies a commitment that may conflict with the fluid nature of adolescence. As Harris (1969, p. 2) humorously remarks, "the responsible thoughtful young adult of one day can suddenly be the heedless infant of the next". Waddell (2018, p. 13) echoes this confusion, comparing the adolescent's fluctuating identity to Alice in Wonderland's experiences, "being so many different sizes in a day is very confusing."

In this developmental phase, where separation and individuation are paramount, what feelings does intensive psychotherapy evoke, and how are they experienced? Green (2009, p. 187) argues that intensive treatment may contradict the adolescent process, suggesting that non-intensive work would be more beneficial, "it goes against the progressive developmental grain of the adolescent process to offer them the `dependency' inherent in intensive treatment". Meltzer (1973) similarly claims that psychoanalytic methods may not be efficient for understanding adolescence. Parsons (1999) advocates for less frequent contact, allowing adolescents to 'go with the flow' of their developmental process, while Alfille-Cook warns that adolescents need to be "ill enough to need it, but well enough to use it" (2009, p. 72).

However, emerging research paints a more hopeful picture, despite the limited studies. A recent systematic review by the ACP (Midgley et al., 2021) identified only four evaluative studies on intensive treatment in child and adolescent psychotherapy from 1965 to 2020, with most research focusing on non-intensive approaches. Notably, the IMPACT study evaluated short-term psychoanalytic psychotherapy (STPP) and demonstrated its efficacy in treating adolescent depression.

While intensive psychotherapy studies are scarce, findings from the systematic review indicate that intensive treatment may yield greater gains for children with enduring difficulties, suggesting a need for this approach to facilitate significant change. Evidence also points to lasting improvements across various mental health issues (Fonagy, 2015). One included study, Fonagy and Target (1994,1996) analysed 763 closed cases of children aged 3-18 and noted a "dose-effect relationship between treatment length and magnitude of change" (1994, p. 52),

implying that longer, more intensive therapy is more effective. However, no definitive conclusions can be drawn about age-related treatment outcomes.

Furthermore, studies on adult patients with depression provide encouraging evidence; Cuijpers (2013) found that increasing therapy sessions from one to two per week enhanced effectiveness. Midgley (2021) emphasises the need for further research to determine when intensive psychotherapy is clinically and cost-effectively recommended. Although this study does not focus on evaluative outcomes, it aims to gather insights from child psychotherapists regarding their adolescent patients experiences and engagement with this treatment.

Therapists' experiences of psychoanalytic work with adolescents

Wilson (1991) notes that working intensively with adolescents is a nuanced decision, as many feel frightened and overwhelmed by the commitment and intensity of psychoanalytic psychotherapy. He describes adolescence as a state of "mass contradictions," placing therapists in similarly contradictory positions where they must remain flexible, adapting to various aspects of the same patient while maintaining reliability and consistency. The adolescent is trying out new identities and the therapist needs to be able to receive these. The therapist balances "respecting the adult and caring for the child in the adolescent" (p. 457), allowing for adolescent exploration while recognising when a more active role is needed.

Brenman Pick (2018) highlights the tumultuous nature of adolescence, describing how adolescents may feel "carried away" and attempt to "carry the object away with them". In this context, the therapist faces a dual storm: that of the initial encounter and the storm of adolescence. She emphasises the delicate balance required, as adolescents may perceive the therapist as either colluding with their ideology or imposing a rival one (p. 137).

To illustrate the complexity of early therapeutic encounters, Brenman-Pick recounts a dream from an adolescent patient during his first week of analysis. The patient, who arrives in a good mood after a concert the night before, dreams a long dream of retelling the experience to someone, perhaps symbolising a desire for connection with the analyst. This suggests an early recognition of the analyst's potential significance in his life. In the dream he also gives a role in his dream to his analyst: that of the listener. Brenman-Pick observes that the adolescent's world, filled with incessant music, often distracts from deeper feelings of unhappiness. She

also adds that the dream reveals a wish to carry her away with him on a "continuous uninterrupted longed-for experience of early infancy" (p. 138). In this case the dream makes conscious a notion, which is usually unconscious, of what beginning an intensive therapy might bring up in a patient: a deep wish for a continuous caring experience reflecting the patient's early infantile wishes. The dream also conveys to the analyst something about the patient's adolescent state of mind, the incessant activity of the music as a defence against thinking and being in touch with one's own depressive feelings.

Adam Phillips (2011) explores the enjoyable aspects of working with adolescents despite their inherent challenges – such as moodiness and risk-taking. He describes adolescents as suffering from a "malady of the ideal" (Kristeva's term, p. 188), he adds, "paradise is an adolescent invention with its Adam and Eves, Dantes and Beatrices." In his view seeking ideals serves the purpose of aiding their separation from family and the development of identity. Phillips identifies pleasurable aspects of this work, including the opportunity to revisit one's adolescent conflicts and the intense emotional experiences that remind us of our own passionate lives. Furthermore, he adds that in our work with this group we get to see "the beginnings of peoples adult struggles with the real difficulties of living" (p.190).

On a deeper level, he argues that adolescents confront us with our limitations and troubled aspects, framing this as the "pleasures of not trying to be something one can't be. And that is precisely what the adolescent developmentally, is having to work out; what he or she can realistically be?" (p.192). In exposing our powerlessness, we are confronted with our own reality and through this work we can learn to hold this conflict and bear it, learn to live with it rather than living falsely or defending against our reality. To be faced with our own limitations puts us in touch with emotional disturbance and Phillips argues that on some level this is precisely what we most wish, to be emotionally stirred up and 'disturbed'.

In their idealism, adolescents challenge adult self-righteousness, prompting us to expand our thinking and move away from false ideals. Phillips asserts that adolescence is about transgression and testing rules; similarly in therapy adolescents might explore the therapists' internal structures, rules and boundaries, positively churning and questioning our own beliefs and standards in order to try to figure something out for himself. The goal is not to solve the adolescent problem but to "keep an essential conflict alive" (p.192), allowing for greater uncertainty and self-examination within the therapist. Phillips believes that adolescents make

us question our working ideals and treatment goals, our own morality and views about health and cure. Furthermore, he argues that as adolescents themselves are questioning if life is worth living and if so, what makes it worth living; the therapist too is forced to face such existential questions about life and what it is to be alive and living.

Adolescents' expectations of therapy at the onset of treatment

Beginning therapy is inevitably intertwined with preconceptions, expectations, hopes, and anxieties. Midgley et al. (2016) explored these dynamics in the IMPACT-ME study, which involved 77 clinically depressed adolescents aged 11-17 as part of a randomised clinical trial. Their findings revealed five main themes: "the difficulty of imagining what will happen in therapy," "the talking cure," "the therapist as a doctor," "therapy as a relationship," and "regaining the old self or developing new capacities." Notably, 70 out of 77 interviews featured the terms "don't know" or the more adolescent "dunno." This uncertainty reflected various responses – ranging from indifference or reluctance towards therapy, a way of dealing with anxiety, or perhaps an awareness of the reality of not knowing considering this was their first time. For some adolescents it was a way of shutting down and for others "a precursor to an imaginative engagement with an unknown experience" (p.15).

The prominence of the 'I dunno' theme highlights its significance, suggesting a link to hopelessness, a common feature of depression. Certainly, any therapist can imagine a session with an adolescent where the 'dunno' or 'I don't know' is present, sometimes in passing other times rather stubbornly persisting, in this way the research interviews interestingly perhaps mirrored what therapist may often encounter: the difficulty in engaging adolescents or what others, such as Waddell, have conveyed as the difficulty in finding a space to think with adolescents. The vignettes provided in this research illustrate the skilful, gentle, as well as persistent probing (verbal and non-verbal) done by the researcher interviewers' in trying to get a little bit closer to the underlying thoughts and feelings behind the 'dunno'. I think this also mirrors the therapists need for adjustment of technique and analytic stance to help adolescents find their way towards thoughts and thinking.

Another way of looking at the 'dunno' considering the other findings, such as seeing the therapist as a doctor, might suggest ambivalence about engaging in a relationship which might stir up feelings of dependence that for the adolescent can feel threatening, because

developmentally at this stage there is a struggle between “a wish for emotional closeness and distance, between autonomy and inter-dependence” (Midgley et al., p.19). Hence it might be preferable to see it as a ‘cool and professional’ relationship without the complex feelings of the transference.

While most participants hoped therapy would improve their well-being, a small minority expressed feelings of bleakness. Some expected that merely talking in a non-judgmental space would provide relief, while others feared that it might be uncomfortable or revealing. The majority associated talking therapy with a medical model, envisioning therapists as individuals who could provide cure. Conversely, a minority recognised therapy as a relational experience that involves understanding oneself and being understood.

Weitkamp et al. (2017) conducted a qualitative study on adolescents’ expectations of psychodynamic psychotherapy, revealing that many felt uncertain about what to expect and perceived the process as potentially difficult and lengthy. Some adolescents preferred to avoid expectations to prevent disappointment, while others expressed anxieties about safety, boundaries, and control over the therapeutic pace.

Faced with uncertainty, adolescents often turned to media representations, such as lying on a couch or group therapy, to fill the gaps in their understanding. Despite their caution, they articulated hopes for therapy, particularly related to identity development and self-understanding. Researchers noted a concerning lack of initiative among participants, which could signify a transference dynamic where adolescents expect the therapist to fulfil a parental role, highlighting their reluctance to take personal responsibility.

Bronstein and Flanders (1998) examined initial contacts with adolescents (aged 14-21) in psychotherapy consultations. They emphasised the overwhelming intensity of feelings that many adolescents experience, which often leads to compulsive actions as a defence against anxiety. The vignettes they presented illustrated the reluctance of adolescents to acknowledge their need for help and their ambivalence toward seeking assistance, reflecting a push and pull between independence and dependence.

Use of dreams and the arts in the early stages of therapy

Dreams have occupied a central position in psychoanalytic practice since the foundations of psychoanalysis (Freud, 1900), and from then onwards different schools of thought have considered the dream in very diverse ways. For this research, I am interested in investigating adolescents' use of dreams in the beginning stages of intensive work and how these dreams reflect their thoughts, feelings, and the overall transferential experience of beginning psychotherapy.

Flanders (1993) notes that while dream analysis is common in psychoanalytic literature, it remains an area which is under-researched in terms of empirical studies. We know that clinical papers often refer to dream material, as can be seen in this literature review (example on pg.14). Despite the extensive use of dreams in clinical papers, there is little research focusing specifically on adolescents' early dreams in intensive therapy.

In work with adults, however, Perelberg suggests that dreams provide a clue to the patient's state of mind, inner world as well as providing crucial links related to the transference and analytic process. In her paper *The Oracle in* Dreams (2000), Perelberg focuses specifically on the significance of the first dream brought up in analysis. She suggests that some patients' initial dreams may act as a 'condensed narrative' that anticipates the future course of the therapy. These dreams often encapsulate key elements of the transference relationship, predicting how this dynamic will evolve as therapy progresses. Unlike previous research that linked first dreams to early childhood memories (Bessler,1961) or to broader aspects of the analytic process, Perelberg emphasises the direct connection between these dreams and the transference.

Similarly, Waddell (2002) gives two examples of adolescent patients, Tom and Simon, whose dreams at the beginning of the analytic work in her view described their internal predicament. Waddell first presents the following dream from Simon:

> He encountered a large pink, fleshy snail in the corridor of the Obstetrics and Gynaecology Department of a hospital in which he was currently doing a psychology placement. Inside the hollow of the articulated tail was a huge cavity in which fellow students were cavorting

> with a perverse, sacrilegious, orgiastic air. "Come on in" they cried, "it's fun in here". He joined in, but swiftly became overwhelmed by the sexually charged atmosphere and rushed out again. He fled along a corridor, finally tunnelling his way into a lecture theatre and taking up a position where the professors usually stood, on the podium behind the projector. (p.109)

Waddell goes onto elaborate on her understanding of her patient's dream, which she locates in Simon's unconscious anxiety about sexuality and intimacy and his defences against anxiety by hiding 'behind the projector' and becoming a pseudo-adult identified with the professors.

Waddell then focuses on Tom's dream: "He was trying to play tennis on an indoor court of which one of the walls was missing. Every time he threw the ball up to serve, it hit an unnaturally low ceiling and bounced back at him prematurely, making it impossible to set the ball in play." (p.109)

Waddell understands Tom's dream as a communication of a lack of early containment as illustrated in the missing wall. Furthermore, she interpreted the ball that bounces back with an internal object with an unreceptive mind, which bounces back the infants' communications.

There is so much more that could be said but due to space constraints I have summarised Waddell's analysis of her patients' dreams. The key points that are of relevance to this research are that the first dream in analysis can, in Waddell's view, convey something of the patient's internal predicament, their state of mind and the predominant early mode of relating, for example reflecting adhesive and projective tendencies, as illustrated above.

This perspective provides a unique framework for understanding how adolescents might similarly use dreams at the beginning of therapy to convey something of their internal world and object relations, potentially offering insights into the unfolding therapeutic relationship.

In the tradition of relational psychoanalysis, the function of dreams in therapy has been extended beyond dreams dreamt at night to the idea that dreaming, or daydreaming, can be understood as a form of thinking while awake, especially as part of the analytic session. In his paper on *Talking as dreaming*, Ogden suggests:

> Forms of talking generated by patient and analyst that may at first seem 'unanalytic' because the patient and analyst are talking about such things as books, poems, films, rules of grammar, etymology, the speed of light, the taste of chocolate, and so on. Despite appearances, it has been my experience that such "unanalytic" talk often allows a patient and analyst who have been unable to dream together to begin to be able to do so. I will refer to talking of this sort as 'talking-as-dreaming'"(2007,p.14).

The kind of dreaming that Ogden writes about is synonymous with unconscious thinking. Ogden argues that the analyst helps the patient, through talking-as-dreaming, to "coming into being in the very act of dreaming and talking in a voice that felt like his own" (p.29). I think that what Ogden describes in a process in which the patient, through the analytic process, becomes able to find a voice in themselves, which can be used as an intimate shared language to communicate with their analyst. I wonder whether the use of the arts can also be understood through a similar lens – that is, as an alternative language – used to convey significant unconscious communications to the therapist; through the symbolic form of the arts unconscious wishes could find a way to expression.

The idea that psychoanalysis, arts and culture have much in common is nothing new. In their book *Mirror to Nature* (Rustin & Rustin, 2002) and in *Researching the unconscious* (Rustin, 2019) the authors reflect on the tradition in psychoanalytic writing to discuss the dramatic arts as well as literature and art. In their view, one of the connections between the arts and psychoanalysis is the concern for truth and the epistemophilic instinct, a desire to understand our world through learning from experience of emotional engagement. Freud thought that the arts like psychoanalysis consists of revealing the suppressed "compelling us to recognise our own inner minds" (2002, p.2).

Building on this connection between the arts and psychoanalysis, as well as on Ogden's work, in my clinical experience I have often noticed that my adolescent patients use their interest in arts as a means to communicate something of their internal world. For example, a young adult

female patient began a session speaking about the movie *Fight Club* (1999), conveying her identification with Edward Norton who suffered with sleeplessness. Elaborating further on this material we talked in more detail about the plot of the movie, in which Edward Norton and Brad Pitt are the same person, but Brad Pitt is the projection of whom Edward Norton wants to be or could be. This expansion of the material felt very related to the patient's internal struggle. She would often struggle to see her more capable side as a part of herself. It helped us to understand how she could often see herself in this very split way – either struggling or fantasising about an ideal version of herself finding it difficult to have a more integrated view of herself.

Considering this, my research includes specific questions concerning the arts, such as literature, films, music, as well as dream-work, to investigate how these may communicate something of the adolescent patient's internal world.

Gaps in literature

In this literature review I began by exploring the psychoanalytic understanding of the psychic task of adolescence, and this provided us with an overview of themes such as a search for identity, separation-individuation and mourning. Then I looked at beginnings from a psychoanalytic point of view, with a particular focus on the transference and countertransference, which get set in motion when beginning psychotherapy. As there was no existing research on beginning intensive work with adolescent patients, I focused on the findings of a research project about beginning psychotherapy with adult patients. I then gave a brief overview of the findings of evaluative studies related to intensive psychotherapy with adolescents. Following this, I explored therapists' experiences and thoughts on working with adolescents and adolescents' expectations about beginning therapy. Finally, I explored the literature related to dreams and the use of the arts in the context of beginning psychotherapy.

The literature review identified a gap in the literature, as there are no publications which investigate the beginnings of intensive psychotherapy for adolescents and young adults. Furthermore, there is a lack of any evaluative recent studies into intensive psychotherapy with this group. This might reflect the lack of funding for research in the NHS, the public context in which most psychoanalytic psychotherapy with adolescents currently is currently carried out by psychotherapy trainees.

It would be important to carry out more research to build an evidence-base for intensive work with adolescents and young adults, so that it would be possible to advocate for a broader delivery of psychoanalytic psychotherapy for this age group in the public sector. As the limited existing literature has found, intensive therapy may yield greater gains for children with chronic difficulties, suggesting that this treatment may be more effective in facilitating significant changes in such cases.

I hope this project might contribute to a better understanding of the meaning of beginning intensive therapy for adolescents and how intensive therapy is used by this age group. It might also bring into focus some of the challenges of beginning intensive work with adolescent patients, which could lead to changes and adjustments to support this early phase of the work.

Methodology

Aims

In this study I wanted to explore trainee child and adolescent psychotherapist's understanding of their adolescent patient's experience of beginning and settling into intensive psychotherapy. For this project the term 'intensive psychotherapy' is used to describe psychoanalytic work with a minimum frequency of three times a week. My hope was to understand the following in more detail:

- What is the therapist's experience of the adolescent's conscious or unconscious phantasies, preconceptions, anxieties and hopes when beginning intensive psychotherapy?

-What is the therapist's understanding of the early transference-countertransference dynamics and how can these help us understand the adolescent's experience of beginning intensive psychotherapy?

-What is the therapist's experience of how adolescents use the arts and dreams in conveying something of themselves in the context of beginning therapy.

-What is the therapist's experience of what their adolescent patients were looking for in having a space of their own?

-What are the therapist's perceptions of how their adolescent patients make use of their space?

The following sections will describe the methodology used to achieve these aims.

Recruitment

I initially interviewed five trainee Child and Adolescent Psychotherapists (CAPs) to ensure a range of experiences while maintaining a manageable sample size for in-depth analysis. The criteria for inclusion required that participants were either currently engaged in intensive work with an adolescent or had done so at some point during their training. I focused exclusively on trainee CAPs because it is exceptionally rare for qualified child and adolescent psychotherapists to offer intensive psychotherapy within the NHS. To focus on therapists' understanding of the initial phases of intensive psychotherapy, participants needed at least three months of post-assessment experience working intensively with an adolescent.

After receiving ethical approval from the Tavistock Research Ethics Committee (TREC), I recruited trainees from the Tavistock's Child and Adolescent Psychoanalytic Psychotherapy program who worked across various teams within the NHS Trust with adolescents and young adults aged 14-25. The search included participants from diverse experiences across specialist services and community CAMHS. I aimed to recruit a diverse group in terms of gender, ethnicity, and cultural background.

Recognising the potential influence of pre-existing relationships with some participants, I took this into account during recruitment. I approached teams via their managers, then contacted team administrators to facilitate communication with clinicians. An introductory Participant Information Sheet was provided, outlining the study, emphasising voluntary participation, and detailing that participants could withdraw up to three weeks post-interview. Those interested could have an informal conversation before confirming their participation and signing a consent form.

Of the five recruited CAPs, four interviews were included in the analysis. One was excluded because during the interview it became apparent that the patient had prematurely terminated treatment, which did not adequately cover the settling-in phase central to this study. Additionally, the participant spoke about two cases interchangeably, leading to confusion that hindered analysis of specific transference and countertransference dynamics. Although insights from interrupted treatments could have been valuable, the decision to exclude this interview was discussed in supervisory and research seminar meetings to maintain the study's focus on how adolescents engage with intensive therapy.

Of the CAPT's who took part in the study, three were female and one male. All participants were of a white British or European background and worked in various NHS settings. They were at different stages in their training and therefore had different levels of experience. The final sample of participants was not as diverse as I hoped it would be. Three interviews took place in person and one interview was conducted online via Zoom. I have given participants pseudonyms: Anna, Luke, Nadia and Maya for purposes of anonymity.

Design

I chose Interpretative Phenomenological Analysis (IPA) as the research method because my study focuses on individual clinicians' understanding of their intensive work with adolescents. IPA is well-suited for this aim, as it explores how individuals make sense of their lived experiences (Pietkiewicz & Smith, 2014). Rooted in phenomenology, hermeneutics, and idiography, IPA was developed in the 1990s by Jonathan Smith as a qualitative approach to psychological inquiry, particularly suited to exploring complex, emotionally nuanced experiences in health and clinical settings. The theoretical foundations of IPA allow researchers to engage deeply with the subjective world of the participant, while acknowledging the interpretative role of the researcher.

A key strength of IPA is its idiographic focus, which enables detailed, in-depth exploration of individual narratives while also allowing for the identification of patterns across cases. This makes it particularly appropriate for understanding how trainee Child and Adolescent Psychotherapists make meaning of the early stages of intensive psychotherapy, a process that often involves layered and emotionally charged reflections. Given my interest in how adolescents use dreams and the arts to express their experience of beginning treatment, IPA's emphasis on bringing themes to life through rich personal accounts felt especially apt.

The dual interpretation process in IPA involves participants making sense of their experiences, followed by the researcher interpreting the data to understand those interpretations. In this study, an additional layer of complexity was introduced, as participants were asked to reflect not only on their own professional experiences, but also on the emotional communications of their adolescent patients. This layered structure enabled insights into both the participants' internal processes and their understanding of their adolescent patient's inner world. There will thus be multiple layers of meaning-making, with participants drawing on their in-the-moment

experiences, post-session reflections, and insights from supervision and team discussions, while I further interpret these reflections as the researcher.

While other qualitative methodologies were considered, including thematic analysis and grounded theory, these were not selected. Thematic analysis, while flexible, offers less depth in terms of exploring the lived, subjective experience of individuals, and grounded theory is oriented toward theory development, which was not the primary aim of this study. IPA stood out for its capacity to encompass experiential depth, psychological complexity, and the relational and interpretative nature of clinical work—making it the most appropriate choice.

I gathered data using semi-structured interviews, which allowed for flexibility and the emergence of new themes. In formulating interview questions, I focused on open-ended inquiries to encourage participants to reflect freely. As Rustin (2010) suggests, interview responses can mirror the framing of questions, so I aimed to let the narratives unfold organically, using prompts only when necessary.

Please see the interview schedule in Figure 1 below:

Figure 1

- At the beginning of the interview to ask the participant to introduce the patient/ piece of work they wish to talk about.
- Can you tell me about the beginning of intensive work with this adolescent patient?
- What has it been like being in the room with the patient at the beginning of intensive work?
- Is it possible for you to say something about this patient's unconscious phantasies and preconceptions in relation to beginning intensive psychotherapy? What about their anxieties and hopes?
- What can you tell me about the early transference and countertransference dynamic?
- Sometimes adolescent patients use dreams, metaphors, music and film in conveying something of themselves in the context of beginning therapy? Was this the case for the patient you are describing and if so, could you tell me something about that?

- What do you think the patient might have been looking for in having a space of their own?
- What was your particular impression of how the patient made use of their space?

In line with the psychoanalytic orientation of this study, I made the decision to include psychoanalytic language in the interview schedule, asking directly about concepts such as unconscious phantasy, transference, and countertransference. This approach was intended to resonate with the clinical language and conceptual frameworks familiar to the participants, all of whom were trainee psychotherapists. It allowed for a shared clinical vocabulary and enabled participants to speak in depth about aspects of their work that might otherwise remain implicit or unspoken. One advantage of this approach is that it can elicit rich material, facilitating reflection on unconscious processes and the intersubjective dynamics of therapy.

However, there are also potential limitations. Using theoretical terms within interview questions may have shaped or constrained participants' responses, inadvertently leading them toward certain formulations or away from others. On reflection I wonder whether using psychoanalytic language could have inhibited spontaneity or reinforced a particular frame of reference at the expense of alternative ways of thinking about experience—or whether, had the questions been framed differently, a different kind of narrative might have surfaced. There is also the possibility that by shaping the interview through a psychoanalytic lens, I may have inadvertently excluded certain meanings or created a sense that the interview was constructed 'by people in the know, for people in the know'. This raises interesting questions about what prompted me to take this approach. I was particularly interested in the specificities of the experience, especially the unconscious dynamics and phantasy life in the early stages of an intensive therapeutic relationship and hoped that the use of shared psychoanalytic language would help make this level of clinical thought accessible within the interview space.

I was mindful of these dynamics during the interviews and aimed to maintain a balance—inviting reflection in psychoanalytic terms while also allowing space for participants to define experiences in their own words. The semi-structured format and open-ended questions were important in mitigating this risk, as they supported the emergence of diverse narrative forms.

I emailed all participants a brief outline of the interview schedule in advance. I explained that preparation was not expected, although they were welcome to reflect on the questions beforehand if they wished. I did, however, invite them to recall a piece of intensive work with an adolescent patient so they would have time to consider this in advance. The degree of preparation varied: two participants chose to reflect in the moment, while the other two reviewed the questions and considered their responses more deliberately.

Since the discussions involved clinical work, confidentiality was emphasised. At the start of each interview, I reminded participants to avoid disclosing identifying details about their patients. I assured them that any accidentally shared identifying information would be redacted, and I carefully omitted such details from vignettes used in the analysis. I would also think carefully at every stage of the process about how I would make use of the specific details that participants share about their patients so that nothing identifying is used. There were ethical considerations regarding using dream material to which I gave quite a lot of thought and sought advice. I decided to include vignettes of dream material in a way that emphasises the point the participant is making and the theme of the dream, whilst making sure any material is under 'thick disguise'.

All interviews were audio-recorded and manually transcribed to allow for a deeper re-engagement with the material. I also made notes on impressions and observations afterward, which provided valuable context for the data analysis and helped capture the interview's atmosphere.

Data analysis

I followed Smith and Nizza's (2022) approach for analysing each interview. The analysis began during transcription, allowing me to recall the interview's atmosphere, including pauses, laughter, tone of voice, and body language. After transcribing, I read the document multiple times, making initial observations, impressions, and questions in the right-hand margin.

After two or three readings, I made experiential statements in the left-hand margin, aiming to capture the core of the participant's expression or inferred meaning. I then listed these statements, printed, and cut them into individual pieces, grouping similar ones and eliminating duplicates. I developed Personal Experiential Themes for each group, with two to three subordinate themes, completing this process for all four interviews.

Next, I examined the Personal Experiential Themes across all interviews, looking for patterns and contrasts. This process helped me cluster related subordinate themes into overarching Group Experiential Themes. I created a table showing subordinate themes, quotes, and their links to the transcripts (Appendix 5), noting that not every theme appeared in every interview but was included for its relevance to the Group Experiential Themes. I reviewed these with my

supervisor, finalizing five Group Experiential Themes, each containing two to three sub-themes, detailed in my findings.

Reflexivity

As a researcher and psychotherapist, I am interested in exploring the role of unconscious process in the interviews and it is important to note that in interpreting the data I will inevitably use the psychoanalytic lens which is concerned with the underlying meaning beyond what is solely communicated through words. I acknowledge that some of the interpretations of the themes were also shaped by the way that participants communicated with me throughout the interview, which involves all sort of nonverbal cues and communications. While Interpretative Phenomenological Analysis (IPA) supports this kind of interpretation, I ensured the interview data remained central to the analysis. As a clinician, I used psychoanalytic theory to hypothesise about the data's meaning.

Being a psychotherapy trainee with experience working intensively with adolescents, I recognise that my experiences and preconceptions may have influenced my interpretation. To mitigate this, I maintained a diary to track my thoughts and feelings, and I engaged in discussions with my supervisor and research seminar to remain aware of potential biases. I consciously avoided favouring narratives that mirrored my own experiences, aiming to ensure diverse perspectives were represented. I also recognise that when I started this project I too was at the early stages of my training and so I was very keen to explore other trainee therapists' experiences, and I hoped that this openness would allow for differences to emerge.

IPA embraces intersubjectivity, acknowledging that while I strive to understand participants' experiences from their perspectives, I will also inevitably bring my own subjective lens to the reading of the material at my level of experience as a trainee.

As noted in the recruitment section, prior contact with participants through my training school or workplace could have affected data collection, either making participants more at ease or more reserved due to our familiarity.

Finally, I grappled with ethical considerations regarding my decision to exclude the fifth interview from the analysis. In retrospect, this interview would have provided a lot worth

exploring, and I recognise how my decision might have mirrored the disruption in intensive therapy experienced by that participant's adolescent patient.

Findings

Five Group Experiential themes were captured from the analysis, these are outlined in Figure 2 below.

Group Experiential Theme	Sub-themes
Emotional Atmosphere	- A flood of feelings - Prickly atmosphere of discomfort and mismatches as therapist and patient are getting to know each other'
Conscious and unconscious expectations, hopes and anxieties	- "Too much", Patient's phantasies and fears about the self - Expectations, anxieties, and phantasies about the therapist - "I don't have a clue", Anxieties about the work – facing the unknown (inside themselves) alongside hope for containment and nourishment
Manifestations of transference and countertransference experiences	- Re-awakening of an early infantile transference relationship with adolescent patient as picked up in the countertransference - Patients bring internal conflict related to dependency and independence into the relationship with the therapist - Navigating distance and closeness
Adolescents' Use of the Arts and Dreams to explore self and others	- The Arts bring into focus adolescents internal world and repressed aspects of themselves - Dreams at the beginning bring into focus the patient's inner world, object relations and anxieties about the therapy
Intensive therapy as a space for confronting unexplored and previously unbearable aspects of self and experiences	- A space for Understanding Oneself and growth - Support with separation and individuation - Negative capability and the importance of negative transference

I will now explore each theme in further detail, giving examples from the interviews to illustrate my findings.

Emotional atmosphere

"A flood of feelings"

All participants reported varying degrees of emotional flooding, with the nature and quality of the intensity taking different shapes depending on the analytic pair.

The trainee participant Maya described the initial contact as vivid and intense, feeling that the patient was "in my face" and "too much," mirroring the patient's struggle of feeling overwhelming for others. Despite this, Maya found the patient lively and engaging: *"One thing that I remember very vividly about the beginning was that the contact was very intense with her, I felt that she was in my face and that she was too much, (...) But I also liked her, she was alive!"*

This duality of feeling overwhelmed yet captivated is evident in Maya's account and also in trainee participant Nadia's account who expressed a sense of intrigue: "*There is a feeling that you will spend a lot of time with this patient, and I think that I felt intrigued to see what she would be like and what she would bring."*

Both participants highlighted a sense of an overwhelming yet exciting atmosphere, full of possibilities. This experience of conflicting feelings in the therapist seemed to mirror the patient's experience, reflecting a shared phenomenon in beginning intensive therapy. Nadia highlighted the patient's overwhelm at having a space of her own, especially given her background as a twin. Nadia: "*There was something about having a space of her own, being a twin and having grown up really with not having a space of her own and that was both exciting and overwhelming..."*

The demand for support from patients added to the feeling of the encounter being "too much". Maya reported feeling worried and pressured by the amount the patient brought to therapy at the start: "*It was intense; the contact, the demand felt high…she left me a bit worried...she would come with lots she wanted to think about."*

Participants noted that their patients showed a significant need for intensive therapy and felt relieved and validated when offered this opportunity. Maya observed the patient's immediate agreement when intensive psychotherapy was suggested: "*When I suggested it [intensive psychotherapy]...She straight away agreed and said 'yes'.*"

Similarly, Nadia reported the patient's eagerness and the overwhelming feeling it induced: *"There was a real eagerness to kind of get going and have this space for herself. I remember feeling quite flooded and thinking, gosh, how are we going to manage this together? I remember going to supervision and feeling quite overwhelmed by how much she had brought."*

Therapists frequently felt anxious about their capacity to manage the intense emotional atmosphere. Trainee therapist Anna described the initial meetings as overwhelming, with the patient often crying and experiencing a flood of emotions, making it challenging to contain in one's mind which had an impact on the capacity to write up the session notes: "*In the first meeting with her, she cried a lot and was very overwhelmed. She over-flows and bubbles over… there was a complete flood of information, writing up was a nightmare."*

Anna also noted the patient's relief and emotional expression when intensive therapy was recommended, emphasizing the patient's feeling of her need finally being recognized: "*When I said to her that the recommendation would be three times a week psychotherapy, she was very pleased, and she expressed this through crying. As if finally, what I need is being recognized and this is what I really need."*

Trainee therapists faced considerable emotional challenges in managing the intensity of the therapy sessions, often feeling drained. Anna expressed that the beginning of therapy was very draining and described the patient's needs as "sucking out" her resources, making it emotionally exhausting: "*I can find her… erm… very draining and in particular...in the quality of her struggling to…recognize her impact on me…but I think with her, her latent need is quite… it is quite sucking… she is quite sucking."*

"Spiked and hedgehog ball of difficulty" Prickly atmosphere of discomfort and mismatches as therapist and patient are getting to know each other.

All participants reported significant challenges at the start of the therapeutic relationship with their patients, stressing a common experience of discomfort and difficulty. Trainee therapist Luke vividly described the initial phase as "*uncomfortable and difficult*," likening it to a "*spiked and hedgehog ball of difficulty."* This metaphor conveys a sense of sharp, prickly distress, emphasizing the deeply uncomfortable nature of the initial struggle. Luke elaborated, "*Something of that (intimacy) felt too hot and too close and that I had no right to say things. Yes, I think that the idea of intimacy felt like a violation...*" This description highlights the intense discomfort with closeness, which felt intrusive and unsettling.

Similarly, Anna described a "*strange experience*" of attempting to connect with the patient, feeling that their efforts were absorbed but not truly integrated or metabolized. Anna recounted, *"I had this strange experience of saying things to her and not feeling like they really impacted on her and that she would just absorb or incorporate and not integrate or metabolise."* The participant went on to add that their supervisor's metaphor, describing the patient as a "jelly" where things "just sink in," encapsulated this experience of futility and non-connection. This lack of perceived impact led to feelings of confusion and a "non-relational" dynamic, further emphasizing the initial disconnect and difficulty in establishing meaningful therapeutic contact.

Maya also experienced a tumultuous beginning, marked by "*a lot of confrontation"* and a struggle to maintain calm and keep thinking amidst high emotions. Maya reflected, "*There was a lot of confrontation between us. I had to work very hard to stay calm and acknowledge the impact on her and on me but to continue thinking. And keep my thinking, you know, the emotions were high especially at the beginning…*" This indicates an atmosphere of heightened tension and emotional volatility, which made the initial phase particularly challenging for both therapist and patient. Additionally, Maya noted an atmosphere of suspicion and mistrust from the patient, stating, "*It was about what were my intentions those she was suspicious about, why would I care."*

<u>Conscious and unconscious expectations, hopes and anxieties when beginning intensive psychotherapy</u>

"Too much" Patients' phantasies and fears about the self

A recurring theme across the trainees' accounts is the patients' fear of being too much for their therapists. Maya's patient questioned whether she was "too unwell" to benefit from intensive psychotherapy. Maya reflected, "*It was hard to take in that she could be given something, that this was something good that she could access. But yes, on one level she was not sure what it meant…"* This uncertainty was compounded by the patient's chronic illness, which exacerbated her fear of being "too much" and feeling like she had too many issues to be helped by intensive therapy.

Nadia provided a similar insight, noting that the patient frequently expressed feelings that her needs could not be managed. *"I think she spoke a lot about feeling that her needs could not be managed, and she had a mother who she felt was overwhelmed by her needs,"* Nadia noted. This expectation of overwhelming the therapist was understood by the trainee therapist as reflecting the patient's fear of being inherently unmanageable and unworthy of care and related to an early experience of a lack of a parental figure able to take in the child's unmanageable emotional experiences.

Anna highlighted another dimension of these fears, where the patient brought intense anxiety about being inherently bad. Anna explained, "*The other safety plan I have had to do with her is about her worry about being a paedophile not that she is one but there is something about wallowing in badness."* This anxiety stemmed from a history of being punished for her vulnerability and difficulties, Anna observed, "*I think that she is used to being punished for her vulnerability and for her trauma and difficulty, with her adoptive and birth mother and I think I got implicated in that feeling."*

Maya's patient, dealing with a chronic illness, feared that the intensive treatment would confirm her worst fears about herself—that she was indeed "too much" and her issues were insurmountable. Maya noted, "*She had a chronic illness (…) So I think three times a week would put her in touch with, it is real I am too much, I have all these issues. She wanted to do as if these things didn't exist."*

Luke described a patient who arrived in a state of crisis, terrified of losing control and falling into a deep depression from which she might not recover. "*She had tremblings of depression and she worried that she would fall down into a black pit and would not be able to come out of it again,"* Luke recounted. This fear of unravelling and the desperate need for containment were

central to her initial experience of therapy, highlighting a profound anxiety about losing control and the need for a stable, robust environment.

These initial experiences highlight the intricate interplay between patients' conscious and unconscious expectations, hopes, and anxieties as they begin intensive psychotherapy. The common theme of fearing to be "too much" or inherently bad reflects what I would understand as deep-seated early anxieties and past traumas that influence therapeutic engagement.

Expectations, anxieties, and phantasies about the therapist

The patients' phantasies of the therapist as an omnipotent, idealised figure, and their concurrent anxieties about potential judgment and misuse of power is a repeated theme across the interviews. Anna described a patient who seemed to view the therapist as a "*passive receptacle*," someone who could be filled with her emotional outpourings without retaliation or response. Anna reflected, "*I think her phantasy would be that I could be something that she could fill up over and over again and that it would not… retaliate or… do anything just to be a passive receptacle."*

Similarly, Nadia noted how a patient initially saw the therapist as an "*ideal object,"* someone who would never let her down. Nadia admitted to complying with this phantasy, even attending sessions while unwell to avoid exposing the patient to the reality of the therapist's limitations. *"I tried to be an ideal therapist for a while until I noticed that I was doing it (...) it was as if I could not expose her to the reality of me having limitations and not being perfect."* Nadia 's patient initially held onto the phantasy of the therapist as an infallible figure, leading the therapist to overextend themselves to meet this expectation. These dynamics perhaps reveal something of the patient's fear of being let down and the therapist's unconscious collusion with this at the beginning.

Luke described a patient looking for a "*benign supportive warm contact with a safe person."* This patient, however, also harboured anxieties about the therapist potentially misusing power, influenced by a series featuring a male psychologist involved in unethical liaisons. Luke noted, "*She took this as evidence that I need to take on how I am to her and that this substantiated her worries at the time."* This patient's fear was juxtaposed with a wish for a therapist akin to

the idealised, ever-available American psychotherapist. "*She had an idea of American psychotherapist who you can call when you want and need,"* Luke noted, reflecting a tension between a wish for an always-available, ever-giving figure and fear of boundary violations by the therapist.

Anna's patient not only saw the therapist as a passive receptacle, the ideal in this case was a figure that could be used for expulsion and projection. *"I do not know if she had a clear idea of what she was looking for beyond a space to evacuate and having someone to ratify and witness her,"* Anna observed.

Maya's patient initially experienced the therapist's curiosity and exploratory questions as judgmental and blaming. "*She would also experience me at the beginning as if I would be saying 'it's your fault' if I tried to wonder what this (risk taking) was about,"* Maya reflected. Maya understood this patient's expectation to be met with blame and judgment to be connected to pre-existing anxieties about being criticized and misunderstood, which gradually shifted over time.

"I don't have a clue" Anxieties about the work – facing the unknown (inside themselves) alongside hope for containment and nourishment

Anna described the patient's reluctance to open up about traumatic experiences, likening therapy to "*opening a can of worms"* that she did not feel ready to confront. Anna reflected, "*She did use (the metaphor) 'a can of worms', saying I am not ready to go there and open a can of worms."* This comment I feel further illustrated the fear of what is inside oneself. Despite this apprehension, the therapist also picked up on the patient's strong desire for her suffering to be acknowledged and witnessed, indicating a hope for understanding in therapy.

Maya echoed this sentiment, noting the initial relief mixed with apprehension about delving deeply into unresolved issues. Maya remarked, "*So yes, at the beginning there was a relief but also this ambivalence we will be looking a lot into things, and this was also scary."* This ambivalence reflects the patient's simultaneous desire for therapeutic exploration and fear of *'looking'* inside oneself and perhaps confronting difficult truths.

Luke highlighted another common thread—a patient's wish to understand familial mental health issues, while grappling with the fear of facing the unknown aspects of her inner world. "*She had some mental ill health in her family and really wanted to get a handle on it and understand the extent to which she should feel frightened of what is within her,"* Luke explained. The patient was able to express these different pulls, a wish to get a better understanding of the "ghosts in the nursery" (Fraiberg, 1975) and intergenerational illness whilst holding fear of facing the unknown aspects of her inner world.

Nadia described a patient who initially exhibited a strong, almost desperate need for therapy, akin to hunger and thirst. This intense desire for containment and nourishment was contrasted with feelings of claustrophobia and a fear of being perceived as too demanding. "*It felt like quite an intense, almost like a hunger and greed and thirst, even though she was late she would arrive a bit like a baby that was made to wait and was really hungry! But it could feel a bit claustrophobic, and I remember she said that her friendships came to an end because people felt she was too much."* Nadia noted. This illustrates how the patient's hope for therapeutic nourishment was accompanied by anxieties about overwhelming others and the potential consequences of her intensity.

Furthermore, Nadia highlighted the patient's attempt to portray herself as competent and in control, despite internal uncertainties and insecurities. "*She spoke in a very jargon way, and she sort of sounded like a business woman but a bit like someone playing at being a business woman, because later it emerged she said 'I actually do not have a clue what I am doing' but it was an attempt to convince herself that she had things sorted and wanted me to feel this too."* Nadia observed. In the context of beginning psychotherapy and not knowing what one might encounter the façade of professionalism perhaps masked deeper anxieties about not knowing and of being exposed as inadequate. Additionally, I thought that this spontaneous remark during the interview "*I don't have a clue what I am doing"* captured the vulnerability and anxiety about not knowing, which trainee therapists will inevitably feel especially with their first intensive patients. Therefore, making it a shared experience between patient and therapist.

Manifestations of transference and countertransference experiences in the beginning stages

Re-awakening of an early infantile transference relationship with adolescent patient as picked up in the countertransference

One significant aspect observed and described by participants is the reenactment or reawakening of the patient's early relationships within the therapeutic relationship. Maya describes the therapeutic relationship developing in a way that echoes the early mother-infant bond. She reflects on the importance of the frequency of sessions in facilitating this developmental process: "*Having three sessions a week gave her more time to develop something, a relationship but also her to develop, not sure I am able to put it well into words but there was something developmental... makes me think of a baby with a mother and having enough time to develop within the relationship."* Maya implies that the consistent therapeutic presence provided a holding environment akin to that of a primary caregiver, allowing the patient to regress as well as develop within the safety of the therapeutic space.

Similarly, Anna observed a regression of her adolescent patient to an infantile state: " *She is like a baby or a young child. At times I say to her do you realize that you are speaking to me in a baby voice? She was adopted when she was two years old, so this history was always present."* The patient's adoption history and early unresolved relational trauma seemed to resurface in therapy, manifesting in her regressed behaviour.

Moreover, in the interview with Anna there seemed to be a suggestion that the initial period of the work can feel like the work of pregnancy, akin to 'holding a baby' inside oneself and waiting for the birth. *"I have been seeing her… 9 months... This time span feels meaningful in itself as a time span. (…) It is interesting to think about the beginning because it feels that things have started emerging in the therapy in a way that she also describes as things are 'coming out' and things she has not spoken about before having started coming out."* Anna's comments, I think, suggest a shared phantasy as the patient remarked the following when beginning treatment: "O*n her second session she said to me, 'I know that I will be seeing you on my birthday', which was nine months ahead."* Both patient and therapist seemed to hold an idea of their work and relationship developing over time like a pregnancy. There is also a hint at 'birth' and '9 months' perhaps suggesting that both patient and therapist are in touch with the potential of the therapy to create something new, a second birth, new life in a symbolic way.

Both Maya and Anna highlight their patients' expectations of a fused – almost symbiotic – relationship, where the therapist is presumed to intuitively understand the patient's needs without explicit communication. Maya noted:

*"It was difficult at the start she felt that she had to explain things to me as if somewhere she felt that the object should understand without her telling me, it was a very **fused** relationship and that we had **different** minds and that even if I didn't get something it was not necessarily bad."*

And Anna shared: *"Initially it was very challenging to get myself into the dynamic I felt like a blank faceless person, it was very strange, and then it was very helpful in supervision to have instructions about how to use the transference to make her aware of me as someone in a relationship with her."*

These experiences perhaps reflect an early way of relating where the infant does not yet differentiate between self and other, and does not see the caregiver as a separate entity with a mind of their own. It also conveys the therapist's struggle and confusion whilst trying to navigate the pull towards fusion and more separate states. The therapists describe the effort in making sense of the projective processes taking place.

A striking countertransference experience described by both Anna and Luke is the feeling of invisibility and non-relational dynamics. Anna felt like a reflective surface, with the patient absorbing information without integrating it:

"*It was quite weird because she would do this very flooding evacuation, I felt **pinned** to my seat but also, I felt quite invisible, I do not think the impact on me was thought about at all or who I was. And she opened with I had a load of therapists… but I cannot remember her name. There was a real sense (pause) of me feeling quite invisible or a **reflective surface** on which she could bounce."*

Luke had a similar experience of being treated as an inanimate object, part of the therapy space, or as if he did not exist, rather than a separate human being:

"*She would claim the space immediately a sense having already settled … and that feeling that she had a birth right to be here. I was aware that she maybe wanted to move into a new room*

that she could make her own space and put up some things! […] the more ambivalent part was that she never thought she really had a place or was really there in the therapy. One significant thing was that she was the first of three and her siblings […] needed a lot of specialist care in the first year and in the following years. And my patient was looked after by a relative who was someone who herself struggled (with MH issues). […] The (patient's) use of the space was a kind of absolute one and I too was an assemblage of the space like a doorknob, and it took a while to feel I was there too and then we were able to think about her sibling situation and the real difficulty of there being another person who turned up and wrecked everything."

Luke experienced his patient's use of therapy space in this absolute way in which the therapist was merely like '*a doorknob'* as a reenactment of sibling rivalry, with the patient attempting to dominate the space and exclude the therapist. Nadia and Luke's narratives bring to light the themes of sibling rivalry and an early kind of enmeshment. Nadia felt a twin-like fantasy, where the patient viewed the therapist as an undifferentiated part of herself, leading to intense sense of fusion, something beyond dependency, perhaps more 'sticky' and 'adhesive':

"She had no other commitments and found relationships very difficult and there were no other relationships in her life apart from her twin. Maybe I became like another twin, and something very quickly felt enmeshed and made the gaps between sessions harder but there was quite an overwhelming feeling of her life centering around these sessions I do not know if dependence is the right word."

The patients' unconscious phantasies of an ever-giving, boundary-less therapist emerged vividly in the narratives. Luke described the patient's unrealistic expectations:

"*She had an idea of an American psychotherapist who you can call them when you want and need. That I had limits when I would be available and when we would see each other and that I was not absorbable within her enterprise and (need to be separate) because I was a separate person and someone she sometimes did not agree with. Initially this jabbing and spikiness and rubbing up against someone a foreign object different to you and she found that upsetting and disillusioned. She didn't know why that was but something was wrong she felt, whether it was me being a man or the wrong therapy or too much but she thought she would be comforted."*

Patients bring internal conflict related to dependency and independence into the relationship with the therapist

Maya vividly describes the initial resistance of an adolescent patient to the dependency that therapy inherently entails. Maya reflects, "*It took a bit of time (to negotiate times of sessions) which was not just about the practical side…Especially in the beginning, it is hard to face that this is something important that you depend on, and you are aware of your dependency."* This reluctance was understood by the therapist to stem from an unconscious fear of vulnerability of needing another person, as the patient preferred to manage independently to avoid potential hurt "*it was hard to see herself as someone who needed another person, she would rather manage things on her own in order not to be hurt."*

Over time, the patient began to recognize the importance of therapy and formed a strong attachment, which Maya also reciprocated: "*I felt more connected to her. I see her three times a week; it was intense for me too."* This mutual involvement highlighted the deepening of the therapeutic relationship, which intensified the patient's internal conflict between dependence and independence.

The patient's external behaviours, such as partying and drug use, were initially framed by the patient as ordinary adolescent exploration. However, Maya identified a deeper underlying wish not to need the therapist, as the patient claimed, "*she would tell me that she took drugs and that this helped her feel better and it was hard to imagine that she could depend on me."* This behaviour could be seen as a defence against the vulnerability of dependency, revealing a struggle with integrating the need for support into her sense of self.

The therapeutic space often became a battleground for the patient's internal conflict, with the therapist being cast in a parental role. Maya notes, *" I was worried how much would she act out and put herself at risk (…) and sometimes she wanted me to be like a parent tell her right and wrong and she could rebel."* This dynamic allowed the patient to externalize her struggle, creating a conflict with the therapist rather than facing it internally.

Nadia observed that her patient exhibited a strong resistance to progressing in therapy, reflecting a deeper unconscious fear of growing up and becoming more independent. Nadia describes, "*she wanted this space to go on forever; she did not want to get better and therefore*

the therapy to end." Nadia thought that this resistance was tied to an unresolved process of mourning the loss of an idealised object, a significant early struggle with separation. The patient's wish to remain at the beginning stage of therapy could also reflect the typical movement in adolescence between regressive and progressive pulls.

Nadia further elaborates, "*there was something so complicated for her about the beginning of her life and the very early process of separating from your caregivers and developing and moving into the depressive position."* This patient's desire to avoid the progression of therapy highlights a fear of losing the therapeutic space, which had become a substitute for the unresolved early loss. In the participant's view the therapy, in this case, was about helping the patient navigate these early developmental challenges in a more ordinary way, as Nadia states, *"It felt like the therapy was about helping her to move into the depressive position in an ordinary way and accepting being separate."*

Luke highlights a unique aspect of his adolescent patient's struggle with separation: the fear of being colonized by the adult world, represented by the therapist and the therapeutic process. Luke articulates, "*adolescents feel danger of being colonised by us the therapists, psychoanalysis, the adult world, and they really need to feel free of that."* This metaphor of colonization captures the patient's fear of losing their autonomy and being overtaken by what seems to be perceived as the cruel demands of adulthood.

Navigating distance and closeness

Maya reported that her patient initially struggled with the concept of boundaries, often confusing the therapeutic relationship with more intimate, sexualised relationships she had previously experienced. Maya noted, *"It was hard to navigate being patient and therapist... she was not sure whether there was something more of an erotic nature, she used to do this a lot, sexualize relationships, and have sex with friends and so there was a lot of confusion. I remember she was telling me it is just sex; it is just sex! (laughs) I think there was that confusion with me too, are we friends?"* reflecting the patient's difficulty in distinguishing between the therapist's role and her previous relational patterns. The patient's confusion over the nature of their relationship and her tendency to sexualize interactions complicated the

establishment of clear boundaries, particularly regarding the ending of sessions: " *I could become a person that says I don't care about you."* Maya noted, *"She could feel me quite detached from her and as if I would not care if she left,"* This tension illustrates the patient's fear of rejection and her difficulty in accepting the therapeutic limits, which initially led her to perceive the therapist as uncaring and detached. Over time, this dynamic shifted, as Maya observed some developmental progress in her relationships.

Anna observed that the patient's approach to relationships was characterized by control and a tendency to intrusively dominate others. Anna described, *"She was very controlling... She had to fill up the objects with the things she wanted to, so that she can be perceived in the way that she desired but I think that she is terrified of relationships. I think she actually has a really deep desire for emotional intimacy. There is something about not knowing how to get close and not knowing how to make contact is to intrusively fill people up with her. She becomes quite parasitic, and everyone becomes an aspect of her".* Anna understood this way of relating as demonstrating a deep fear of true emotional intimacy.

Anna's reflections also reveal how the patient's pre-existing relational patterns, such as masochistic online sexual relationships and early experiences of abuse, influenced the dynamic with the therapist. She commented: *"I quickly felt implicated in quite a sadistic countertransference... my instinct would be to interpret in a very cutting way or to really jab a knife in."* This dynamic forced the therapist to confront feelings of being a *"nothing object or a sadist or an abuser,"* illuminating the intense projections and the challenge of navigating these roles within the therapeutic setting. This struggle was partly attributed to the patient's history of being punished for her vulnerability, which she unconsciously reenacted in therapy. Through supervision, Anna realised the patient was unconsciously drawn to a sadomasochistic way of relating. The therapist's awareness from experience of this way of relating helped to create a space where the patient's involvement in sadomasochistic relationships could be thought about.

Similarly, Luke reported that his patient needed to keep the therapist at a distance, expressing suspicion of the male therapist's intentions, feeling that he might be manipulative or voyeuristic: "*She was very unsettled about my maleness... She needed me to understand that conventionally she was right to be suspicious of a man."* The patient likened the therapist to a "*voyeuristic documentary maker"*, perceiving him as someone who would exploit her

vulnerabilities for his gain and then abandon her. The therapist acknowledged he felt that there is a temptation with adolescents to become "*like a fly on the wall documentarian"* as they can often lead quite exciting and interesting lives. The "*fly on the wall"* documentarian, in this case could be a kind of object relationship where the therapist is identified with an object that cannot really engage but remains looking on from a distance.

Initially, Luke's patient experienced his interventions as intrusive, describing them as "*jabbing and injecting her"* with his thoughts. The patient's initial perception of the therapist as a dangerous and violent intruder meant that she felt that she had to keep the therapist and his thoughts out. This seemed to be particularly linked to the male gender of the therapist. In the countertransference the therapist experienced the relationship as existing in a "*policing way"* and in the presence of a *"fist of censorship".* This restrictive relational atmosphere seemed to be related to the patient's anxiety about whether what this male therapist had to offer was dangerous and threatening.

Luke found that addressing and owning these projections in the transference was crucial for progress: " *taking up the transference where I too was experienced as a very unsafe person who she really doesn't trust and is jabbing her with these horrible things and entering into that and taking up the transference with her.*" This acknowledgment facilitated a shift from initial discomfort to a more collaborative therapeutic relationship "*And she came to understand that it would be ok that it might be really difficult to be two people with two different separate minds but that we could do that and take what comes and face it together."*

Nadia described feeling positioned as "younger" reflecting the patient's attempts to manage distance and closeness through a dynamic that made the therapist feel like an unreachable maternal figure or child in the presence of a distant maternal object. Nadia noted, "*There were times also that I was made to feel younger than her. So, I think it was quite hard for her to allow me to be in a more maternal or parental role. But I think that was also her way of making me feel like she was an out of reach mother. "* Additionally, Nadia observed something interesting in how the patient used the physical space of the therapy setting: " *In the first session she lay on the couch it did seem to open up something quite huge about her early experiences (…)there were few times when she would come and sit up and if she would want to be less vulnerable, more in charge and maybe have more contact with me."* This physical positioning seemed to play a crucial role in how the patient managed vulnerability and control, allowing herself to be

closer and more dependent on her therapist at times and drawing away from this closeness to maintain some distance.

Across these narratives, similarities are evident in the adolescents' initial resistance to vulnerability and intimacy. Whether through sexualization of the relationship, controlling behaviour, suspicion of the therapist's intentions, or role reversals, each patient exhibited some fear of closeness.

Adolescents' use of the arts and dreams for exploration of self and others

The Arts bring into focus adolescents internal world and repressed aspects of themselves

Nadia recounted a patient's fascination with erotic literature, which paralleled a period of intense therapeutic engagement characterized by erotic transference. " *I do remember that there was a period in the beginning (...) I think there was an erotic transference and there was an excitement that had a sexual quality to it about this contact with me that was obviously more intense and focused than anything that she had experienced before. She spoke quite a lot about reading erotic literature and she would describe escaping into this phantasy world."* Nadia reflected. This engagement seemed to provide the patient with means for exploring sexuality but also complex emotions which manifested in the therapeutic relationship. The therapist also thought that there was an added function which was related to seductive behaviours aimed at preventing separation. *"It kind of intensified as we approached the first break (...) where it felt that there was something a bit seductive going on to try to make me not leave her or not reject her or something like that."*

Nadia also noted the patient's interest in spiritual symbols, particularly related to three women representing death, fertility, and new life. This symbolic framework reflected the patient's evolving transference, where the therapist was perceived alternatively as an older maternal figure or as a twin, as well as the patient's own shifting identifications. Despite these rich symbolic associations, Nadia acknowledged a missed opportunity to fully explore these in the therapy particularly in here and now of the transference. "*I do not think that I ever interpreted that in relation to me but we did think about it in relation to her and I think she spoke that she identified most with this old woman who represented death and there being something about a*

rejection of a younger part of herself, allowing herself to be, (pause) well I suppose it links to her wanting to be more grown up and more independent than she maybe was."

Luke contributed insights into how films and cultural references served as potent tools for self-expression and exploration, which I will comment on further in the discussion. Referencing a film the patient admired, Luke observed, "*She was a big fan of the film 'I may destroy you'... But film and cultural stuff was very important in the work. One of them was about a female serial killer who entices men in a sexual way and then murders them. […] her films were for the (particular) community, and we were talking about this, and she suddenly felt so violated … and I had no right to talk to her about this as I was not part of that community. So, this was another facet of not having any right to think about things with her just very enticing but not having any right.*"

Luke also reflected on the absence of music for his patient. "*Then there were other things that were quite sad she said she did not listen to music it might make her depressed and she felt very worried about that […] I was very available and ready for her interests and what moved her and what she loved and… when those things were kept out there was a sense early on of this really important thing missing (…) Only later it was possible to bring in music and how she felt about things and allowed associations in her mind more freely and could draw on a wider pool of things that she didn't necessarily have to have a position on but could just enter her."*

The therapist's observation about the absence of music and the patient's fear of listening to music is taken up to have symbolic meaning in communicating a somewhat barren inner landscape. This leads the therapist to have his own associations "…*free associating I recalled an interview with the Irish writer Sebastian Barry he was asked about his inspiration and his troubled childhood and what he could understand about that. He said that how work was about raising a thousand kingdoms to make up for that one patch of land that was never there."* He picks up that something very important is missing from the patient's life, with the exclusion of music, but the patient feels furious and pitied when this is recognised, anger perhaps being a defence against the pain of loss.

Maya also highlighted the challenges and nuances in adolescents' artistic engagement. Maya discussed a patient who used drawing during sessions as a means of managing anxiety and

maintaining a sense of control. "*She brought a paper and pen and she would be drawing... It was more like creating patterns for a month and then she stopped using it,"* Maya recalled. This artistic practice initially served as a transitional object, providing comfort and structure in the therapeutic space. The patient's shift away from drawing coincided with increased comfort and readiness to engage more directly in therapy.

Dreams at the beginning bring into focus the patient's inner world, object relations and anxieties about the therapy

Participant Nadia recounted a dream her patient reported in the early stages of therapy. In this dream, the themes were related to being a child and 'indoors' with a parental figure feeling unsure if it's safe to be let outside. An initial theme of safety related to children being outside was contrasted with a stark contradiction of a bloody mess that spilled everywhere. As Nadia noted, the dream seemed to convey "*her fears of starting therapy, letting something out, and wondering if it was safe to let out the child parts of her and maybe a fear of making a mess."*

Participant Anna described a theme of her patient's early dream as if being on a desert island unable to get through to anyone for help. The theme of this dream starkly illustrates the patient's profound sense of loneliness and her perception of the unconscious as a perilous and overwhelming space. Anna shared her understanding of the dream "*I remember thinking that it was about her being all alone and she was very lonely and surrounded by water which I considered to be the unconscious and emotional depths and it being very dangerous and feeling how do you navigate your way through it to reach other islands or me? I was thinking about all her internal objects being dead or murdered by her."*

<u>Use of intensive therapy as a space for confronting unexplored and previously unbearable aspects of self and experiences</u>

A space for understanding oneself and growth

Maya described how intensive therapy facilitated the patient's self-understanding and development: "*She always had a question why she was so depressed when she was younger and why did she self-harm. I think she wanted to know what was so wrong with her. Over time, it became also about understanding her chronic illness and how it affects her. Initially, it was too much to go there."*

Maya reflected on how at the beginning the patient wanted to use the therapy to help her grapple with understanding her depression and self-harm suggesting that sometimes young people find it difficult to pin down what they struggle with and why, needing support to untangle and make sense of their difficulties. As the therapeutic relationship progressed the patient was able to bring into the therapy her chronic illness something that at the beginning felt like a 'no go' area and 'too much' later became something that could be thought about and confronted in the therapy.

Maya further elaborated on the therapeutic process: "*I could see very clearly how the intensity made change more possible. The patient did make use of it and changed. She felt more grown up, and the three times a week allowed not only the understanding of herself but also for something to develop—for her to develop and her capacity to create different types of relationships."*

Maya reflected that the intensity of the frequency of the sessions provided more space for the patient to bring her more troubling and repressed difficulties and allowed time for development to take place. It could also suggest that it was of course not just the space of the three times a week sessions but the psychic space that the therapist offered, which communicated to the patient that the therapist has a mind that can face and digest difficult emotional experiences. As Maya noted the patient's process of opening-up and trusting the therapist developed in the context of the therapist making herself emotionally available and receptive to the patient: "*She brought a lot of feelings, and it was hard to have a space in my mind… to have a space in my mind to be… to be disturbed! For her disturbance and to be disturbed by her."*

Nadia highlighted the patient's journey of self-exploration, seeking to uncover a deeper understanding of her identity beyond superficial adult like behaviours. Nadia noted *"I think that she very much did not know who she was […] she was trying to behave in a grown-up*

adult way but in a way that was quite surface level and beneath that I do not think she really knew who she was."

Similarly, Luke noted his patient's struggle with her internal development and sense of identity: "*She felt that she should be feeling more settled (…) within herself more than she found herself to be, but when she looked within herself, she found she hadn't begun much at all but had been very stuck. We thought about the work at the beginning, that she could settle, attend, and participate. The more ambivalent part was that she never thought she really had a place*."

Luke articulated the metaphor of finding a home through therapy when talking about his patient's feeling that she never really had a place. Luke shared that in preparing for the interview he recalled an interview with the Irish writer Sebastian Barry: "*He said how work was about raising a thousand kingdoms to make up for that one patch of land that was never there. And I thought of her when I thought of this interview today…*"

Luke's associations when thinking about his patient captured something of her deep unconscious experience of being displaced and unhoused and her search for what has been lost or perhaps never had. I believe Luke's comments reflect his patient's wish and hope of finding a therapeutic home, a piece of land on which they can settle and a hope to be contained, found and helped to understand themselves better.

Support with separation and individuation

This section explores how the therapeutic process becomes a battleground for issues of dependency, separation and the fear of leaving the safety of the therapeutic environment.

One salient aspect described by Nadia is the patient's reluctance to progress and leave the beginning stages of therapy. Nadia reflected on this stagnation: "*What I would say is that it was therapy that was very difficult to move forwards in, so I think in some ways we never left the beginning. It was very cyclical, it felt very cyclical, and I think she was very invested in staying or in not making progress because she wanted this space to go on forever, she did not want to get better and therefore the therapy to end".*

This cyclical pattern could be understood as a reflection of the patient's fear of growing up and becoming independent. The therapy becomes a metaphorical cocoon, a place where the patient can avoid the responsibilities and challenges of adulthood. The therapist linked the process of supporting the patient towards separation and independence to moving into the depressive position and becoming more of a separate person: "*It felt like the therapy was about helping her to move into the depressive position in an ordinary way and accepting being separate and that when you are a certain age you start nursery and become more of a separate person."*

The notion of therapy as a cocoon is further elaborated by Nadia, who describes the patient's desire to remain in a protected, regressive world within the therapeutic space: "*I am just thinking about this idea of settling in and how for her I think it was a kind of settling in for good sort of feeling. So, there was something actually quite complicated... She referred to the room as a cocoon, something very snug and cozy in and so I think I felt aware, well not a danger of settling, but like you can settle in but there will also be an ending*."

This snug and cozy cocoon seemed to be understood as having the function of a retreat from the outside world, a haven where the patient can avoid the anxieties associated with growing up and deny the reality of there being an ending. However, the therapist remained mindful of the necessity for an eventual ending, highlighting the tension between the comfort of the therapeutic space and the need for separation and independence.

Luke introduced the concept of oscillation, emphasising the non-linear nature of the therapeutic process and its link with separation and individuation. "*I wonder if that is something about adolescents that they too can feel danger of being colonised by us the therapists, psychoanalysis, the adult world and they really need to feel free of that... But also, there was a constant oscillation between settlement, (settling) and unsettlement and the need for that […] I am really questioning this linear idea of beginning and settling in and maybe it is more realistic to say that things are oscillating all the time. Especially for adolescents, this idea of settling might be disturbing*."

Luke's reflection suggests that some adolescents may perceive the therapist and the therapeutic process as threatening their sense of autonomy and individuality. The constant oscillation between feeling settled and unsettled might mirror the adolescent's internal struggle with separation and individuation, there is a wish to remain attached like Nadia's patient and never

having to face the loss and pains of separation as well as a fear of becoming engulfed and overtaken by the other, driving a need for separation.

Anna highlighted the conflict of dependency and the struggle for independence. Anna's comment speaks to how intensive therapy brought about unsettling realizations and emotions for her patient: "*When we started three times a week, it was that thing—the more you want, the more you need."* (P2, pg.3 C36). This sentiment captures the paradox of therapy, where deeper engagement often leads to the surfacing of more complex and challenging feelings and greater awareness of one's dependency.

Negative capability and the importance of negative transference

This subtheme explores the need for a therapeutic space where confusion, uncertainty, and not knowing can be tolerated. It encompasses the therapist's ability to inhabit the negative transference and be experienced as a "misunderstanding" object, allowing adolescents to process distressing and previously unthinkable experiences.

Maya describes the profound challenge of holding space for the patient's intense and disturbing feelings. The patient's use of the therapist to hold her anxiety, which otherwise might be dissociated from, is a critical element of the therapeutic process. Maya reflects on the difficulty and importance of this task: "*She brought a lot of feelings, and it was hard to have a space in my mind… to have a space in my mind to be… to be disturbed! For her disturbance and to be disturbed by her."*

This quote underscores the therapist's role in being a container for the patient's anxiety and disturbance, a concept resonant with Bion's (1962) idea of containment. The therapist must possess the negative capability to sit with and digest these difficult emotions, allowing the patient to eventually do the same. "*There were things like her chronic illness that she thought I would not understand, and it was so interesting that I myself have a health issue not the same as hers, but it was interesting that she felt that I cannot understand."* Maya allowed herself to be a non-understanding object and also to occupy a space of not knowing despite having some personal experience of chronic health issues. Perhaps this allowed an expansiveness in the therapy and facilitated a process of greater exploration allowing the patient and therapist to

enter a new dimension leading to new meaning making. Maya reflects: "*Over time, she began to understand her chronic illness and its impact on her. Initially, it was too much to think about, but intensive therapy helped her digest these difficult emotions."*

Nadia discusses the challenges of engaging with the patient's anger, particularly when it involves deeply personal, socio-politically charged issues such as racial difference. Nadia initially struggled to take up the negative transference but eventually recognized its necessity: *"I think that there was a resistance within me at first to taking up the negative transference (...) But what did happen was that her anger did start coming into the sessions in relation to our racial difference that was the first explosive session we had where she did get very angry (...) and that became her platform for her to express her grievances in relation to me and feeling of anger about what I could not possibly understand of how hard she has had it ... And it was difficult to acknowledge the truth and the reality of our difference (...) and notice what was happening but that was very difficult to think about with her...*

I: Why was it difficult from your perspective?

Nadia: I think for me it was very new territory to be thinking so explicitly about race and difference and there was also a way in which whatever I said felt inflammatory and it felt as though she felt she had found a dead-end point in which she could say no you really do not understand."

This experience allowed the patient to bring forward her deeply held grievances and begin to process them within the therapeutic relationship. The difficulty for the therapist lay in acknowledging the reality of their differences, occupying the negative transference of being a non-understanding object while maintaining the capacity to think about these emotions together. The patient's expression of anger and experiences of racism brought the therapist into new and challenging territory, it is this '*new territory'* the unexpected spontaneous realm which is stumbled upon that therapist and patient seem to fear the most, whilst simultaneously yearning to get to, so that something could be worked through.

Reflecting on her practice, Nadia expresses regret for not allowing enough space for the patient's more negative emotions at the start of the therapy: "*Looking back, I regret not allowing*

enough room for doubt, ambivalence, and resentment. It was a big deal for this patient to start intensive psychotherapy, and I overlooked that at the start."

These reflections underscore the essential role of negative capability and putting up with not knowing in facilitating genuine psychoanalytic exploration. The therapist's ability to hold and process negative emotions creates a space where patients can confront and integrate previously unacknowledged or dissociated aspects of their experiences. This transformative potential of therapy lies in its capacity to make room for the negative, allowing for a deeper understanding and acceptance of the self.

Discussion

Following on from the findings chapter I will now discuss the results in further depth and reflect on them within the context of the psychoanalytic body of work outlined in my literature review.

Emotional atmosphere

All of the participants conveyed a sense of emotional intensity being present at the beginning of intensive psychotherapy with their adolescent patients. Wittenberg (2022) describes how beginnings provoke deeply rooted anxieties, dating back to the earliest moments of life, as the new-born is confronted with the unfamiliar and terrifying, yet wondrous, world. This duality of feelings – excitement at the new yet dread at the unknown – reflects the emotional atmosphere described by therapists in this study.

Indeed, the vividness with which therapists recalled these initial encounters suggests there has been an emotional impact which has been hard to forget. Notably, the participants in this study were trainee therapists handling their first intensive adolescent cases which might of course contribute to the memorability and intensity of the encounter.

Across all accounts, the intense emotional atmosphere appeared to be mutual. The patients' overwhelming emotional needs, coupled with therapists' reactions of being 'flooded' or feeling that the patient was 'too much', suggest the beginning of therapy often activates deep, unconscious emotional currents that may feel overwhelming for both parties. The literature also supports the idea that an "unconscious storm" is set in motion when two people meet within a psychoanalytic framework (Reith et al., 2018). This research adds to that body of

knowledge, with participants describing a parallel phenomenon, specifically the experience of an emotional 'flood' emphasising perhaps its reciprocal nature and how both therapist and patient feel caught in its currents. Both metaphors – storm and flood – evoke human vulnerability and helplessness in the face of unpredictable natural forces, which mirrors the emotional atmosphere of beginning intensive psychotherapy in the cases explored in this research.

Findings point not only to how patients may come to us at the beginning, in a state of emotional upheaval which is described by the therapist as a flooding, but as the literature review suggest complex unconscious dynamics get set in motion when an analytic pair meets "the multiple and simultaneous forms of communication, levels of mental functioning, and intense intersubjective phenomena including projective identification and identity confusion, role responsiveness and mutual enactment" (Reith et al., 2018, p.76). Thus, the initiation of intensive psychotherapy appears to stir an unconscious emotional storm, disrupting both the patient's and therapist's sense of stability.

Trainee therapists described feeling worried about their capacity to manage the work and their resources being drained and 'sucked out'. Despite these challenges, there was a recognition among the therapists that these overwhelming feelings were, in part, communications from the patient. From a psychoanalytic perspective, it can be understood that patients, particularly in the early stages of therapy, project unwanted or intolerable emotions onto the therapist (Bion, 1962), and might use the therapist as a "toilet breast" (Meltzer, 1967), an object into which to evacuate, as they have not yet developed the capacity to verbalize or process these feelings themselves. The participants Nadia and Anna suggested feeling taken over by the flooding, they pointed out the essential need for space and separation, to regain their own mind from being drowned and flooded, whether through supervision or by writing up the session, bringing to light the need for supervision from early on to provide a "triangular space" (Britton, 1989).

The theme of conflicting feelings of excitement and overwhelm seen in the patients' reactions mirrors the therapists' own internal struggles, revealing a parallel process. Nadia's reflection on her patient's simultaneous excitement and struggle for her own space, particularly in the context of her twin identity, highlights the significance of the therapeutic space as both liberating and anxiety-inducing. This resonates with Bollas' (1987) idea of the unthought known, where the patient's unconscious emotional reality is awakened in the therapeutic space.

The patient's eagerness for intensive therapy, as described by Maya and Nadia, might indicate an unconscious longing for recognition and care.

I was interested in how some of the themes which the participants brought were reflected in the interview process. I recall feeling excited to discover new things and learn from the interaction with colleagues and peers but also feeling a level of anxiety – wondering if I as a new researcher am equipped enough to be undertaking the interview, whether we will manage to think together and come to some sort of insight and learning needed for this project.

Furthermore, it is interesting to think about whether more experienced therapists or psychoanalysts might relate differently to the intensity of beginnings in intensive work. Perhaps they would be less destabilised by the emotional impact of the early stages, having previously travelled through the arc of a therapy—from beginning to middle to end—multiple times. Their clinical experience might offer a firmer internal frame, and the memory of endings may provide reassurance that the turbulence of beginnings can be worked through. Moreover, the depth of their own personal analyses may contribute to a greater capacity to metabolise the anxieties stirred in the countertransference. It also remains a question of how therapists from different training traditions might engage with these early dynamics in distinct ways, in relation to technique, or transference. While the intensity of the beginning may be a universal experience in intensive work, the way it is tolerated and understood may vary significantly depending on experience, training, and personal analytic history.

I was curious about the metaphor of the 'spiked and hedgehog ball of difficulty', shared by Luke. It powerfully captures the discomfort and challenges therapists might face in their early encounters with patients. The awkwardness of some early sessions, where intimacy feels invasive and 'too hot', reflects the delicate nature of establishing a therapeutic alliance in psychoanalytic work with adolescents. I was wondering if Luke was bringing our attention to the activation of defensive structures, the hedgehog's spikes or rolling into a ball are part of its protective mechanisms. Luke might have been drawing our attention to how his patient might have felt little and vulnerable as a hedgehog, but also very anxious about the intimacy that psychoanalysis demands due to the fear of being overwhelmed or intruded upon and therefore prepared to protect and defend herself. It also reminded me of an adolescent patient I worked with whom for a long time held a jacket or a cushion covering their core, or another patient

who for a long time wore a blown-up puffa jacket in the sessions. Therefore, for some patients the initial atmosphere might feel particularly threatening – as Luke says, *'like a violation'*.

Anna and Maya further elaborate on the difficult atmosphere highlighting strange, suspicious and confrontational beginnings. What I think all the above accounts have in common is the fact that there are two people in the room who are new and therefore unknown to one another. The therapists seemed to pick up that what their patients were communicating was a suspicion of the other and not knowing whether they can trust the other and defending against contact in their own particular ways. By being confrontational, spikey, suspicious, or simply detached and non-relational. These could be seen as defences against intimacy or a protection in the face of the unknown other, echoing Wittenberg's (2022) notion of the emotional risks involved in embracing new experiences. Both therapists and patients, much like individuals stepping into any unknown territory, seem to grapple with the uncertainty and emotional vulnerability inherent in the start of therapy.

Conscious and unconscious expectations, hopes and anxieties

The findings of this section echo themes from the literature, particularly Wittenberg's (1970) reflections on the unconscious expectations that both patients and therapists bring into the therapeutic relationship. Wittenberg describes the patient's unconscious fantasy of the therapist as someone who can "take away all the pain", provide everything they have "ever longed for", or serve as a "dustbin" for unwanted emotions (p.11). This resonates strongly with the experiences described by the therapists in this study, who noted their patients' phantasies of the therapist as an ever-available, passive receptacle.

Anna, Luke, Maya, and Nadia each observed that their patients initially viewed them as idealised figures, capable of absorbing limitlessly whilst being a 'passive receptacle'. The wish for a therapist who is omnipresent and omniscient seemed to reflect an unconscious need for an idealised, ever-giving object. While therapists attributed this wish to their patients, I wonder whether a parallel unconscious desire might exist within the therapist as well. This raises the possibility that therapists, particularly in early stages of treatment and their training might also strive toward becoming this 'ideal object,' motivated by their own narcissistic desires as well as an enactment of the patient's transferential wish.

These unconscious phantasies – of the therapist as all-giving or, alternatively, as a persecutory figure – highlight the presence of paranoid-schizoid anxieties (Klein, 1946), where the object is split into being either wholly good or wholly bad. The anxiety about the therapist misusing power or as a harshly judgmental figure is the other side of the idealization dynamic. Beginning intensive psychotherapy may thus provoke a wish to be cared for by an omnipotent figure, as a defence against unbearable anxieties of a more persecutory nature.

The therapists' descriptions also support Meltzer's (1967) concept of the "toilet breast", where the early stages of analysis involve patients dumping their unwanted psychic and emotional content onto the therapist. This raises the question of whether these projections are specific to the start of therapy and to what extent they are likely to persist for some patients as part of more entrenched dynamics.

The experience of 'being too much' was prevalent in the interviews, with therapists describing their patients' fear that they were 'too unwell', 'too difficult', or 'too bad' to be helped. Nadia and Anna linked this fear to a lack of containment in their patients' early life experiences. Luke's patient, who feared 'falling into a black hole' and not being able to recover, suggested worrying about a profound psychic crisis reminiscent of Esther Bick's (1968) descriptions of infantile fears of disintegration. Waddell's (2018) exploration of adolescent development reminds us that as young people move toward independence, infantile anxieties often resurface, stirring deep-seated fears of disintegration and loss. This patient's fear of a 'deep depression' may be understood as an unconscious fear of separation, echoing unmanageable infantile anxieties evocative of Bion's concept of nameless dread (1967).

Though the therapists hinted at connections between their patients' early experiences and current anxieties, they did not always make these links explicit. However, it was evident that these feelings—of being too much or beyond help—were tied to a phantasy internal object for whom they were 'too much', and this was experienced by the therapist in the countertransference.

The subtheme 'I don't have a clue' captures the interplay of the shared experience of 'not knowing' in therapy. The therapist, like the patient, faces the unknown. While the patient's anxieties may be more immediate, the therapist often experiences a parallel process of uncertainty. As Bion (1974, p.13) suggests "In psychoanalysis, when approaching the

unconscious—that is, what we do not know—we, patient and analyst alike, are certain to be disturbed. In every consulting-room, there ought to be two rather frightened people: the patient and the psychoanalyst." These anxieties are perhaps more pronounced in trainee therapists, who are still developing in their clinical role. However, every therapist, no matter how experienced, must embark on each new therapeutic journey afresh, and this open stance allows for a genuine encounter with the patient's material, wherever it may lead.

The interview findings speak of the ambivalence patients felt toward the therapeutic process, expressed with a simultaneous fear of confronting the unknown within themselves and a desire for emotional nourishment and containment. Anna's patient, for example, used the metaphor of 'opening a can of worms' to describe the reluctance to face traumatic experiences, while Luke's patient wished to better understand the 'ghosts in the nursery' but was frightened of what she might find. This ambivalence—wanting to know but fearing what might be uncovered—aligns with Wittenberg's (1970) observation that anxiety about 'looking' inside oneself is common at the start of analysis. The dilemma between turning a blind eye or facing something, between avoidance and confrontation, reflects the broader struggles that are present in all psychic life, the instinct to avoid and not know.

For many patients, there is a deep fear associated with looking inward. The unknown depths of the unconscious can seem dangerous, even frightening. Ogden (1992) also reflects on the dangers of stirring the unconscious mind, and the therapists in this study noticed their patients' awareness of this risk. For the therapist, the challenge lies in pacing the therapeutic work delicately, attuned to the patient's capacity to confront difficult truths. Despite the fear, patients also expressed a wish to understand themselves better, highlighting the internal conflict between wanting to know and fearing the unknown within. Nadia poignantly described her patient's need for therapy as akin to hunger and thirst, capturing the desperate longing for containment alongside anxieties about being perceived as too demanding.

These findings align with the literature on psychoanalytic work with adolescents, which emphasises the ambivalence young patients feel about engaging with therapy and the transferential relationship (Weitkamp et al., 2017; Midgley et al., 2016; Wittenberg, 2022). The emergence of 'I don't have a clue' in the interviews reflects the adolescents' genuine anxiety about not knowing what they might uncover in therapy, both within themselves and I think, in relation to the therapist, feeling unsure at the beginning of what kind of therapist they are with.

Manifestations of transference and countertransference experiences

In the literature review, Waddell reminds us of the oscillation between different states of mind throughout development, that "the adult may be found in the baby; the infant in the adolescent…" (2018, p.11). The exploration within this research of the beginning stages of intensive psychoanalytic psychotherapy with adolescents highlight a common theme of early infantile transference, with patients regressing to an infantile state and unconsciously expecting a fused relationship with the therapist. Reading these accounts often evoked the sense that therapists were, metaphorically, attending to the 'baby in the room', addressing the infantile aspects within their adolescent patients.

From a psychoanalytic perspective, adolescence is understood as a time of regression towards infancy, an oscillation that reflects the adolescent's attempt to explore and define their emerging identity. The findings of this research align with the literature, suggesting that adolescence involves revisiting infantile states as part of the broader processes of growing up, separating, and individuating. This re-visiting of infancy may be interpreted as part of the work of mourning and re-examining early object relationships within the transference and countertransference dynamic.

Consistent with Meltzer's theory of the "gathering of the transference" during the initial stages of analytic work, the findings emphasise the intensity of transference and countertransference phenomena in the early phases of therapy (1967). In these first encounters, as Ogden (1992) notes, the therapist experiences the patient's "living past"—where unconscious phantasies and internal object relations are lived out, rather than verbally expressed. The therapeutic setting allows these unconscious dynamics to emerge and be worked through within the transference-countertransference relationship.

The observed transference and countertransference dynamics in the early stages of intensive therapy with adolescents are specific to this participant group and their clinical work. Notably, three of the adolescents had experienced some sort of disruptions in early caregiving experiences.

Merging and Part object relations

A predominant theme in the countertransference experiences of the therapists was the patient's unconscious wish for a fused and merged relationship with them. Maya and Anna observed the developmental and the maternal aspects of the transference, evidenced by references to pregnancy, mother-child relationships, and notions of birth and birthdays. Nadia's patient explicitly wished for the therapy 'to go on forever', resisting any notion of separation. The imagery and language evoked an unconscious desire to be 'inside' the therapist-object.

While this wish for merging was common across cases, the quality of the experience varied, sometimes even within the same therapeutic dyad. In some cases, the need for merging felt more developmental and relational. This brought to my mind Waddell's words: "But many babies do not have the opportunity to discover themselves in a mind that is able to register their gusts and storms, passions and pleasures and to respond accordingly" (2002, p.45). The infantile transference might communicate the patient's deep desire to be seen and contained by a responsive mind. The therapists may have picked up on their patients' experiences of emotional deprivation, confronting the absence of a sufficiently attuned object.

In other cases, the wish for merging seemed to carry a more defensive quality. Therapists described feeling invisible, like a reflective surface or even an inanimate object, in their countertransference, suggesting a regression to early infantile states where the object was an extension of the self—a 'twin'. These descriptions evoke Klein's (1946) concept of part-object relating, where the therapist is perceived not as a whole, separate being, but as a partial object, serving a function for the patient without requiring full recognition of separateness.

The therapists' countertransference experiences of being treated like inanimate physical objects—'a doorknob', 'a reflective surface', or 'a passive receptacle'—point to the adolescent patients' unconscious defences against recognising the therapist as a separate individual. Part-object relating serves a purpose, offering containment (passive receptacle) or insight and understanding (doorknob opening doors), but it prevents genuine object relating with a separate human being. These defences may be linked to keeping at bay persecutory anxieties: Klein suggested the infant is not only frightened of being left alone (separation), but of being left with a bad persecutory presence. Therefore, in phantasy to survive these unbearable persecutory anxieties the infant might wish to be right inside the mother's body, which in fantasy is full of goodness, and therefore become so fused to feel that he has acquired her idealised qualities. Furthermore, the descriptions of a reflective surface and doorknob could be

understood as a communication about an object akin to a 'convex container' (Williams, 1997) an object unable to take in the infant's projections that pushes or bounces these back.

All the therapists reflected on the difficulty of establishing a relational dynamic in which both therapist and patient were acknowledged as separate yet connected individuals. In cases where the therapist was perceived as an inanimate object, there was an unconscious denial of separateness – one which evokes a primitive, possessive object relationship. At times the quality of this transference relationship seemed to be of an acquisitive kind, where the patient wishes to have and possess and take over the other. For example, when Luke mentions 'colonisation' and 'absorbable', Nadia observes a twin like fantasy and 'enmeshment' beyond dependency, or Anna her experience of a controlling and 'parasitic' relationship. Bion (1970), when describing types of relationships, defines a 'parasitic' relationship as a destructive kind where "what is product of the association is something that destroys both parties to the association" (p.78). This description sits alongside and in contrast with a definition of a "commensal relationship", in which two people partake in a creative endeavour rather than destructive one.

In these early developmental stages, Klein's paranoid-schizoid (PS) position, characterized by splitting, sadism and control of the object, may offer insight into this dynamic. One hypothesis is that the initial stages of the therapeutic relationship parallel a similar development. Before reaching a more depressive position where the therapist is experienced as a more integrated or whole object, the therapist is often perceived in a part-object manner, dominated by sado-masochistic dynamics. For example, Anna reflected on her countertransference, feeling like a 'sadist or abuser', while Luke experienced being perceived as a 'voyeuristic documentary maker', 'fly-on-the-wall observer', or even 'jabbing and injecting' into the patient's psyche. Maya reported feeling that her patients experienced her as 'uncaring and detached', or that the relationship became sexualised as a defence. Similarly, Nadia felt she was seen as an unreachable maternal object.

In these early stages, therapists often struggle with negative transference and countertransference oscillating between feeling like a passive, useless object or being perceived as overly intrusive. Finding the right balance of closeness and distance is particularly challenging in the beginning of intensive work with adolescents. This can be understood through the lens of "*core complex"* anxieties (Glasser, 1979), where the intimacy and intensity

of the therapeutic relationship triggers deep-rooted fears of being overwhelmed or ‘colonised’, as Luke described. The sexualization of the relationship, as described by Maya and Nadia, can also be seen as a defence against the anxiety provoked by closeness and intimacy. The participant’s conveyed that they had to work very delicately to find this balance in the clinical encounter.

This conflict related to closeness and distance seemed closely connected to their patient’s mixed feelings about dependency and independence. A common thread is the adolescent’s ambivalence toward dependency, which manifests as resistance to therapy and the closeness of the therapeutic relationship. As Maya observed, patients struggle with recognizing their dependency, as they equate needing someone with a potential risk of rejection or abandonment. With her patient behaviours such as drug use and promiscuous relationships seem to have been understood as defences against this vulnerability, reflecting the patient's desire to remain self-reliant. However, this kind of risky behaviour might also communicate an unconscious wish to test the therapist's reliability.

Another key theme is the adolescent’s resistance to progression in therapy, which might reflect unconscious fears of growing up. This tension between dependence and independence was ubiquitous across the findings which perhaps is not so unexpected considering this is such a central conflict during adolescence and young adulthood. These findings are supported by the literature in this review which recognises the contradictory impulses of adolescence.

All therapists spoke of engaging with the negative transference, recognising it as crucial to understanding their patient better and enabling shifts in the work. The therapists seemed to be working within the psychoanalytic understanding that unconscious phantasy and projection distorts the patient's perception of the therapist, who is no longer seen for who they are but instead as a reflection of early object relationships within the patient’s inner world. The participants in this study reported that their countertransference responses helped them understand what type of figure – or 'object' – they represented in the patient’s mind at that moment in therapy. By considering the patients' histories, clinicians drew links between their patient’s early experiences and the object relations dynamics being enacted within the transference.

As mentioned earlier the transference countertransference dynamics of each couple were unique and multilayered, constantly shifting and darting about, indeed there seemed to be a '*haphazard'* quality as described in the literature (Meltzer, 1967). It was fascinating, however, to realise just how much richness and detail the trainee therapists had manage to gather and make sense of in relation to the transference and countertransference dynamics. Writing up this section of the discussion felt the hardest, as there seemed to be so much detail to hold in mind and so many contradictory experiences. I wondered whether my struggle in writing this section mirrored something of the transference and countertransference struggle of the therapeutic couple as the accounts conveyed confusion and great effort in trying to make sense of the negative transference and all the different unconscious processes taking place.

Supervision I think played a key role in helping therapists make sense of these dynamics. Nadia noted that supervision helped her understand her countertransference as 'split-off' aspects of the patient, and Anna found supervision useful in recognizing her role in a sadistic dynamic. Though not all participants commented on supervision, I think it provided a 'third' position (Britton, 1989), offering a new perspective on the therapeutic relationship. All the participants conveyed that the work with their patients had been thought about in depth and I think that there was an implicit understanding that this depth of thinking did not happen in isolation but through the supportive structure of intensive case supervision.

Finally, the literature, including Ogden (1992) and Meltzer (1967), suggests that transference material in initial sessions does not emerge from past experiences but is a new response to the analytic situation. Participants' reflections on newly created meanings within the transference align with Ogden's concept of the "analytic third", where the experience within the therapeutic encounter leads to a new way of understanding the shared unconscious dynamics in the room, allowing the patient to discover aspects of himself which he has not been acquainted with before (1992, 2004).

<u>Use of the arts and dreams to explore self and others</u>

Participants described diverse ways in which their adolescent patients engaged with the arts to explore and express their inner world. The content of the findings has been disguised and summarised to ensure confidentiality, whilst at the same time trying to preserve the original meaning of the material.

Nadia's patient, for instance, used archetypal forms from myths to express her unconscious identification with an older woman in fantasy. Through their work together, they developed a shared understanding of this material, linking it to the patient's rejection of the younger and dependent aspects of herself. Similar to how dreams operate in therapy, the patient's use of myths conveyed complex identifications, illustrating how the use of artistic symbols can communicate profound aspects of the self and one's internal struggles.

Furthermore, this patient seemed to be bringing a wish to explore sexuality through erotic literature, and the three figures might be seen as capturing something of the challenges of moving into a new stage of life, from adolescence to adulthood. The therapist understood this material as communicating the adolescent patient's struggle with integrating the different aspects of herself including her lively, creative and fertile self, which is perhaps linked to this patient's fears related to a more mature and potent adult sexuality.

Nadia noted that this early phase in therapy coincided with an erotic transference, suggesting that the patient used the erotic literature to convey her own feelings about the therapeutic relationship. Therefore, it seems that not only does the patient use the arts to convey her state of mind, but there is a connection between the erotic literature, the transference relationship and the here and now of the analytic process. I believe the literature provided a third space 'out there' to explore what might have felt 'too hot' in the transference, allowing some distance from the intensity and immediacy of these feelings.

Nadia expressed in the interview that she did not feel that they fully explored the meaning of the archetypal figures. This led me to consider how the patient's engagement with the arts can sometimes feel abstract or, as Ogden (2007) suggests, 'unanalytic'. Such material may be overlooked, seen as a distraction rather than integral to the "total transference situation" (Joseph, 1985). As trainee therapists, we may hesitate to allow ourselves to dream, free associate and be in a state of reverie. This led me to consider whether it is an achievement in itself to create a setting in which the material related to the arts can be used in a creative, playful and symbolic way; this would be akin to Ogden's proposition that the therapeutic pair needs to foster an environment where meaning can be 'dreamed into existence'.

Furthermore, I was thinking of our human limitations in the face of the expansive and unchartered territory of the unconscious and that some communications may take a long time

to understand, and we may never understand them in their entirety. Similarly, Ferro (2012) underscores the importance of reverie and 'negative capability' in making sense of raw, meaningful material. Of course, as therapists, we must also contend with our own limitations, including times when we may not attune to or resist our patients' unconscious communications.

Alongside the content of the 'Arts' material, I think it is important to consider its function and use within the therapeutic relationship. Nadia speculated that her patient's references to art served to keep her engaged during periods of separation, while Luke observed that his patient sometimes used film material to seduce, only to later reject and exclude him.

Films in the therapy with Luke's patient seemed to act as dream like material and provided alternative access to the unconscious of the patient as well as transference dynamics. The films referenced by Luke explore power distribution and redistribution, the difference between unwanted and regretted contact, sexuality and gender as well as an in-depth exploration of sexual violence and abuse. All of this seemed to shed light on the patient's inner object relations as well as her experience of the therapy and therapist. This patient could often experience the therapist as an intrusive abuser but also through the therapy became more in touch with her own destructive drives. The films the patient chose to explore in the therapy seem to reflect on power imbalances, coercion, gender dynamics and victim and perpetrator dynamics and identification. The films grapple with nuances related to consent as well as clear cut violations. In *I may destroy you* all the characters struggle to categorise what has happened to them and feel unsure how to feel to begin with.

In this case it seems that film characters are used to express and have access to repressed and less socially acceptable feelings such as murderousness and sexual desire. Additionally, film is used to communicate unconscious transference anxieties which are too disturbing, such as worries about misuse of power and abuse, and sexual transference. In the context of the beginning of psychotherapy, the patient may also be using these films to express the uncertainty related to contact and therapeutic intimacy with the therapist, feeling unsure whether it is wanted or not, consensual or not, and just overall confusion and attempt to make sense of what this contact actually means.

In as much as the use of the arts is significant in the clinical encounter, I think that its absence may also reflect a lack of resonance in the patient which can have clinical implications and is

worth exploring in the therapeutic relationship. For example, Luke observed an absence of music in his patient's life, which he understood to have a symbolic meaning leading him to associate to 'a patch of land that was never there'. Luke understood his patient's rejection of music was to do with an experience of not having had something early in life and a communication of an internal barren landscape. The internal restrictive atmosphere mirrored in the rejection of music began to shift as the therapy progressed, and the patient was able to allow music into the room and in her life, reflecting a growing spontaneity and internal freedom.

Maya's patient used drawing, creating patterns at the start of the therapy. This practice initially seemed to serve to provide comfort and structure. The patient's shift away from drawing coincided with increased readiness to engage more directly in verbal discussion in therapy. Although the drawings had a somewhat obsessional and defensive quality, they nevertheless communicated the patient's state of mind and provided something of a 'transitional space' to navigate the early stages of therapeutic relationship.

The participants seemed to reflect on how the patient's creative expressions, through film, literature and drawings, often conveyed unconscious anxieties and desires that were challenging to address directly. The arts seemed to serve as an 'analytic third' resembling play or drawings in work with children, which had different functions: it is used as a space to explore and hold intense and disturbing feelings and thoughts, to communicate, to exclude, to keep a distance, to reveal and to conceal and to defend against the intensity of the analytic relationship. This indirect communication posed opportunities in therapeutic understanding, as the patient navigated between expressing internal conflicts and protecting vulnerable aspects of themselves by locating them in the arts as "transitional space" (Winnicott, 1951,1971) – there for both parties to have a look at and think about whilst maintaining some distance. This also brings to mind Britton's formulation about 'triangular space' as a requisite for creativity and development. Furthermore, in the therapy the use of film, literature, drawings and music added yet another layer of meaning related to beginning the therapeutic process and transference and countertransference dynamics.

Dreams

The dreams reflected on in these findings suggest that dreams at the beginning of therapy bring into focus the patient's inner world, object relations and anxieties about the therapy. These findings are in line with psychoanalytic literature in particular Perelberg's (2000) paper 'The Oracle in Dreams' and Waddell's work (2002, 2018).

The themes which Nadia reflected on related to her patient's dream seemed to reflect the patient's ambivalence about starting therapy and her fear of unleashing her inner child parts and repressed emotions. The children symbolize these vulnerable aspects, while the parental reassurance of safety could be seen to represent the therapeutic space's potential for security and growth. The blood, however, could indicate anxiety about sexuality and the messiness of entering the adult world (for example signifying a period), a stark reminder of her fear that therapy might lead to uncontrollable revelations. The dream material also offers significant insights into the patients' internal object relations. Nadia's patient's dream might reflect an internal containing object that provides safety and encouragement, which the patient might hope the therapist to be. By contrast, the blood and messiness might represent the patient's uncontained inner self, or a 'leaky' container. The theme of this dream might capture the ambivalence towards these internal objects strikingly present at the beginning of therapy: a desire for safety and reassurance juxtaposed with fear of chaos and mess which cannot be contained.

The theme of the dream which Anna reflected on relates to a desert island. The imagery of Anna's patient's dream of isolation on a desert island suggests a profound sense of disconnection and fear that the internal support she needs is unavailable or destroyed. Her attempts to communicate but being left unheard reflect her struggle to connect with these internal objects and a pervasive fear of abandonment. In the context of beginning intensive therapy, this dream conveys her internal expectation that therapy might leave her just as isolated and unheard.

Both dreams share common themes of fear and anxiety about the therapeutic process, reflecting the adolescents' trepidation about revealing their innermost selves. The first patient's dream reflects her uncertainty about 'letting out' her early vulnerabilities, and the potential messiness of confronting her burgeoning sexuality. In contrast, the second patient's dream emphasises her profound isolation and fear of navigating the dangerous, unconscious territory alone, with no hope of being rescued or understood.

Kohon (2000) defines a psychoanalytic understanding of dreams as “the symbolic dramatic representations of past or present repressed wishes, traumas, and conflicts… and can be considered as more or less successful attempts by the patient to communicate to the analyst a situation of anxiety” (p.76). In addition, Perelberg, building on Freud’s concept of repetition compulsion, writes about the ‘atemporality’ of dreams and that apart from containing connections to the past and present, they also contain a ‘template for the future’ (expectations of object relations). Thus, in her view dreams dreamt during psychoanalytic treatment convey that which the patient wishes to work on and think about “so that these experiences are not repeated, unmodified, into the future” (p.124).

What do these dreams tells us about patterns in dreams at the beginning of intensive psychotherapy? I believe that these dreams highlight these adolescents' initial phantasies and expectations of therapy: fears of making a mess, anxieties about revealing too much, and a deep-seated expectation of abandonment and isolation. Alongside this they express a wish for joint creative work, a wish to let things out and find a safe space in which to work through transference relationships with one’s internal objects. They talk to the internal struggles faced by adolescents in psychoanalytic psychotherapy, illustrating how the therapeutic process can begin to unravel and bring into focus their repressed fears and desires. These early dreams set the stage for further exploration within the therapeutic process, offering a valuable window into the adolescents' inner worlds.

The findings related to the arts and dreams seem to concur with the psychoanalytic understanding that unconscious phantasies and states of mind are expressed not only through the symbolism of dreams but also through the patient’s relationship with particular artistic creations.

Intensive therapy as a space for confronting unexplored and previously unbearable aspects of self and experiences

Despite the challenging nature of beginning intensive psychotherapy with adolescents, participants seemed to agree that their patients made use of the treatment as they gradually settled in. The findings suggest that what adolescent patients needed most was help in grappling with aspects of themselves and their experiences that had could not be confronted before. Intensive therapy provided a vital space for the exploration of these previously unreachable

and unexplored parts of the self, echoing the idea that therapy can "open the possibility of finding new perspectives, new understanding in the presence of someone who could potentially receive and contain the unmanageable." (Reith et al., 2018, p. 105)

Bion's model of container-contained (1962) is relevant here. The therapist, much like a mother in relation to her infant, provides a space to receive the patient's raw, unprocessed feelings and experiences (β-elements). These can then be digested and transformed into something more bearable (α-elements). This process, which Bion linked to the therapist's capacity for reverie, allows the patient to develop their own capacity to think and process experiences that had previously been too overwhelming. This holding function becomes critical in allowing the young person to begin making sense of previously undigested and unbearable aspects of their inner world.

What would otherwise be repressed or acted out can emerge in therapy, often involving intense negative emotions like rejection or hatred. The therapist's role in tolerating and containing these emotions enables the adolescent to begin making meaning of their experiences. For example, Maya's patient initially sought help for depression and self-harm, but as therapy deepened, she could explore previously unbearable aspects, such as her chronic illness. The frequency and intensity of therapy allowed the patient to bring forth repressed aspects and it provided the psychic space necessary for deeper emotional work.

Maya emphasised that 'the intensity made change more possible'. The structure of intensive therapy not only facilitated self-understanding but also fostered emotional growth. As the patient developed new relational capacities, Maya reflected on the importance of having 'space in [her] mind to be disturbed' by the patient: this observation resonates with Bion's concept of containment, where the therapist's mind becomes a space for processing difficult feelings. Maya's comment suggests not only that it was essential to allow herself to be receptive to the patient's disturbance but that this will inevitably mean feeling destabilised and disturbed too.

In all three interviews, participants reported that their patients seemed to have a desire to understand themselves on a deeper level, and for some (such as Luke and Nadia's patients), intensive therapy provided a space to explore their more authentic selves, shedding pseudo-adult identities. This resonates with Waddell's description of adolescence as a "process of becoming", marked by interrogation, self-definition, and mental pain (2002, p. 45). The

findings also contribute to the literature by highlighting the adolescent's wish to let go of these false identities and perhaps explore and find their *true self*, as Winnicott might describe (1960a). Similarly, Nadia's patient, while appearing adult-like, struggled with a deeper sense of self.

Luke's patient experienced a similar struggle with feeling 'stuck' in her internal development. I believe his metaphor of 'raising a thousand kingdoms to make up for that one patch of land that was never there' captured the patient's unconscious experience of searching for a stable sense of an internal home. Both therapists illustrate that for many adolescent patients intensive therapy becomes a space where they can confront not only their external difficulties, but also their internal sense of displacement and confusion.

The findings of the research seem to echo those of the literature review, in that as Meltzer (1973) suggests the adolescent is concerned with '*knowledge and understanding'* and that this involves turning back towards the object in this case the therapist for support with digesting confusion and distress.

Maya's comment about 'allowing something to develop' recalls earlier associations with pregnancy and the parent-infant relationship, where a facilitating environment and containing relationship is essential for growth (Winnicott, 1965). Maya's comment made me think about the state of mind of the therapist who must remain receptive to being disturbed, while also holding onto the potential for developmental progress.

The theme of containing previously undigested experiences runs consistently throughout this section. However, while only one participant explicitly mentioned their own personal analysis, it prompted reflection on the importance of therapists' own experiences of being contained, as this enhances their capacity to help patients traverse difficult emotional terrain.

The research also highlighted the role of intensive therapy in supporting adolescents through the task of separation and individuation and mourning. Many patients used therapy as a place to explore their dependency on the therapist while also resisting the process of growing up. This echoes findings in the literature, where resistance and ambivalence are seen as typical features of adolescent therapy, as adolescents grapple with their conflicting feelings about dependency on another adult (Meltzer, Waddell).

Waddell (2018) notes that adolescents often resort to defences to manage the pains of separation and the feelings of inadequacy that arise. The findings support this, as each participant described the different defences their patients employed. Nadia, for instance, noted her patient's cyclical pattern of progress, where the therapeutic space became a "snug and cozy" cocoon, allowing the patient to retreat from the anxieties of adulthood. Adolescents often experience therapy as both a place of refuge and a potential threat to their autonomy, where the therapist may be perceived as 'colonising' their sense of self.

The capacity to tolerate uncertainty, what Bion (1970) called *negative capability*, emerged as crucial in facilitating the patients' ability to process difficult, previously unthinkable emotions in the therapeutic process. It allows the therapist to suspend judgment, refrain from premature conclusions, and hold space for the patient's disturbing material without retreating into defensive positions. Maya's experience of holding space for her patient's disturbing feelings highlights this aspect of therapy. She described the challenge of having a 'space in [her] mind to be disturbed' by the patient's anxieties, particularly around her chronic illness.

Nadia's account I believe points to the need not only to engage in the domain of negative capability but to also inhabit the negative transference. Initially struggling with the negative transference, Nadia eventually recognised that the patient's anger was a crucial platform for deeper exploration of her grievances. The therapist's willingness to occupy the position of a 'non-understanding object' allowed the patient to confront her feelings of alienation and the complexities of racial difference. This dynamic demonstrates the therapeutic importance of not only holding space for negative emotions but also being open to the unexpected and challenging aspects of the therapeutic process, what Nadia called entering 'new territory'. This speaks to the therapist's role in creating a 'psychoanalytic space' where new emotional territory can be explored, and meaning can emerge from previously unprocessed experiences (Ferro, 2012).

The findings suggest that intensive therapy provides adolescents with a vital space to confront and work through their most difficult and repressed emotions. However, the therapist's capacity to tolerate uncertainty, to hold negative transference, and to remain emotionally available is central to facilitating this process. These elements create a therapeutic environment where adolescents can move from dissociation or unintegration to integration, fostering greater self-understanding and emotional growth.

Across the findings, the following expressions stood out: Luke's quote about his view that his patient 'never thought she really had a place' and his associations to a 'patch of land', Maya's comment about her patient needing a 'space in my mind', Anna's comment about her patient wanting and needing more of the therapy, and Nadia's comment about 'new territory'.

I believe that the underlying communal theme may be around a wish – perhaps unconscious – for a room or space of one's own in the therapy. This would not reflect a physical space but a symbolic container, a space where adolescents' can find a voice of their own, where the therapy may become "a profoundly quiet place as he [the patient] realises that he must find a voice to tell his story. This voice is the sound of his thoughts that he may never have heard before" (Ogden, 1992, p.170).

The accounts of the therapists convey that they have been able to create a 'psychoanalytic space' with their patients, but at the same time the therapists have reflected on the tension and difficulty that holding such a space requires. Both patient and therapist experience a pull towards wanting to get to new territory but at the same time there is a risk for both patient and therapist. As Nadia expressed there was an 'explosiveness' when she and her patient started exploring what had previously been unthinkable and therefore allowing ourselves to be affected and 'disturbed' might also be feared.

Concluding comments and clinical implications

As I reflect on the findings, I am struck by their complexity and multi-layered nature, which resists a linear understanding. Delving into exploring the process of beginning psychotherapy, I noticed a certain fluidity and non-linearity—what might initially seem 'haphazard' is better understood as what Quinodoz (1997) explored in his paper on *Transitions in Psychic Structures In The Light Of Deterministic Chaos Theory* in which he reflects that the underlying structure of the mind, of unconscious phantasy is fluid and non-linear which speaks to our understanding of the mind's inherent complexity (Lush, 2011, 2017). Participants such as Luke spoke about the unsettled nature of the work, while Nadia described its cyclical quality. The theme of 'floods' mirrors this, representing the emotional currents that flow between therapist and patient. In essence, this research points to constant shifts in emotional states, object relations, and unconscious phantasy, echoing the non-linear developmental process itself.

The purpose of this research was to get closer to the stories from the clinic room and to focus on individual experiences and I think it is important to say that the material is very individual and unique to each patient-therapist couple. The material reflects how internal and external worlds intersect to shape the therapeutic process. For instance, in Luke's work with a female patient, the transference was marked by her fearful and suspicious phantasies of him as a potential violator, shaped by the fact that Luke is male, and his patient is female. Similarly, Nadia's work with a patient of a different racial background focused on issues of race and difference, highlighting how external factors such as race influence the unfolding of therapy. These examples illustrate the complexity of the therapist-patient dynamic, where both internal and external factors intertwine and how external factors bring aspects of unconscious life to the fore. As the quote from Ogden in the literature review noted, each patient and therapist couple are created and moulded by each other in "reality as well as in fantasy" (1992, p.198). It seems important to acknowledge the diverse manifestations of beginning psychotherapy specific to the personalities of the two participants and the therapist's ability for containment of these early dynamics.

I think this research provides a perspective on why beginnings of intensive therapy – in these particular cases – tended to be inherently more chaotic and intense than the later stages of the treatment. Wittenberg's (2022) insight that beginnings stir up echoes of previous beginnings feels particularly relevant here. This research suggests that there is a different process taking place at the beginning of intensive psychotherapy, which is specific to that stage of the therapy. For example, at the start of therapy patients seem to use the therapist in an evacuative way, as a "toilet breast" (Meltzer, 1967). However, as the therapy progresses the findings suggest that patients search for a mental space where they could explore and transform the relationships with their internal objects. Intensive therapy provides a space where these internal dynamics can be digested, whether through dreams, the arts, or transference-countertransference dynamics. Bion's (1962) concept of containment becomes crucial in this process.

Trainee therapists, as revealed in the research, expressed how challenging it can be to start an intensive case. They emphasised the importance of supervision as a means of containment. This study highlights the significant learning experience that intensive therapy provides for both the patient and the trainee therapist. In an era where training programs face pressure to

reduce the time spent on intensive therapy and supervision, this research underlines the value of this formative experience.

Moreover, the research points to the importance of frequency in therapy. It is the increased frequency that allows for the expression of negative transference and enables the therapist to become the 'hated' figure, giving patients the opportunity to explore emotions they may not have previously had the space to express. Furthermore, it is the frequency of the sessions, the intensity of the therapy, which create the conditions via the setting in which the infantile transference comes to the fore and can be addressed in the here-and-now of the therapy.

In conclusion, the findings highlight the profound complexity of intensive therapy with patients in the developmental stage of adolescence and young adulthood. The interviews emphasise the unique oscillation between dependency and independence, a psychic balancing act that brings adolescents into contact with their past experiences and early object relations. As described, adolescence is not just a chronological phase but a reworking of the internal psychic landscape, where old identities are shed, and new ones are sought, often accompanied by intense emotional turmoil.

I am left with a question: whether the initial intensity, and the wish for a merged and possessive early object relationship, could also be understood as evidence of an erotic transference? Whilst in the findings the intensity was mainly interpreted as expressing early infantile wishes within the domain of the pre-oedipal and maternal object relationships, this approach may be overlooking the sexual component of the transference that is so central in the treatment of adolescents and young adults (Jackson, 2017).

Strengths and limitations

A key strength of this research lies in its psychoanalytic lens, which offers a deep understanding of unconscious processes and a nuanced analysis of therapeutic dynamics. However, the psychoanalytic focus may also be a limitation, as incorporating perspectives from other theoretical frameworks could have enriched the findings and provided a more diverse outlook. Involving clinicians from varied training backgrounds and different experience levels could have broadened the study's insights, addressing potential blind spots and offering alternative views on both internal and external factors.

The study aimed to capture therapists' experiences with adolescents aged 14–25, recognising that younger adolescents may engage differently in therapy compared to young adults. The sample, however, was skewed towards therapists working with older adolescents and young adults (17–25). This introduces an inbuilt limitation, as the findings are shaped by work with older adolescents and young adults, and do not capture the experiences of therapists working with younger adolescents. This is a significant gap, as younger adolescents may engage with therapy in notably different ways. Recent research by Steponaityte and O'Keeffe (2024) at the Brent Centre highlights important age-related differences in engagement with open-ended psychoanalytic psychotherapy. Their findings suggest that younger adolescents may benefit more from time-limited interventions, and that engagement is also shaped by contextual factors such as school commitments, the involvement of parents, and broader systemic pressures. They also note differences in dropout rates according to ethnicity and socioeconomic background, underlining the importance of attending to these contextual variables when thinking about therapeutic fit and accessibility. These findings highlight the complexity and nuance of adolescent engagement in psychoanalytic psychotherapy and point to the need for a more differentiated understanding of which kinds of therapeutic approaches work best for different subgroups within this broad developmental phase and about the developmental and environmental conditions under which such work might be possible—or when it may not be indicated.

Additionally, the study only included therapists working with female patients, limiting gender diversity. Exploring gender dynamics, particularly how they shape early therapeutic interactions, could deepen understanding. For example, the case of the male-female therapeutic couple, raised questions about whether the male may have been perceived as more 'unsafe'—which deserves further exploration.

Although it was beyond the study's scope to include direct adolescent perspectives, this could be seen as a limitation. The choice to focus on trainee therapists was intended to emphasise understanding of unconscious processes. Methodologically, the small, idiographic nature of the study means the findings are specific to the participants and not generalizable, aiming to provide meaningful descriptions rather than broad conclusions.

Relying solely on therapist interviews may introduce retrospective bias. Incorporating other data, such as session notes, could offer a more dynamic view of the therapeutic process. Despite

these limitations, the study contributes significantly to the field by addressing a gap in the literature on intensive psychotherapy with adolescents and young adults, highlighting the complexity and richness of the early stages of therapy. This research also adds to the literature of therapist's experiences of intensive therapy with young adults. Moreover, the study highlights the value of intensive psychotherapy for adolescents and young adults and the varied ways in which they use this therapeutic resource.

Future research

This study points to several areas in need of further exploration. There is a scarcity of recent qualitative and quantitative studies evaluating intensive psychotherapy with adolescents and young adults, particularly concerning the contexts in which this approach is most beneficial. Expanding the evidence base for intensive psychotherapy is crucial, especially in light of the shift toward short-term, less intensive treatments. Without stronger evidence, the availability of intensive therapy within the NHS may be at risk.

Further research on the initial stages of therapy with this age group could guide therapists in adapting their approaches to address adolescents' unique challenges and ambivalence. This could help create a therapeutic space that balances adolescents' desire for autonomy with their need for support.

Reflections

I was drawn to explore the early stages of intensive psychoanalytic therapy partly because I was beginning work with adolescents when I chose my research topic. My own experiences starting psychoanalytic training added a personal curiosity about these beginnings.

During the writing and transcribing process, I grappled with a sense of intrusiveness, feeling like a third party intruding into the sacred therapist-patient relationship, especially given the profound nature of analytic work. This feeling was heightened when considering adolescents, who are often portrayed as fiercely protective of their privacy. I began to wonder if my sense of intrusion reflected a parental transference, mirroring a parent's perceived intrusion into an adolescent's world. I also considered whether I identified with what one participant described as being an 'interested fly on the wall documentarian'.

I reminded myself that my motivation stemmed from a deep appreciation for intensive psychotherapy and a desire to advocate for its value, particularly for adolescents. While often seen as focused on socialising or acting out, adolescents are deeply engaged with their inner worlds, wrestling with identity and individuation. This journey of self-discovery is lifelong but particularly intense during adolescence, manifesting through introversion, extroversion, or sometimes, refusal to engage in thought.

Reflecting on my title 'finding a room of one's own' I thought of the importance for an adolescent to have his/her own room, with four walls and a door which they can close when they want some privacy and separateness. A room represents more than just a physical space: it symbolises a boundary where they can be alone, without an adult's intrusion. At times, adolescents may engage with the therapist from behind the symbolic closed door, choosing when to speak and when and whether to allow the therapist in. This need for distance can be understood as part of their developmental process rather than an attempt to exclude the therapist, resist thinking, or deny their feelings. It signifies the adolescent's assertion of boundaries and autonomy, marking the space where they can explore their emerging identity in private (in the presence of another). For therapists, respecting this need for separateness feels crucial – being comfortable with not fully understanding, with remaining outside the room without an anxious impulse to intervene, allowing the adolescent to gradually emerge as and when they feel ready to.

An interesting reflection came from Luke, who challenged the implied linearity in my title, "beginning and settling in." While I didn't change the title, his observation and Nadia's comments about the cyclical nature of therapy significantly shaped my findings. This insight aligns with psychoanalytic ideas about the tension between progressive and regressive forces. Adolescence, in particular, intensifies these fluctuations, but as Waddell (2002) reminds us, development is a lifelong process. Nadia's view that her therapy "never left the beginning" questions whether a true distinction exists between "beginning" and "settling in". This made me reconsider how my framing of the research may have shaped the findings, possibly limiting other potential insights by emphasising the separation of these two stages.

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Appendices

The Tavistock and Portman NHS
NHS Foundation Trust

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

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

Iva Ajder
By Email

27 February 2023

Dear Iva,

Re: Trust Research Ethics Application

Title: 'Finding a room of one's own': exploring adolescents' experiences of beginning and settling into intensive psychoanalytic psychotherapy through their therapists' perspectives and accounts'

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

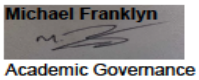
Please be advised that any changes to the project design including changes to methodology/data collection etc, must be referred to TREC as failure to do so, may result in a report of academic and/or research misconduct.

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

I am copying this communication to your supervisor.

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

Yours sincerely,



Academic Governance and Quality Officer
T: 020 938 2699
E: academicquality@tavi-port.nhs.uk

cc. Course Lead, Supervisor, Research Lead

Appendix 2: Information Sheet

The Tavistock and Portman NHS
NHS Foundation Trust

'Finding a room of one's own': exploring therapists' understanding of adolescents' experiences of beginning and settling into intensive psychoanalytic psychotherapy

You have been given this information sheet to invite you to take part in a research project. This information sheet describes the study and explains what will be involved if you decide to take part.

What is the purpose of this study?
As part of this study I want to explore how trainee child and adolescent psychotherapists understand their adolescent patients' experiences of beginning and settling into intensive psychoanalytic psychotherapy.

Who is conducting the study?
My name is Iva Ajder. I'm a researcher working for the Adolescent and Young Adult Service and Fostering, Adoption and Kinship Care Team. I am training to be a Child and Adolescent Psychotherapist at The Tavistock and Portman NHS Foundation Trust. This project is being sponsored and supported by The Tavistock and Portman NHS Foundation Trust and has been through all relevant ethics approval (TREC). This course is overseen and certified by The University of Essex.

What's involved?
Explanation: purpose of and background to research

This small scale explorative qualitative research project aims to explore child and adolescent psychotherapy trainees' understanding of their adolescent patients' experiences of beginning and settling into intensive psychotherapy. My aim is to bring into sharp focus the trainee therapists' stories of what happens in the consulting room with adolescents in the hope that it can expand our thinking about the nuances and complexities of this phase of psychoanalytic work with adolescents.

What will participating in this project involve?
The project is an inquiry into trainee child and adolescents' understanding of their adolescent patients' experiences of beginning and settling into intensive psychotherapy. For this you will be invited to take part in an individual interview. This will mainly be for you to talk freely about the topic with some prompts from myself. During the discussion I would be interested to hear about your experience of working with adolescents and young adults in intensive psychotherapy.

All interviews will last between 60 and 90 minutes and will be audio recorded. These interviews will be conducted face to face, however, it is possible that due to COVID-19 they will take place via video link such as Zoom. If it is possible to complete the interview face to face it will take place at your usual place of work to try and suit everyone involved. No extension to your usual working hours will be necessary.

Do I have to take part?

No, it is completely your choice whether or not you take part in the study, there is no expectation or obligation to participate nor consequence for choosing not to do so. If you agree to take part, you can withdraw at any time without giving a reason, up to three weeks after participation in the interview. If you decide to withdraw all data collected from and about you will be destroyed immediately.

Criteria to take part in the study:

- Currently working for one of the services as a child and adolescent psychotherapy trainee
- At least three months of intensive work with an adolescent aged between 14-25
- The work can be ongoing or completed

What will happen to any information I give?

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 5 years after the study has finished. The interview will occur securely and confidentially using end-to-end encryption on Zoom. The interview will be audio recorded and this file will be kept on a password encrypted laptop. The audio recording will be destroyed once it has been 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.

Quotes from the transcript will be used in the write up of the project but these will be de-identified. However, please note, it is possible that other colleagues who know you well may recognise you in some of the quotes used, although every effort will be made to prevent this. Any extracts from what you have said that are quoted in the research report will be entirely anonymous.

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. Other data from the study will be retained, in a secure location, for 5 years.

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/
https://www.ghc.nhs.uk/privacy-notice/

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, Sonia Perez sperez@tavi-port.nhs.uk

There will be limitations to the confidentiality of information provided if it is deemed yourself or someone else is at risk.

What will happen to the results of the project?
The results of this study will be used in my Research Dissertation Project and Doctorate qualification. It may also be used in future academic presentations and publications. I would be happy to send you a summary of the results if you wish. Please contact me to request this if it of interest to you.

What are the possible benefits of taking part?
There will be no direct benefits for you. However, it is hoped that the interview will provide a space for you to consider and reflect upon your experience in a way that may be helpful for future work.

Are there any risks?
No, there are no direct risks. However, I am aware that emotionally challenging discussions may arise from the interview. If needed details of a confidential service you can access will be provided.

Contact details
I am the main contact for the study. If you have any questions about the project or would like to discuss this further please don't hesitate to contact me. My contact details are:

Iva Ajder
Email: iajder@tavi-port.nhs.uk
Telephone: 07840086500
Address: Tavistock and Portman, 120 Belsize Lane, NW3 5BA

Alternatively, any concerns or further questions can be directed to my supervisor:
Dr Margaret Lush
Email: mlush@tavi-port.nhs.uk

If you have any concerns about the conduct of this research, the researcher or any other aspect of this research project please contact Helen Shaw, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk).

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

Appendix 3:

Consent Form

Project title: 'Finding a room of one's own': exploring therapists' understanding of adolescents' experiences of beginning and settling into intensive psychoanalytic psychotherapy

Name of researcher: Iva Ajder

- I_____voluntarily agree to participate in this research project. ☐
- I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
- I understand that my participation in this study is voluntary, that there is no obligation to participate and that I am free to withdraw at any time without giving a reason, up to three weeks after participation in the interview. ☐
- I understand that the interview will be digitally recorded and transcribed as described in the participant information sheet. ☐
- I understand that the information I provide will be kept confidential, unless I or someone else is deemed to be at risk. I understand that as the sample size for this study is small, whilst every effort will be made to anonymise the interview, it is possible that I might recognise myself in the final piece of work. ☐
- I understand that direct quotes from the audio recording may be used in this research study but will be made anonymous to the reader and held securely by the researcher. ☐
- I understand that it is my responsibility to anonymise any examples referring to cases I chose to discuss during the interview. ☐
- I understand that the results of this research will be published in the form of a Tavistock& Portman and University of Essex Doctoral research thesis and that they may also be used in future academic presentations and publications. ☐

Contact details:

Researcher: Iva Ajder Email: IAjder@tavi-port.nhs.uk

Supervisor : Dr Margaret Lush Email: mlush@tavi-port.nhs.uk

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 study has been formally approved by Tavistock Research and Ethics Committee.

Appendix 4:

The Tavistock and Portman
NHS Foundation Trust

Post-Interview Information and Debrief Letter

Project Title: 'Finding a room of one's own': exploring therapists' understanding of adolescents' experiences of beginning and settling into intensive psychoanalytic psychotherapy

Name of Researcher: Iva Ajder

Thank you very much for taking part in my study.

I hope that through your invaluable contribution, this study will help to enhance our understanding of trainee child psychotherapists' perspectives on their adolescent patients' experiences of beginning and settling into intensive psychotherapy. Additionally, I hope your insights may be helpful to future trainees and clinicians in thinking about how they approach intensive psychotherapy with adolescents.

If you have experienced emotional distress you can speak to your GP or if would like to speak to an external agency, you can contact the following:

Mind
By telephone: 020 8215 2243
By email: supporterrelations@mind.org.uk
By post: 15-19 Broadway, Stratford, London E15 4BQ

Unforeseen questions or concerns may arise for you now your part in the study has ended. If you have any questions or would like further information please do not hesitate to contact me.
Email: iajder@tavi-port.nhs.uk
Phone: 07840086500

If you have any concerns about my conduct over the course of this interview or any other aspect of this research study, you can discuss this with me (iajder@tavi-port.nhs.uk), my supervisor Dr Margaret Lush (mlush@tavi-port.nhs.uk) or Helen Shaw, Head of Academic Governance and Quality Assurance, Tavistock and Portman NHS Foundation Trust (academic-quality@tavi-port.nhs.uk).

Thank you again,

Iva Ajder
Child and Adolescent Psychotherapist in Doctoral Training