

**How do child and adolescent psychoanalytic psychotherapists
understand treatment review meetings?**

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Abstract

Objective

Treatment review meetings are a routine part of clinical practice in NHS Child and Adolescent Mental Health Services (CAMHS), yet they remain largely unexamined within psychoanalytic literature. This study explores how child and adolescent psychoanalytic psychotherapists understand and experience reviews. It aims to illuminate the emotional, relational and institutional meanings of these meetings, considering how psychoanalytic thinking can contribute to understanding their complex dynamics.

Methods

A qualitative design was adopted, grounded in Braun and Clarke's Reflexive Thematic Analysis (RTA). Six ACP-registered child and adolescent psychotherapists, all practising within NHS CAMHS, participated in semi-structured interviews. The interviews invited participants to reflect on their experiences, feelings and theoretical understandings of treatment reviews. Data were analysed inductively and interpretively, with particular attention to transference-countertransference dynamics and the researcher's reflexive position as a trainee psychotherapist.

Results

Four overarching themes were identified: (1) Tensions inherent in 'Bringing things together' (2) Reviews as a site of ambivalence (3) Feelings of exclusion and intrusion about (4) 'Being aware of what parents can tolerate'. The findings reveal that reviews evoke deep

anxieties about judgment, responsibility and therapeutic progress, yet also offer opportunities for linking and containment when handled reflectively.

Conclusions

Treatment review meetings, though often perceived as administrative necessities, can be understood psychoanalytically as spaces where clinical, parental and institutional states of mind intersect. Recognising their emotional significance allows psychotherapists to use these meetings more creatively, fostering shared thinking and collaboration across the therapeutic system. The study highlights the value of psychoanalytic reflection within NHS settings and calls for greater attention to such dynamics in clinical training and research.

1. Introduction

Treatment review meetings are an established feature of clinical work in NHS Child and Adolescent Mental Health Services (CAMHS), yet they have received little psychoanalytic attention. These meetings – where the child’s therapist, parent worker and parents come together to discuss the child’s treatment – occupy a complex space between therapy, assessment and accountability. They are encounters where multiple perspectives, emotions and unconscious processes converge, often revealing powerful tensions. Despite their ubiquity, psychoanalytic literature has tended to treat reviews as peripheral, focusing instead on the consulting room encounter. The present study aims to address this gap by exploring how child and adolescent psychoanalytic psychotherapists understand and experience treatment review meetings in their everyday CAMHS practice.

The study is located within a psychoanalytic epistemology and that draws upon concepts such as transference, counter-transference, projective identification, as well as ideas about the super-ego and the parental couple, to examine what is evoked for therapists in the review setting. Using Reflexive Thematic Analysis (Braun & Clarke, 2006, 2022), the research treats therapists’ reflections as co-constructed narratives that illuminate both individual and institutional processes.

Through semi-structured interviews with six ACP-registered psychotherapists, the study investigates how treatment review meetings are thought about, managed and felt. The findings show that reviews, though often seen as routine, are charged with powerful unconscious feelings, as well as ambivalence; they can foster understanding and collaboration, yet also evoke guilt, envy and rivalry. By applying psychoanalytic ideas to this

neglected institutional encounter, this study seeks to deepen an understanding of the emotional realities shaping clinicians' work in CAMHS and to reframe reviews as potential spaces for containment, thinking and shared meaning.

2. Literature review

2.1 Introduction

By identifying and critically assessing available literature relating to treatment review meetings, this literature review will situate the present study within the context of child and adolescent psychoanalytic psychotherapy treatment review meetings with parents as commonly practised within NHS CAMHS teams. Initial searches confirmed that review meetings have not been as widely studied as other aspects of psychoanalytic psychotherapy with children and adolescents. This literature review is split into three sections:

1. A comprehensive search of the literature relating to psychotherapists' understanding of treatment review meetings
2. A narrative review of the literature on treatment review meetings, locating them historically and examining their place in the current practice of child and adolescent psychoanalytic psychotherapy
3. A narrative review of psychoanalytic concepts as they apply to treatment review meetings

2.2 Aims of the review

This literature review aims to define and explore the concepts and ideas relating to psychotherapists' understanding of treatment review meetings through a critical appraisal of relevant literature and research, as well as opening up further fields of enquiry as indicated by the literature.

2.3 Objectives

The two objectives of this literature review are:

1. To identify, define and critically evaluate the key concepts and ideas as found in relevant research and articles pertaining to psychotherapists' understanding of treatment review meetings
2. To consider the role of psychoanalytic concepts as they relate to psychoanalytic psychotherapy treatment reviews

2.4 Comprehensive literature search strategy

A comprehensive database search for relevant literature was conducted using key terms to elicit literature on psychotherapists' understanding of treatment review meetings. These were applied using Boolean operators. The literature search was conducted on EBSCO to access databases of APA PsycInfo – for psychological and psychoanalytic studies – and PEP Archive – the largest digital collection of psychoanalytic sources. Peer-reviewed and Academic Journals were included as additional criteria. The search terms and the number of articles returned by each search are as follows:

Search No.	Search terms	Results
S1	review OR assess OR measure OR evaluat* OR feedback	2,168,760
S2	treatment AND psychoanal* AND psychotherap*	44,369
S3	child* AND (adolescen* OR teen*)	488,031
S4	parent OR parents	340,906
S5	NHS AND (CAMHS OR 'child and adolescent mental health')	9,077
S6	parent work* AND child psychotherap*	206
S9	S1 AND S2 AND S3 AND S4 AND S5 AND S6	29

Table 1: Results of comprehensive literature search

The final number of papers and studies produced by the search was low, with no results directly addressing child and adolescent psychotherapists' understanding of treatment review meetings. The titles and abstracts of all studies were read, after which 18 papers remained. These were then read in their entirety (see Appendix 1 for PRISMA 2020 flow diagram).

Of the remaining studies, those that approached treatment reviews did so as part of case studies or within on-going parent work in child psychotherapy, or more general 'parent involvement', or in measures to assess the efficacy of psychotherapy. Additional literature was therefore included via snowballing and Google Scholar, although these studies, articles and contributions also referred minimally to treatment reviews.

Given the dearth of studies focused on treatment reviews, it was not possible to identify core themes on the subject from the literature review. In response to this, I turned to the reflective thematic analysis method, which will be used to analyse the data later in this study. According to this approach, Braun and Clarke (2006) suggest:

There are different positions regarding when you should engage with the literature relevant to your analysis – with some arguing that early reading can narrow your analytic field of vision, leading you to focus on some aspects of the data at the expense of other potentially crucial aspects (Braun & Clarke, 2006, p. 86)

Braun and Clarke (2006) distinguish between an inductive and a theoretical approach to the literature review. In light of the initial results of the literature search, the inductive approach was preferred, which is “enhanced by not engaging with the literature in the early stages of analysis” (Braun & Clarke, 2006, p. 86). This approach allowed for themes to be identified from the comprehensive literature search results, plus additional snowballing, that could be organised based on themes emerging from an initial analysis of the interview data. This approach also resonates with the remarks of du Plock (2014), who, in considering the reflexive function of literature reviews, says:

[I]t is important to approach the creation of the literature review with the understanding that its function is not only to show the reader that you have explored relevant existing publications; it is also, and more fundamentally, the process by which the researcher identifies their specific research focus (du Plock, 2014, p. 67)

To this end, concepts and findings from the comprehensive literature search were incorporated into a wider narrative review of the literature and approached according to my research focus and initial data analysis.

By “weaving together a common line of argument” (Booth, Sutton, Clowes & Martyn-St James, 2022, p. 202) from different studies and sources, a narrative review can shed light on complex issues, advance theoretical models, and contribute towards ‘best practice’ (Booth et al., 2022). However, a potential weakness of narrative reviews is that they do not consider the

full range of data, which could lead to bias or omission of research which does not fit with the researcher's viewpoint (Aveyard, 2007; Jahan, Naveed & Zeshan, 2016). In their discussion of the 'establishing the gap' model – which aims for a more complete survey of the literature – versus the 'making an argument' model, Braun and Clarke (2022) argue that:

We think it's useful to get beyond the filling the gap idea, and conceptualise our qualitative analyses as contributing something to a rich tapestry of understanding that we and others are collectively working on, in different places, spaces and times. Within the making an argument approach, you're aiming to set the scene and provide a theoretically-informed and located rationale *for your research* (Braun & Clarke, 2022, p. 120)

My training as a child and adolescent psychotherapist allowed me to organise the literature search data based on my understanding of psychoanalytic theory and practice, and my position within a CAMHS service, which reflected my specific understanding of treatment reviews. A comprehensive literature search, using inclusion and exclusion criteria, can provide a counterpoint to this, while also offering a basis for a later widening of the lens through a narrative approach (Ferrari, 2015). Such a 'narrative synthesis', as proposed by Booth and colleagues (Booth et al., 2022) and adopted below, thereby helps to limit the scope of the field and aims to "give the reader a contextualised understanding of what is currently understood, that situates what you've done, and convinces them that it is interesting and important" (Braun & Clarke, 2022).

2.5 Narrative synthesis literature review

2.5.1 The value of treatment reviews

Involving parents in the psychotherapy of their child is an important aspect of the treatment, particularly as practised within the NHS. This is reflected in the NICE guidelines for depression, which state that: “Concurrent work with parents is a key aspect of the CAPT [child and adolescent psychotherapy] approach” (National Institute for Health and Care Excellence [NICE], 2019). Under the sub-heading “Care of all children and young people with depression - Good information, informed consent and support”, it continues:

Healthcare professionals should make all efforts necessary to engage the child or young person and their parents or carers in treatment decisions, taking full account of patient and parental/carer expectations, so that the patient and their parents or carers can give meaningful and properly informed consent before treatment is initiated (NICE, 2019)

Similarly, the Association of Child Psychotherapists (ACP) includes work with parents as a core feature of the training and work of child and adolescent psychotherapists:

Child and Adolescent Psychotherapists may see children and young people individually or with other family members and can support these relationships as well as those with carers and professionals. Concurrent work with the parents or carers of children in therapy is an important part of the child psychotherapy approach (Association of Child Psychotherapists [ACP], n.d.)

These guidelines reflect the literature that:

[O]penness and building a sense of trust and shared goals are essential elements in building a strong therapeutic alliance that is an important predictor of treatment outcomes (Coyne, McNamara, Healy, Gower, Sarkar and McNicholas, 2015, p. 567)

Although sparse, the literature that mentions treatment reviews emphasises the ways in which these can support the child's treatment. These include: reset and reaffirm commitment to the therapy (Cregeen, Hughes, Midgley, Rhode & Rustin, 2017); ensure an alliance with parents (Gourbin Riley & Avdi, 2024); provide the therapist with valuable information about the patient's development and external world, and bring together different perspectives about the child (Rustin, 1999); support parenting capacities (Rustin, 1999); review treatment progress and goals (Gourbin Riley & Avdi, 2024; Cregeen et al, 2017). Treatment reviews also serve the child's therapy by enabling a separate space for parents' questions and concerns about the treatment (Klauber, 1991), while also supporting parents' concurrent sessions with a parent worker (Horne, 2000) and giving the child the experience of important figures coming together support their therapy (Crockatt, 2009). Parents' involvement in the therapy process is positively associated with improvements in their child's emotional and behavioural functioning (Nuñez, Fernández, Alamo, Midgley, Capella & Krause, 2022), while the quality of the relationship between the parent and child's therapist has been shown to be a better indicator of the treatment coming to a 'mature' termination than that between the child and the therapist (Kazdin, 1996).

2.5.2 Treatment reviews: outside of the analytic scope

The literature on treatment reviews suggests that reviews are outside of the scope of psychoanalytic interpretations and separate from the treatment 'proper'. Awareness of this

appears early in the history of child psychoanalysis, where Melanie Klein devotes several pages in “The Psycho-Analysis of Children” (1932) to managing this “one problem” (Klein, 1932, p. 75) (for more on Klein’s relationships with parents, see Sherwin-White [2017]):

It [the problem] is not, strictly speaking, of a technical nature but it is of importance in the work of the child analyst. I refer to the analyst’s dealings with the parents of his patients. In order for him to be able to do his work there must be a certain relation of confidence between himself and the child’s parents. The child is dependent on them and so they are included in the field of the analysis; yet it is not they who are being analysed and they can therefore only be influenced by ordinary psychological means (Klein, 1932, p. 75)

This approach is echoed in the psychoanalytic literature, with Donald Winnicott (1942), in reference to consultations with parents, advising that psychoanalysis ought to be “kept completely out of the picture” (Winnicott, 1942, p.76).

Reflecting on this ‘one problem’, Whitefield and Midgley (2015) state that: “[i]n the early history of child psychoanalysis, working with parents was initially viewed with some caution” (Whitefield & Midgley, 2015, p. 273). Nonetheless, contemporary accounts of engagement with parents echo Klein’s ‘ordinary psychological means’ approach towards working with parents. Rustin (1999) comments that treatment reviews can “be used to support the more adult aspect of the parents’ personalities” (Rustin, 1999, p. 211), thereby allowing them to think about their child’s needs rather than falling prey to unconscious repetitions. More recently, in their literature review of parent work in general, Gourbin Riley and Avdi (2024) emphasise the ‘straight bat’ approach for review meetings:

Nowadays, ad-hoc and regular meetings with parents, often called ‘reviews’, are considered fairly routine [...]. The overall aim of these meetings is to ensure a basic alliance with parents to gain their support and sustain the child’s therapy. The patient is clearly and solely the child, and the therapist’s work is directed to their inner world. Review meetings with parents are an opportunity for the therapist to gather information about and around the child and for both parties to discuss the treatment progress (Gourbin Riley & Avdi, 2024, p. 374)

In her paper “Fostering parental growth and enhancing the therapeutic alliance”, Deborah Marks (2020) argues for the centrality of a therapeutic alliance with parents in work with children and adolescents. She also includes observations about reviews that sound a note of caution when contrasted with the definition of writers such as Gourbin Riley and Avdi (2024). Marks warns against review meetings becoming “perfunctory encounters” that focus on gathering information, which can make the child’s treatment seem “remote and hard to engage with” (Marks, 2020, p. 21). This comes at a cost of recognising, as Marks (2020) suggests, that:

Parents whose children are referred to therapy may have a deep sense of humiliation, guilt, anger, distress, isolation, confusion and despair. They will have often had a series of tick-box style contacts with a range of professionals, which will have usually failed to be meaningful and ultimately have eroded their hope. By the time they engage with the child psychotherapist, a defensive stance, placing the child at the centre of the problem, may have become entrenched (Marks, 2020, p. 22)

This idea is shared by Rustin (1999), who emphasises the relational aspect of encounters between parents and their child’s therapist:

The idea of parents choosing from a menu of what is available places the whole interchange at a consumerist and narrowly cognitive level and leaves to one side the meaning of the relationship that is being established as soon as a conversation about family difficulties is started (Rustin 1999, p. 214)

According to this concept, an approach that denies the therapist as a ‘feeling person’ is rejected, which can appear to the patient as “falseness or imperviousness” (Brenman Pick, 1985, p. 29) as opposed to a “genuine co-Participant in an ongoing process” (Anastasopoulos & Tsiantis, 1996, p. 5).

2.5.3 The value of psychoanalysis in understanding treatment reviews

The literature on reviews and consultations between the parent and therapist, while recognising that the treatment review is not a purely analytic or a therapeutic encounter, points to the unconscious process at play – both from the parents’, but also from the therapist’s side. The literature suggests that accounting for parents’ states of mind is of value for reviews:

The concept of anxiety is what seems to be missing from much of the parenting discourse, and to be one without which the experience of parents cannot be properly described. Whether we are thinking of the parents of a distressed or ill baby, a defiant toddler, a bullied school-child, a depressed or acting-out or anorexic adolescent, what all are struggling with is their worry, panic or despair (Rustin, 1999, p. 209)

Literature on parents’ anxieties in relation to their child’s treatment is broad and long-standing, with Klein (1932) commenting that: “The relationship of the parents to their child’s

analyst entails difficulties of a peculiar kind, since it touches closely upon their own complexes” (Klein, 1932, p. 75). These can encompass parents’ worries, panic and despair (Rustin 1999) as they approach review meetings; guilt, shame and jealousy between the parent/s and therapist (Klein, 1932); rivalry (Dowling, 2019); parents’ “sense of failure and incompetence, and their dread of being despised and humiliated by those felt to be more successful at being a grown-up. [...] Linked to this is unconscious envy, with its corrosive impact on relationships which stir up a sense of need” (Rustin, 1999, p. 216); as well as states of mind that are based on projective identification (Meltzer, 1967). Clinicians and writers agree that reviews are not the site upon which to address such ‘complexes’, which can become a “disturbing element” in the child’s analysis (Klein, 1932, p. 76).

The following psychoanalytic theorists provide valuable thinking about the parent’s state of mind when their child is undertaking psychotherapy. Winnicott argues that:

Parents who come to consultation are feeling guilty about their child's symptom or illness, and *the way in which the doctor behaves will determine* [my italics] whether they will calmly return to taking responsibility which they can well take, or anxiously hand over responsibility to the doctor or clinic (Winnicott, 1942, p. 71)

Furthermore, Rustin argues for an understanding of ‘partnership’ that includes the unconscious, as well as acknowledging the patient’s (or family’s) dependence on the clinician for help: “The ‘partnership’ discourse is related to the issue of rights, and the right of patients to be fully informed and to be given choices is sometimes interpreted in such a way as to reduce their right to be understood, looked after and given what is appropriate from the point of view of professional expertise” (Rustin, 1999, p. 214). More recently, Slade suggests that it is important to create:

...an environment in which the parent can begin to hold the child in mind [which] depends upon our capacity to first – and perhaps for a very long time – hold the parent in mind (2008, p. 222)

In this context, Sutton and Hughes (2005) suggest that, as part of their concept of ‘psychotherapy of parenthood’, transference interpretations can be a welcome component of work with some parents in treatment reviews to re-establish the working alliance.

2.5.4 The impact of treatment reviews on the therapist

How psychotherapists understand or anticipate parents’ primitive and persecutory feelings not only has significance for the review meeting, but also for appreciating the impact of these on the therapist’s conscious and unconscious state of mind. One aspect of this, as Sutton and Hughes (2005) have suggested, is the parents’ possible transference to their child’s therapist. Clinicians may be aware of, for example, the shame, feelings of failure and fear of authority that many parents can experience – particularly in relation to reviews – but may not consciously expect this to be defended against through “aggression and hostility towards the professionals who are viewed as blaming or authoritarian” (Sutton & Hughes, 2005, p. 172).

Jaqueline Godfrind, in “The influence of the presence of parents on the countertransference of the child psychotherapist” (Godfrind, 1996), examines the complex ways in which the parental presence clouds and weighs upon the therapist’s countertransference:

[...] the parental presence introduces parameters liable to disrupt the therapist’s functioning on the one hand through intrusions at the level of *the setting*, and on the

other hand at the level *of the fantasy interactions*, both conscious and especially unconscious, that are at play between parents and therapist (Godfrind, 1996, p. 99)

The parental presence and state of mind can destabilise both the patient and the therapist by their influence on the stability and permanence of the setting. This can lead to feelings of rage and bitterness (Godfrind, 1996), or helplessness and frustration (Anagnostaki, Zaharia & Matsouka, 2017), in the therapist towards the parents, which can lead to grievances, rivalry and rescue fantasies (Goodman, 2017) being elaborated in fantasy, which may then influence the work with the child. The encounter with the patient's parents destabilises the therapist in a further way:

The function of the child therapist is a very complex one. Its exercise puts one in a conflictive fantasy position between identifications with the role of parent and of child. On the one hand, the understanding of the child means immersion in an infantile world, which obviously takes the therapist back to her own childhood; whereas, on the other hand, the role of therapist is, whether one wishes it or not, an adult, parental role which is constantly revived by the child's projections (Godfrind, 1996, pp. 106-7)

2.5.5 Conclusion

The, albeit limited, literature as it pertains to this study indicates that treatment review meetings are a site of profound and often unconscious, persecutory anxieties. Child and adolescent psychotherapists are trained to recognise and work with these, as well as acknowledge the impact of these on their own unconscious. However, ambivalence surrounds the role of the unconscious in reviews. Although the reviews fall outside of the usual

therapeutic and clinical practice of therapists, these unconscious anxieties remain. In the following section, I will explore psychoanalytic concepts as they relate to the unconscious forces at play in review meetings.

2.6 Narrative literature review

2.6.1 The role of transference, counter-transference and projective identification in reviews

The unconscious processes of transference, counter-transference and projective identification underpin a psychoanalytic approach to working with children and young people. These psychoanalytic ideas also enable psychotherapists to be attuned to unconscious processes and states of mind of parents, particularly the persecutory anxieties provoked by treatment reviews (Halton, 1994). However, to do so requires a particular understanding of how these concepts pertain to treatment reviews – an area of work that is:

[...] often fraught with transference and countertransference issues, all played out within the framework of a relatively amorphous and poorly defined treatment situation (Slade, 2008, p. 209)

Freud (1905) first identified transference in his work with ‘Dora’ – his 18-year old patient, who was exploited by the adults in her life, including her father, and sexually assaulted at 13 by Herr K, a family friend, as part of an “interfamilial soap opera” (Mahony, 1996, p. 9) – describing it as:

[N]ew editions or facsimiles of the impulses and phantasies which are aroused and made conscious during the progress of the analysis; but they have this peculiarity,

which is characteristic for their species, that they replace some earlier person by the person of the physician (Freud, 1905, p. 116)

The concept of transference was developed significantly through psychoanalytic work with children, particularly with the ideas of Melanie Klein, who saw transference not as limited to repressed impulses and trauma, but as “total situations, transferred from the past into the present, as well as emotion defences and object relations” (Klein, 1952, p. 55).

Betty Joseph (1985) built upon Klein’s idea of the ‘total situation’ to encompass early relationships, internal figures, fantasies, impulses, etc., while allowing for “constant movement and change” (Joseph, 1985, p. 453), i.e. transference is present in all of the patient’s material and from the moment the patient enters the therapeutic situation (Moustaki, 1981). Engaging with parents’ transference onto their child’s therapist is complex for the child psychotherapist, where ‘minimal contact’ between parent and therapist – which aims at “preserving the purity of the transference, and keeping the therapy and the child’s wider environment separate” (Horne, p. 53, 2000) – ensures that the reality of the therapist remains hidden from the parents, meaning that the brief moment of contact afforded by the review meeting may become a site of concentrated transference feelings.

Like transference, counter-transference was initially viewed as a hindrance to psychoanalytic treatment, something that had to be recognised and “overcome” through self-analysis (Freud, 1910, p. 145), which would allow the therapist to distinguish between their unconscious processes and those of the patient. The transmission of feelings and phantasy through the transference, and their reception through the therapist’s counter-transference, is enabled through the process of projective identification, whereby that which is felt to be unbearable is projected. This has a “powerful effect on the recipient” (Joseph, 1987, p. 169)

and frequently leads to them “acting out the countertransference deriving from the projected feelings” (Halton, 1994, p. 16).

Counter-transference feelings play a crucial role in making sense of the transference feelings (Joseph, 1985). Contemporary views on counter-transference “have embraced the realisation that the analyst’s identity includes a feeling person” (Hinshelwood, 1999, p. 814). Paula Heimann (1950) stresses the inter-relational aspect of psychotherapy and distinguishes between the therapist’s emotional response as specific to the patient and as separate to the patient’s projections (Bott Spillius, Milton, Garvey, Couve & Steiner, 2011). Brenman Pick (1985) further explores the difference between the counter-transference as product of the patient’s transference (and so a tool for psychoanalysis), and the therapist’s own, pathological, counter-transference response. She goes on to explore how, through projective identification, the feelings of the patient can find purchase in the mind of the therapist, at which point the therapist must disentangle what is the patient’s projection (and the intended counter-transference response) and what is the therapist’s own feeling.

Outside of the consulting room – such as around review encounters – projective process can continue to have an impact on professionals and institutions. Emanuel (2002a) describes how primitive defences against anxiety and distress encountered in children and families can be replicated in the system itself due to a lack of containment of the “powerful emotions communicated to [the professionals] via the mechanism of projective identification” (Emanuel, 2002a, p. 167). In turn, the system responds by re-enacting and replicating the initial experience of neglect, thus failing the children and families in their care. This re-enactment, Emanuel writes, emerges as a replacement for thought; where the defences of children and families include “attacks on linking’, which, when replicated in the system, limit

professionals' capacities to "think clearly and make use of outside help" (Emanuel, 2002a, p. 164).

For such feelings to be understood requires the therapist's openness to deeply unconscious and non-verbalised communications, which provide information about the patient's acting out of object relations (Joseph, 1985). In addition, the "child's suffering tends to evoke the analyst's parental feelings, which have to be controlled so that the proper analytic role can be maintained" (Bick, 1962, p. 330). These features lead Bick to state that: "the countertransference stresses on the child analyst are more severe than those on the analyst of adults" (Bick, 1962, p. 329), due to the content and its mode of expression, which arouses the therapist's unconscious anxieties. Within CAMHS settings, this has particular resonance:

The destructiveness directed against thinking and integration that is part of mental illness is felt intensely by those around them, most of all the relatives but also the workers. The fragmentation and confusion in some of the patients can arouse enormous anxieties, not only in them but also in those close to them (Hinshelwood & Skogstad, 2000, p. 13)

Together, the concepts of transference, counter-transference and projective identification provide the therapist with a framework for understanding the unconscious processes at play in review meetings. This is particularly important when considering that reviews are composed of multiple people and hence entail shifts and changes of emotion during the encounter; where transference is potentially dispersed across several relationships, counter-transference is a collective as well as individual phenomenon, and projective identification operates not only between individuals, but within a treatment and institutional context itself.

2.6.2 Oedipal anxieties, triangulation and implications for the therapist

The unconscious dynamics explored above are bound up with the Freud's discovery of the Oedipal complex, and are mobilised by oedipal anxieties stirred up in review meetings by the triadic nature of the child's treatment between parents-child-therapist (Gvion & Bar, 2014). Navigating the triangulation inherent in the Oedipal complex is a fundamental stage in development, and requires the child to accept the parental relationship and relinquish "the idea of sole and permanent possession of mother" (Britton, 1989, p. 84). This is a seismic shift for the child's development, and the loss of the previous dyadic relationship, if not tolerated, can develop a persecutory character:

In the phantasied tragic version of the Oedipus complex the discovery of the oedipal triangle is felt to be the death of the couple: the nursing couple or the parental couple. In this phantasy the arrival of the notion of a third always murders the dyadic relationship (Britton, 1989, p. 100)

The arrival of a third brings with it a host of feelings that the child must contend with:

Thus, the powerful realities of love and hate are, from the start, built into the human experience. The mother, so loved, becomes also hated for having betrayed a primary trust. Envy of her has already arisen, for being the one who has the needed resources and is in control of them. Then the conviction that precious things are being offered to somebody else adds jealousy to envy; jealousy of him to whom those loved, and loving, resources are now being given. The struggle with the vicissitudes of triangulation begins (Waddel, 2002, p. 63)

The feelings stirred up in the psychotherapy of children re-awaken Oedipal anxieties by introducing a confidential, exclusive, child-therapist relationship from which the parent is

excluded (Gvion & Bar, 2014); where the parent is positioned as an observer with strong feelings towards the ‘excluding’ therapist:

This involves not only the parent’s envy of the therapist and the fantasized perfect relationship between ‘therapist-mother’ and child, but also the parent’s envy of the child’s therapy (Horne, 2000, p. 60)

Such feelings can be exacerbated by the format of treatment reviews, where, due to an ‘adultification’ of the review meeting – where unconscious factors and parents’ emotional needs are relegated to a discussion of the child’s treatment – contact may remain at a professional, dispassionate and cognitive level, thereby foreclosing the recognition and mourning of the lost parent-child relationship. Acknowledging parents’ feelings may require allowing for their murderous feelings against the therapist, which are projected and feared to result in similar feelings from the therapist. In this respect: “What appears as dispassionate may contain the murder of love and concern” (Brenman Pick, 1985, p. 21).

Furthermore, the two clinicians – the child’s therapist and the parent worker – present at reviews can be perceived as a professional (or clinical) couple, whose connection can be experienced as both exclusive and usurping of the relationship established between the parent and the parent worker in their sessions. In addition, Rustin (1998) comments on therapists “who want to train and work as child psychotherapists [and] usually have a profound identification with the child’s point of view” (Rustin, 1998, p. 210). Such an identification may provide a stable, and unconscious, foothold for parents’ oedipal anxieties of exclusion, which can complicate the therapist’s capacity to acknowledge them. This is seen in “Collaborative work with parents”, where Magagna and Piercey (2020) discuss a therapist’s meeting with the mother of Mary, a seven-year-old girl:

Mother: ‘Well, I just want to be in the room too. I want to know what’s going on and Mary won’t tell me.’

At this point angry feelings welled up inside the therapist as she experienced mother as intruding into the therapy and obstructing it when she didn’t bring Mary to the sessions (Magagna & Piercey, 2020, p. 281)

Such responses to parents’ oedipal anxieties in treatment reviews, and the unconscious feelings attached to these, can have implications for how reviews are perceived:

A sense of demoralisation about the prospects of fruitful engagement may then become the professional response to parents who appear angry, inflexible, enmeshed with the child, envious or avoidant (Marks, 2020, p. 21)

This can lead to unhelpful dynamics in the treatment review, with parents often seen as “saboteurs” (Jacobs, 2015, p. 373). Developing upon Silber’s (2015) ideas about ‘childism’ – the prejudice against children coupled with the prioritisation of adult status – Jacobs (2015) contends that:

[I]t is parents who have been undermined, castigated, and disempowered in the analytic world in what might properly be called parentism. Thus, child therapists have too often demonized parents, setting up another kind of binary – that between the rescuing and expert therapist who knows what is best for the child – the better caregiver – and the destructive, neglectful, or narcissistically competitive parent (Jacobs, 2015, p. 374)

2.6.3 The role of the super-ego in treatment reviews

Navigating the triangulation inherent in the Oedipus complex, and renouncing a once-exclusive relationship, has far-reaching emotional implications that may re-emerge in the treatment review encounter. According to Freud (1917), the object that is given up becomes internalised by the child, yet it retains the excluding, forbidding and criticising aspect of the Oedipal configuration. In “Mourning and Melancholia”, Freud (1917) presents the process by which, in melancholia, this loss erects in the mind a structure that impoverishes the ego “on a grand scale” (Freud, 1917, p. 246):

[O]ne part of the ego sets itself over against the other, judges it critically, and, as it were, takes it as its object (Freud 1917, p. 247)

Freud developed this idea in “The Ego and the Id” (Freud, 1923), where he revised his earlier topographical model of the mind based upon psychic agencies, as opposed to levels of awareness. Here, Freud describes the functions and relationships of the id, ego and super-ego, with the super-ego the “heir to the Oedipus complex” (Freud, 1923, p. 48):

The super-ego is, however, not simply a residue of the earliest object-choices of the id; it also represents an energetic reaction-formation against those choices (Freud, 1923, pp. 34)

As the child was once under a compulsion to obey its parents, so the ego submits to the categorical imperative of its superego (Freud, 1923, p. 48).

The concept of the super-ego has been developed and adapted by a variety of thinkers (see Weiss, 2020; Barnett, 2007). Melanie Klein located the emergence of the super-ego at a much earlier stage than Freud, and emphasised the role of aggressive and destructive feelings

directed against the lost object / part-object, which become split off and projected, and come to form the basis of the punitive super-ego, creating “idealised and threatening figures” (Weiss, 2020, p. 727) and which give rise to guilt and fears of persecution (Steiner, 2017).

In the context of treatment reviews, these ideas suggest that the super-ego’s origins in early triangulated relationships may be re-activated within the review setting, where multiple authority figures and evaluative functions are present. Therapists and parents may thus come to embody aspects of the internalised, forbidding and castigating, parental couple or punitive super-ego, evoking guilt, self-criticism or fears of judgement in both parents and clinicians.

2.6.4 The therapist’s super-ego and in treatment reviews

How discussion of the super-ego relates to psychotherapist’s understanding of the treatment review situation is nuanced. James Strachey (1934) explores the role of the analyst in containing their patients’ id-impulses, presenting a figure in the analyst that mitigates the anticipated harsh super-ego response, which can be re-introjected by the patient. This is most effectively done through mutative interpretations (Strachey, 1934). In doing so effectively, the analyst must be able to address the patient’s id-energy “while it is alive and actual and unambiguous and aimed directly at himself” (Strachey, 1934, p. 80), while ensuring that the analyst’s “own unconscious impulses” (Strachey, 1934, p. 80) remain in check.

Sedlak builds upon Strachey’s ideas, arguing that the analyst’s ‘own unconscious impulses’ imply a fear that a mutative interpretation will reveal to the patient the analyst’s own “hitherto unexpressed and maybe unconscious affective response” (Sedlak, 2019, p. 46). Making a mutative interpretation thus becomes understood as communicating the “analyst’s hostility while it is alive and actual and unambiguous and aimed directly at the patient”

(Sedlak, 2019, p. 47). Such a dilemma may enter the treatment review situation, where the confluence of the therapist's identification with the child patient, the feelings of envy, jealousy and hate aroused in the parents by the oedipal situation, and the meeting of the parents' and therapist's unconscious, create a fertile ground where feelings of judgment and being judged abound. Sedlak (2019), however, suggests further that the therapist fears that their own hostility is the danger, which he relates to a fear of failing to maintain professional neutrality:

The associated anxiety for the analyst is that the judgement of his own superego will then be turned upon him and will accuse the analyst of having damaged the patient by giving voice to his critical superego and thereby reinforcing the hostility of the patient's superego (Sedlak, 2019, p. 47)

Sedlak is emphasising not only the difficulty for the analyst in receiving the projections of the patient, but also the analyst's difficulties in managing their own counter-transference (Heimann, 1950). Sedlak ends this discussion with:

Strachey indicated that the analyst will be anxious that he will not be able to convey convincingly that his impulse is governed by a normal superego; he will be anxious that his choice of words or his tone or some other non-verbal way of communicating will betray that the interpretation is intended as a criticism or as a punishment, that is to say, an expression of his pathological superego (Sedlak, 2019, p. 48)

While Sedlak is concerned with the analytic situation, many of his reflections on the super-ego pertain to the child psychotherapist in the treatment review situation; where potentially threatening feelings pass unconsciously between parents and therapist under the gaze of a critical super-ego. Sedlak's reflections also touch upon ideas developed by other

psychoanalytic thinkers, such as Brenman Pick (1985), who highlights how negative feelings projected by the patient can ‘mate’ with those of the therapist, resulting in an “analytic superego” that closes down the analyst’s capacity to think (Brenman Pick, 1985, p. 20). Further, Halton (1994) comments that the failure to contain projected feelings can result in interpretations that are experienced as an attack. Here, along with Sedlak’s ‘blind spots’, ideas about transference, counter-transference and projective identification meet with the roles that the therapist takes in the review encounter; where identifications with the child patient and as the adult professional come together to create a multifaceted and complex situation. In response, the therapist may “act out by becoming excessively sympathetic to the patient, taking the others to court in a superior or angry way, or becoming excessively sympathetic to the others, taking the patient to court in a superior or angry way” (Brenman Pick, 1985, p. 20).

2.6.5 The role of the clinical couple in containing review anxieties

As explored above, in treatment review meetings, when projection of the self and internal objects is excessive, the therapist can be aroused to feel “helpless and at the mercy of a ruthless persecuting object that goes on relentlessly and will not be modified by human understanding – the archetypal primitive superego” (Brenman Pick, 1985, p. 28). In mitigating such persecution, Brenman Pick (1985) counsels the therapist to turn to an outside, ‘father’, figure, in the form of colleagues. This offers containment to the therapist, which, in turn, allows the patient to feel contained. A further avenue is the therapist’s personal analysis to reflect on and understand the counter-transference feelings, as opposed to acting on them. It is through this process – where emotions are experienced, digested, formulated and

communicated as interpretations (Brenman Pick, 1985) – that the transference and counter-transference can be used to benefit review encounters.

As the child moves from the splitting of the paranoid-schizoid position to a more depressive understanding of their objects, and recognises that the recipients of its love and hate are the same, several changes take place: the wish to repair for earlier attacks; objects previously imbued with split-off and persecutory wishes become more benign; the super-ego softens and comes to support the ego when judging the role of the self and its capacity for damage:

Thus injured objects, which were felt to be bad, improved in the child's mind and approximate more to the real parents; the ego gradually develops its essential function of dealing with the external world (Klein, 1958, p. 242)

In the treatment review meeting, this is aided by the presence of a third, in the form of the parent worker. While Klauber (1991) has suggested the benefits in some instances of a lone clinician working with both child and parents, this is an exception to the norm. Sutton and Hughes (2005) suggest that parents seeing two clinicians can modify parents' transference to their child's therapist by placing them in an actual relationship and capacity that is prescribed by professional boundaries in relation to their child, thereby allowing them to be perceived as a 'real person' as opposed one imbued with projected, persecutory, qualities. This constellation reduces the "powerful meaning for parents in seeing a single therapist appearing to be omnipotently coping with both them and their child while they struggle to cope with each" (Sutton & Hughes, 2005, p. 180). From the clinicians' perspective:

[...] concurrent, or near concurrent, countertransference experiences of the two therapists may intensify understanding – for example, when the child's therapist may

feel furious towards the parents while the parents' therapist has lost sight of the child (Sutton and Hughes, 2005, p. 181)

In their paper on developing a short-term intervention to address adolescents presenting with heightened risk, Papadima and colleagues (Papadima, Campbell, Tzikas & Nanji-Rowe, 2024) suggest that containment is enabled through joint work in treatment reviews: "Jointly conducting reviews with the adolescent and parents allows contemplation on what is observed, fostering the sharing of perspectives within the family and the therapy dyad" (Papadima et al, 2024, p. 481).

2.7 Conclusion

Reviewing the sparse literature concerning treatment review meetings points towards an encounter that rewards a psychoanalytic lens, allowing for an appreciation of transference, counter-transference and projective identification processes, as well as recognising the role of the super-ego and persecutory anxieties in the encounter. This literature review has highlighted that treatment reviews are an under-studied aspect of child psychotherapists' work, while also, in delving into pertinent psychoanalytic ideas and literature, that they are an area that rewards further study. In the following section, I will present a methodology for exploring this encounter from the psychotherapists' perspective.

3. Methodology

3.1 Introduction

This study aims to explore how child psychotherapists understand treatment review meetings within an NHS CAMHS setting by conducting a small-scale research project analysing semi-structured interviews with child and adolescent psychoanalytic psychotherapists.

3.2 Evolution and aims of study

As part of my clinical training, I was introduced to the concept and practice of reviews as part of my patients' treatment. This aspect of the work was new to me: as a trainee, I was used to opening up and discussing my work with peers, colleagues and supervisors; however, presenting it to my patients' parents alongside a colleague became a source of both professional and personal interest. Treatment reviews were presented to me as an ordinary part of therapists' work, yet they also involve particular demands that fall outside of the day-to-day purview of child psychotherapists. Their purpose was broad: to connect therapist and parents: in which case, what does this entail and to what end? To discuss progress, in which case: what is progress in therapy? To set and review goals: in which case how are these incorporated into the review? To explain the psychoanalytic approach to parents? And if so, how is this done? To learn about the child's external world? I was struck by this variety of questions, as well as the emotional significance – both conscious and unconscious – of reviews for patients, parents and clinicians. I became interested in the myriad ways in which

this encounter – especially between the child’s therapist and the child’s parents – could be experienced and understood. In this context, my interest was inseparable from my status as a trainee psychotherapist, where established practice was not yet instilled in me. This reflects Obholzer’s (1994) recognition that:

Groups and institutions accept newcomers and mould them to the institutional ways of doing things, including joining into their particular version of institutional defences. Eventually, the individual to a large extent loses his or her capacity to be detached and to ‘see’ things from an outside perspective. Yet, to maintain some outside perspective is essential if one is to retain a capacity for critical thought and questioning (Obholzer, 1994, p. 178)

When I approached the literature on treatment reviews, I found brief passages scattered throughout case studies and discussions on parent work. The few references to reviews, however, further piqued my interest. They were, as Rustin (1999) noted:

[A] real chance to integrate diverse perspectives and to enrich the understanding of both parents and therapist, but they can also be difficult occasions in which divergences in aim between therapist and parent may erupt (Rustin, 1999, p. 217)

What would such ‘difficult occasions’ look like upon closer inspection?

In seeking to operationalise my interest for the present study, I explored variations on the theme from the clinicians’ perspective, and thus came across the need to account for the two roles that child psychotherapists occupy in reviews as either the child’s therapist or the parent worker. This was valuable preparation for the current study, and allowed me to see that my interest in treatment reviews was at the same time an interest in the role and function of treatment review meetings and how to integrate multiple positions in this common-place

aspect of child psychotherapists' work. A further question involved unconscious factors in this encounter, and how these are accounted for, particularly when reviews are presented as interactions that take place primarily at the cognitive level. Considering the complex range of themes that come together in thinking about review meetings, and given the dearth of literature on this subject, I broadened my research lens to ask the question of the study participants that I could not answer myself, namely: how do child and adolescent psychotherapists (a profession to which I aspire) understand the treatment review encounter?

3.3 Research design

3.3.1 Inquiry paradigm

I approached this study from a psychoanalytic starting point, with an aim to explore and understand something of the conscious and unconscious processes at play for clinicians in reviews. This starting point forms the basis for the approaches and methods of research used in this study (Punch, 2014). As in all research, my approach is dependent on an assumption about what can be studied and known – about the reality of my field of study – and how I might seek to establish an understanding of this reality (Punch, 2014). These assumptions come together under the term 'paradigm' or 'inquiry paradigm', which broadly encompasses the ontology, epistemology, theory, philosophy and methods underpinning an inquiry. As Denzin and Lincoln (2000) state:

All research is interpretive; it is guided by a set of beliefs and feelings about the world and how it should be understood and studied. Some beliefs may be taken for granted, invisible, only assumed, whereas others are highly problematic and controversial.

Each interpretive paradigm makes particular demands on the researcher, including the

questions he or she asks and the interpretations the researcher brings to them (Denzin & Lincoln, 2000, p. 19)

3.3.2 Ontology and epistemology

My ontological and epistemological approach stem from this paradigm (Denzin & Lincoln, 2000). Both the ontology and epistemology of this study are grounded in psychoanalytic theory, which recognises the existence of unconscious processes and the importance of subjective experiences and interpretations of knowledge. The relationship between psychoanalysis and research is significant:

Research methods are not all-purpose tools, to be bolted-on to any field of study. One would expect that psychoanalysis, with its particular object of knowledge, namely unconscious mental process, would come to have particular methods of research designed specifically for the understanding of this object and its qualities (Michael Rustin, 2009, p. 45)

This study is based upon the view that there is an unconscious, dynamic, world that influences human behaviour, thoughts and emotions, and that informs our understanding of, and interaction with, reality. The ontological position of this study is grounded on the theories of Freud and those developed after him, especially Melanie Klein and later Kleinian thinkers, and acknowledges the unconscious processes underlying the experiences of both clinicians and parents in relation to parent reviews.

If the ontological view expresses ‘what’ is being studied, the epistemology lays out ‘how’ it will be studied. Klein explored in greater detail concepts such as internal objects, through

which we unconsciously make sense of our world, and how these are conveyed through processes such as transference and counter-transference and projection and introjection. The epistemology of this study therefore acknowledges that knowledge is not objective, but is instead constructed and knowable through subjective experiences. This combination of a psychoanalytic epistemology within research is explored by Carlberg (2010):

The psychotherapist has certain knowledge that makes him or her particularly suited to become a researcher. The therapist is trained to reflect and search for the hidden meaning. Focus is directed towards the patient [here: the subject] but, in the same moment, towards him or herself. The therapist's own analysis and many years of supervision have provided training in the use of free association and countertransference as therapeutic tools. Considered in this way, being a trained psychotherapist can be an advantage when doing research (Carlberg, 2010, p. 94)

3.3.3 Qualitative approach

A qualitative methodology was adopted to address my area of interest, with its exploratory focus that encompasses the lived experience of reviews of both the study participants, and of my own subjective experience of the phenomena and of my interpretation of the data:

Qualitative inquiry is personal. The researcher is the instrument of inquiry. What brings you to an inquiry matters. [...] Reflection on how your data collection and interpretation are affected by who you are, what's going on in your life, what you care about, how you view the world, and how you've chosen to study what interests you is a part of qualitative methodology (Patton, 2015, p. 40)

The qualitative approach used in this study also addresses the under-researched aspect of treatment reviews, aiming towards a deeper understanding of the review encounter, as opposed to discovering definitive and generalisable conclusions (Lasvergnas-Garcia & Avdi, 2020).

3.3.4 Research methodology: Reflexive Thematic Analysis (RTA)

For this study, I selected a Reflexive Thematic Analysis (RTA; Braun & Clarke, 2006; 2018; 2019; 2022), an “accessible and robust method for those new to qualitative analysis” (Braun & Clarke, 2022, p. 4):

The aspiring reflexive TA researcher needs to imagine an adventure, where hidden pathways and surprising revelations, things which cannot be anticipated in advance, are part of the journey (Braun & Clarke, 2022, p. 11)

The RTA framework is based on the principle that “people construct their reality and that there are multiple, equally valid, socially constructed versions of ‘the truth’” (Lasvergnas-Garcia & Avdi, 2020, p. 7) as opposed to methodologies such as IPA or Grounded Theory, which have a theory as ‘in-built’ (Braun & Clarke, 2018):

[R]TA needs to be underpinned by theory, as much as IPA and grounded theory do, but the researcher must choose the theories that inform their use of [R]TA, and how exactly they implement [R]TA (Braun & Clarke, 2018, p.109)

This flexible use of theory provides the researcher in an exploratory field of study with a broader horizon from which to identify themes:

Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data. It minimally organizes and describes your data set in (rich) detail. However, frequently it goes further than this, and interprets various aspects of the research topic (Braun & Clarke, 2006, p. 79)

As McLeod (2011) writes, RTA offers researchers into psychotherapy processes a “flexible, straight-forward and accessible” approach to data (McLeod, 2011, p.146), one which studies patterns to uncover meaning. Braun and Clarke (2022) propose six phases for RTA, enabling the researcher to engage with the data so as to capture important elements, while prioritising “meaning, over cause and effect” (Braun and Clarke, 2022, p. 7). The six phases are:

1. Familiarising yourself with your dataset
2. Coding
3. Generating initial themes
4. Developing and reviewing themes
5. Refining, defining and naming themes
6. Writing up

(Braun & Clarke, 2022)

The six phases of RTA are not intended to be rigid or followed linearly, but are a set of guidelines “that should be applied in a flexible manner to fit the data and the research question(s)” (Byrne, 2021, p. 1398). Instead, as Braun and Clarke (2022) point out, theirs is an approach that is ‘method-ish’:

Simply and rigidly following the phases of reflexive TA as a series of ‘steps’ will not guarantee a good analysis (Braun & Clarke, 2022, p. 10)

3.3.5 Reflexivity

The six phases of RTA account for the significance of the researcher and their individual stance. RTA emphasises the ‘active’ role of the researcher:

[RTA] highlights the ways in which themes are active creations of the researcher (rather than just passively ‘emerging’ fully formed from the data) that unite data that at first sight might appear disparate, and often capture implicit meaning beneath the data surface (Braun & Clarke, 2018)

In applying the RTA method, it is important to account of my status at the time of writing as a trainee child psychotherapist. This may include an exploration of the anxieties that accompany my understanding of review meetings – as well as how these may have led to the present area of research – and how these may differ from the perceptions of qualified clinicians towards review meetings. It is also an approach that suits a psychoanalytic epistemology:

The fact is that discovery in psychoanalysis has always depended on a self-critical attitude to clinical data. Psychoanalytic theories assign meaning and connectedness to specified kinds of facts; without attention to the nature of these facts and how they are apprehended, there could be no valid or useful theories (Michael Rustin, 2009, p. 45)

In this way, much like the roles in treatment reviews – where clinicians bring their experiences as both the child’s psychotherapist and the parent worker – the psychoanalytic practitioner as researcher seeks to navigate two roles:

When the two roles are combined, one important question emerges: ‘How can I, as a psychotherapist and researcher, utilise my clinical experience and “knowledge from within” without losing the ability to cast a critical eye over what is taking place?’

(Carlberg, 2010, p. 94)

RTA addresses this question by incorporating within its approach the subjective, active, role of the researcher, along with a practical and robust method of data analysis to deepen an understanding of treatment reviews.

3.4 Ethics

Ethical approval for this study was applied for on the basis of the aims, rationale and methodology for this project. This application was approved by the Tavistock’s Research Ethics Committee (TREC) in November 2023 (see Appendix 2 for TREC form and approval letter).

3.5 Procedure

3.5.1 Participants and recruitment

Participants for this study were recruited from the two inner-city CAMHS teams where I conducted my clinical training. As a trainee working in these teams, I was known to, and knew, the participants, and had also worked with some participants on cases, including attending treatment reviews. This has implications for how some treatment reviews were introduced or alluded to, as well as the relationship between interviewer-interviewee.

The study was introduced during the services' team meetings, after which an email with an attached information sheet was sent to the teams' child and adolescent psychotherapists. Interested psychotherapists were given further information (see Appendix 3 for recruitment information), which contained the contact details of myself and my research supervisor, and six psychotherapists were recruited and dates arranged for the interviews. All participants were ACP-registered child and adolescent psychotherapists with at least two years' experience post-qualification. This requirement was to ensure that there was sufficient experience of reviews, as well as familiarity with both of the clinical roles – as the child's therapist or as the parent worker – usually present at treatment reviews. Prior to the interviews, participants were reminded of their right to stop the interview at any time or withdraw from the study up to two weeks' after completion of the interview. All participants gave their informed consent to take part in the study by signing and dating a consent sheet.

Five interviews took place in-person at the clinicians' place of work while one interview was conducted online via Microsoft Teams. Gender, age, racial and ethnic backgrounds were supplied. I was mindful that, within such a small sample size drawn from my two training posts, such demographic details may compromise participants' anonymity. However, broadly, participants were within the age range of 30-39 to 50-59, had post-qualification experience ranging from 4.5 years to 18 years, and represented a reasonable spread of ethnic backgrounds. While a closer analysis of such demographic information such as gender, age, race and ethnicity may offer interesting information related to treatment reviews, this was beyond the scope of my study.

3.5.2 Confidentiality

Audio recordings of the interviews were transcribed in Microsoft Word and stored anonymously on an encrypted device. During transcription, all identifying data (e.g. clinician and service names) were omitted or anonymised. Signed consent forms were kept separate from any other data in a locked location.

3.5.3 Debriefing

After the interviews, participants were invited to ask questions about the interview and the study that they may have had during the interview, and they were again informed of their right to withdraw their data, as well as the measures in place to ensure confidentiality.

3.6 Interview procedure

The qualitative data to be analysed in this study was obtained through semi-structured interviews of the participants. This decision was made in-keeping with the paradigm underpinning this study. As Hollway and Jefferson (2013) write, it is especially in the epistemological ‘how’ and the chosen method that psychoanalytic concepts are particularly felt, most clearly in the form of the “principle of dialogue, the two-way encounter and influence” (Hollway & Jefferson, 2013, p. 198). Following from Hollway and Jefferson (2013), a narrative approach to the semi-structured interviews was chosen that utilised the ideas of the free association narrative interview (FANI; Hollway & Jefferson, 2013). This:

[...] allows interviewees to follow the threads of their emotional experience as they transform it into freshly discovered meaning. It helps to guard against eliciting from interviewees ‘well worn’ stories and commonplace discourses, depleted of personal meaning and emotionally vivid experience. Its aim is to enable interviewees to give answers that reflect their own concerns even when these are not immediately consciously accessible (Hollway & Jefferson, 2013, p. 199).

This approach allows for stories within the data to develop, which stay “closer to actual life-events than methods that elicit explanations” (Hollway & Jefferson, 2013, p. 57). The FANI approach is not without its critics (see for example Frosch & Emerson [2005] who question its psychoanalytic epistemology; see also Thomas [2018]; for more discussion on FANI, see Lukac-Greenwood & Bager-Charleson [2024]). However, as this study aimed to explore a broad and non-linear experience – reviews happen at intervals in the patient’s treatment and vary from instance to instance and from patient to patient – the more open nature of FANI – coupled with an RTA approach – was preferred.

Taking from the biographical-interpretative method that informs FANI, in developing the interviews I opted for open-ended questions. This was in order to access therapists’ broad experience of treatment reviews and allow them to take the discussion in the direction they wished (Lasvergnas-Garcia & Avdi, 2020).

The interview design phase benefited greatly from the feedback of fellow trainee child psychotherapists, in particular a trial interview that resulted in a more nuanced and less rigid approach to the subject. The feedback from peers thus allowed me to re-think and re-order my interview schedule.

During the actual interviews, I found that my questions often acted as a guide for me, since the interviewees would frequently touch upon or address the issues I sought to explore. Given the exploratory nature of this study, this felt like a natural outcome, and one in-keeping with the FANI interview approach:

This approach therefore emphasises the meaning that is created within the research pair. It also recognises that the story told is constructed (within the research and interview context) rather than being a neutral account of a pre-existing reality (Hollway & Jefferson, 2013, p. 56)

This also meant that the I was able to develop and refine the questions with each interview in an iterative process, with each interview informing ideas which I took from one interview into the next.

3.7 Process of data analysis

To analyse the interview data, I applied the following phases of RTA, as proposed by Braun and Clarke (2022):

1. Familiarisation with the dataset
 - a. I initially used speech-to-text software to transcribe the interviews, re-reading and correcting any errors in transcription whilst listening to the interviews, and ensuring that names and identifying data were anonymised. During this phase, I kept a journal of my associations bearing in mind my position in relation to the data and noting areas of interest for future codes and themes.

2. Coding

- a. I started the coding process with one interview, breaking up the text into component parts and formulating and assigning codes to capture specific meanings. I then consulted my research supervisor to ensure that my application of RTA was appropriate. Whilst coding, I considered ideas for nascent themes, which continued throughout the coding process. Coding was fluid along the spectrum from inductive and data-driven to deductive and researcher-led, reflecting my relationship to the area of study; and explored semantic and latent meaning, which reflects the psychoanalytic nature of the study. Coding was repeated for the remaining five interviews, with revisions and adjustments to codes based upon the data.
- b. After a first round of coding, I revisited the interviews multiple times to ensure that the codes were sufficiently robust and coalesced around the data. Reflecting the back-and-forth of RTA, this process also enabled me to become more familiar with the dataset.

3. Generating initial themes

- a. RTA themes must capture a wide range of data within a shared idea. I thus 'played' with the data, approaching it from multiple angles so as to gain different perspectives of it. Approaches included feeding codes into AI programs, cutting out the codes and arranging and re-arranging them around potential themes, drawing diagrams or doodles to represent connections between themes (Appendix 4).

- b. The greater familiarity with the data afforded by the phases of RTA allowed me to more confidently and freely select apposite data segments from the dataset and discard data that repeated, or did not sufficiently add to, my themes.
- c. Results of my analysis of the data are presented in the following section.

4. Results

4.1 Introduction

This study aims to explore how child and adolescent psychotherapists understand treatment review meetings by interviewing six child psychotherapists working in inner-city CAMHS teams. The interviews were analysed according to RTA. Two rounds of coding of the dataset were conducted, after which they were refined. Once these were felt to have done a “*good enough* job of capturing and differentiating meaning” (Braun & Clarke, 2022, p. 71), themes were developed. Taken together, the codes resulted in 12 candidate themes. As RTA is not a strict, step-by-step, model, I returned to the data and codes in light of RTA’s inductive orientation, which resulted in six themes (for process, see Figure 1). A final revision aligning with RTA’s step five resulted in the final four themes: Tensions inherent in ‘bringing things together’; Reviews as a site of ambivalence; Feelings of exclusion and intrusion abound; ‘Being aware of what the parent can tolerate’ (see Table 2). These themes aim to capture a “shared meaning, united by a central organising concept” (Braun & Clarke, 2022, p. 77), with the interviews suggesting that review meetings are both a site of opportunity, but also significant ambivalence and anxiety, which the clinical couple of the therapist and the parent worker must work together in order to navigate.

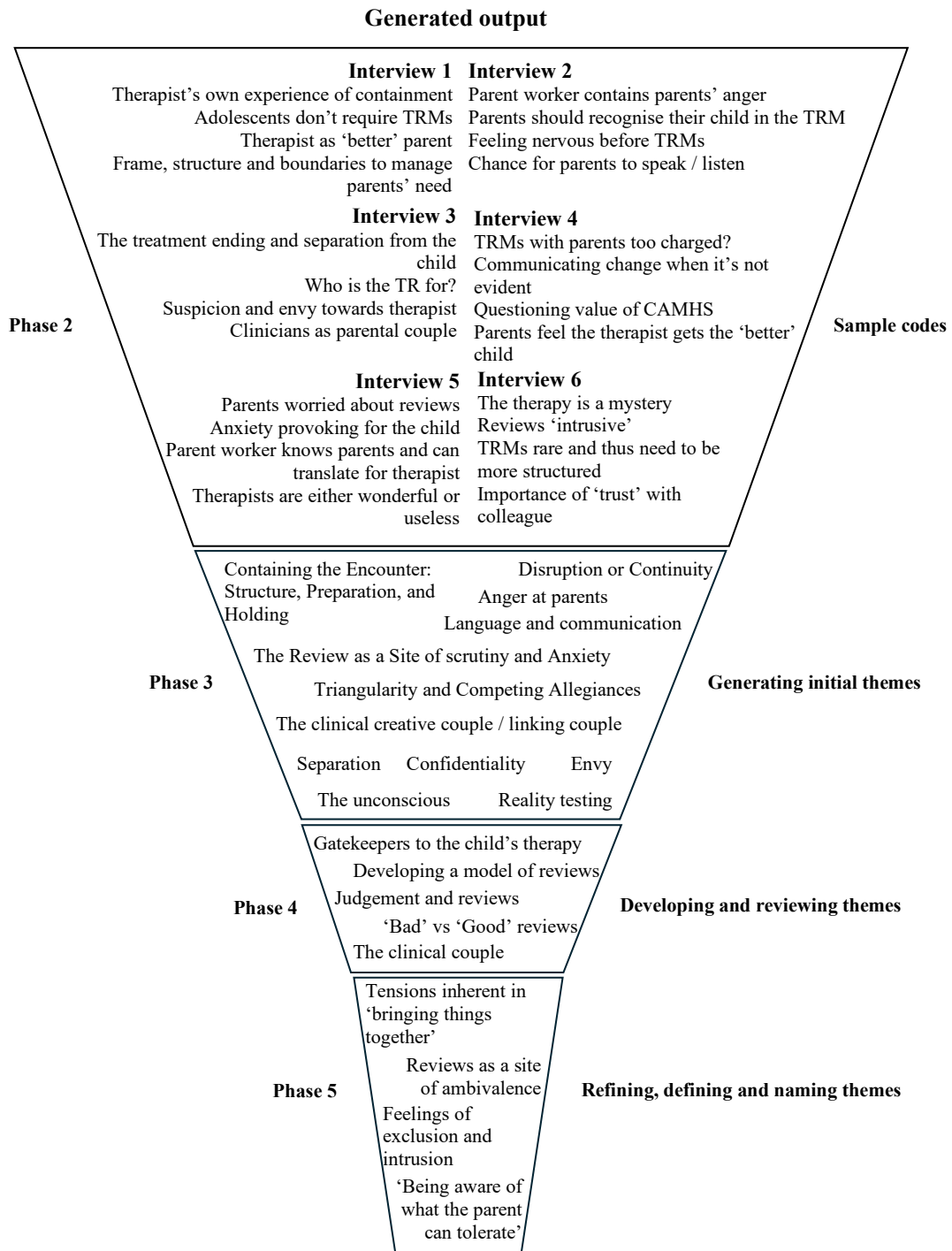


Figure 1: Generated output – codes and themes

Theme	Sub-theme	
Tensions inherent in 'bringing things together'	4.2.1	Tension with the parent perspective
	4.2.2	Tension within the clinical couple
	4.2.3	Goals as a way of smoothing over complexity
	4.2.4	A shared picture of the child
Reviews as a site of ambivalence	4.3.1	The parents' ambivalence
	4.3.2	The child's ambivalence
	4.3.3	The therapist's ambivalence
Feelings of exclusion and intrusion abound	4.4.1	The therapist as gatekeeper
	4.4.2	Adolescents and the need for reviews
	4.4.3	Confidentiality
	4.4.4	The parent worker's function in reviews
'Being aware of what the parent can tolerate'	4.5.1	Difficulties in conveying the therapy
	4.5.2	The clinical couple models thinking and linking

Table 2: Themes and sub-themes

4.2 Theme 1: Tensions inherent in 'bringing things together'

My initial interview question – 'what comes to mind when you think about treatment review meetings?' – elicited responses that focused on the multiple strands of the review encounter – of roles, perspectives, purposes, feelings – and how reviews function as a point of convergence:

Something about coming together... and thinking about... the work that has been done [...] in a bit of a different way (Participant 1)

the review space, it's... yeah: it's bringing things together (Participant 2)

However, this was not a simple endeavour, and the interviews suggested tensions between the different perspectives at the review meeting, as well as the capacity of parents and clinicians to tolerate and engage with these tensions. This aspect was summarised by Participant 6:

The first thing that comes to mind is a chance for the person seeing the child and the person seeing the parent to come together with... with the parent or the carer. [...]
But also there can be points of difference in understanding, or some clarification needed, or different perspectives on the same kind of material (Participant 6)

From the point of view of the therapist, there can be a sense of frustration when their (or alternative) perspectives are foreclosed or not accepted:

So, to try and use the review to help, whether it's a review with the parents or a review... just conversations, with schools... just trying to help them to see a different perspective of the child is equally as important because, otherwise: what's the point of doing therapy if other people aren't necessarily changing? And nine times out of ten, it's the adults around the child who need to change (Participant 4)

The following sub-themes explore the multiple perspectives in reviews that can influence the capacity of parents and clinicians to allow for, and engage with, the points of view of others, and the importance of developing a shared picture of the child and the treatment.

4.2.1 Tension with the parent perspective

Each person in the review situation comes with a relationship to the child and an understanding of the aetiology and meanings of the disturbances that have brought the child to CAMHS. For the therapist, their “*preoccupation is really uhm the... the child in the therapy room*” (Participant 3), “*particularly if you're quite deeply in the transference situation with them*” (Participant 6). This means that as the “*therapist... you can get quite*

identified with the child at times” (Participant 2). Developing a shared understanding of the child with the parents is thus complex, as Participant 6 suggests:

Sometimes it's the same child in my mind [that is presented by parents], but sometimes something different has been described, which then I have to think through. Hmmm. So I might feel in the sessions with the child after a review a bit full of the adults' kind of perception of what's going on (Participant 6)

In this sense, parents' perspective can be felt as competing with the therapist's and can thus be perceived as disruptive to the child's psychotherapy. This need not necessarily be negative – the therapist is learning something they didn't know before, which may alert the therapist to an aspect of the child that they had hitherto not been aware of.

Reviews where there is a rigid adherence to a particular 'version' of the child were considered by the participants to be an indication of an unsuccessful review outcome. This can have a profound effect on the therapist, in particular, who may have developed a different understanding of the child:

You know, some parents use review meetings as a kind of... a bit like, you know, parents evening and an opportunity to kind of tell everyone how awful the child is, or how bad they've been, you know? And they force you into this kind of colluding, witnessing, kind of, you know... object, you know... and if you don't say 'no', then you must agree with them. And it can be really infuriating for young people and really, really, really intrusive (Participant 1)

The capacity to work with a rigid (and negative) picture of the child in the parents' mind, as perceived by the therapist, points towards the need for experience and thoughtfulness of the therapist at the review. When this is missing, therapists may counter with their own rigid

response. Participant 1 immediately follows on from their description of parental denigration (above) by moving to discuss risk and safeguarding, almost as if this is a way that they could protect against the parents' criticism:

And also, just another thing, when there's risk, at a review meeting, as a clinician, you have to be... you have to be... uhm, quite straightforward about that. When you're worried about those things, you're gonna have to talk about it. But it's really difficult. Yeah, because you have... you have to talk about it and you have to say and, you know, in a really practical way and straightforward way, you know, if you're worried about risk or safeguarding. You know, so you might have to talk about, like, practical things (Participant 1)

This second extract shows how therapists can call upon structure and their professional identity in response to ideas about parental criticism of the child. While, from the therapist's perspective, a shift towards the 'practical and straightforward' may silence the 'attack' against the child, it can also serve to project into the parents the disappointment and shame that they have been felt to project into their child and that the therapist seeks to rebuff. Interviews identified this dynamic as potentially exacerbating a tense and conflictual review encounter.

4.2.2 Tension in the clinical couple

The relationship within the clinical couple – between the child's therapist and the parent worker – was another area of tension that contributed towards psychotherapists' understanding of reviews. In this context, the child's therapist and the parent worker approach the treatment review from two different perspectives: one that has greater insight

into the child's experience and internal world, the other into the parents' situation. These tensions and how can they play out in the treatment review encounter were highlighted in all of the interviews:

the therapist can feel they're doing great work with this child. But you know, things are kicking off at school or whatever. And they are probably, maybe, doing very good work, but... but all hell's breaking loose somewhere. And the parent worker is having to hold that. Yeah. So there can be tension between the child's therapist and the parent worker (Participant 2)

Examples of this also included more forceful expressions of frustration where a colleague: “didn't ‘get’ the parent... If I'm honest, I wish that... there was a different parent worker, because so much more could have been gained” (Participant 4). However, the tension between clinicians can be mitigated by the clinicians' relationship, which Participant 5 highlighted as allowing for greater balance. Yet, contact between the clinicians to discuss the case or prepare for the review was often reported as hard to arrange or prioritise. The quality of therapists' relationship was nonetheless an important part of the review, with contact between them an “ongoing process... every month or so” (Participant 6). Participant 3 proposed the review's function in facilitating this relationships:

But I think that's another function of the review as well is to bring us together and take it... like make sure we're doing that as well... (Participant 3)

This comment reflects the review meeting as an opportunity for clinicians to connect and discuss the case, without which the risk for a split or splintered understanding may be heightened.

4.2.3 Goals as a way of smoothing over complexity

As illustrated in the literature review, treatment reviews are often portrayed as cognitive, almost business-like, in nature, where goals and measures to assess the efficacy of therapy can be used to stand in for a potentially “*messy, and kind of, you know, really disorganised*” (Participant 1) encounter:

many times that adults meet about children it's to think about progress, and to think about targets, you know, to think about terms and think about outcomes (Participant 6)

While this approach can offer solid ground from which to approach and assess a child's treatment, the interviews suggested a reluctance towards using goals:

So, I think goals are helpful for that... So it doesn't feel each time you're starting again at the review. But sometimes, I mean, it's funny, I was thinking about a case where we set goals and it feels like I bring the goals and the parents are really not, you know, they're sort of quite resistant to looking at the goals... But they resist this sort of... if it feels like I'm forcing them to look at the goals (Participant 2)

Here, goals can feel like an imposition from the clinicians and are resisted by the parents, perhaps as an imposition of a clinical perspective that does not reflect the parents' view. Hence, assessing a child's psychotherapy may depend on more than goals and measures, but on something more qualitative that not only captures the child's and family's experience of the treatment, but also captures something of the combined experience of those involved in the treatment.

4.2.4 A shared picture of the child

Given the multiple perspectives of the child and the treatment – and the tensions that these may generate between parents and clinicians and between clinicians themselves – interviews stressed that finding common ground is important, yet often elusive. When competing pictures of the child vie in this way:

[It's] really important that the parents sort of can hear from the therapist that they can recognise the picture of their child that the therapist is painting and I think if they can't, that's a real problem (Participant 2)

The capacity to take in something of the parents' relationship to their child, and add to it with their own clinical understanding of the child, was presented in the interviews as a valuable contribution to the review. This was taken up by Participant 1:

[...] bringing unconscious processes to the table is something about making something alive in the room, you know. And as a clinician, seeing a child or a young person is being able to... to talk about what's going on for them in a lively way that you're bringing it to life, that feels... that, you know, that's connected, connecting with experience and then that creates some sort of connection with the parents, you know, and it's that experience of feeling understood (Participant 1)

This 'aliveness' of the child and the therapy has a powerful impact on the review. It allows for a new, more integrated, picture of the child to emerge that can be recognised by parents and clinicians alike, but that also brings together those present in how they can think about the treatment:

a really, really successful review, I guess, is also when the things that the parent and the therapist are sharing, are recognised by each other and kind of... yeah, some feeling of collaboration (Participant 3)

I find that when the therapist gives feedback about the sessions, the parent will often associate to that feedback, and something new... something a little bit more formed will come from that (Participant 6)

The interviews suggest that integrating perspectives allows for creativity in the review meeting and between those involved in the child's therapy. Another way to support the integration of the parents' and therapist's perspectives is, according to Participant 5, to focus on the positive aspects of a 'wanted' child versus something more negative and potentially divisive. This can allay some of the tensions felt to be present and so reduce the anxiety of the encounter, thereby making it possible to think more benignly about the child, the review meeting and its place in the treatment:

I feel that we [therapists] also always think about [patients'] strengths and their positives [in the treatment review]. And I can't think of a case where I could just see the negatives in the child. There was also always something that was... was positive (Participant 5)

Especially where anxious parents may be anticipating a litany of faults, emphasising the child's positive attributes can enable a more integrated picture of the child to emerge. This experience allows for a relationship to be established between parents and clinicians that can tolerate and allow different perspectives.

4.3 Theme 2: Reviews as a site of ambivalence

Participants spoke about reviews providing the opportunity for parents to hear from the therapist about their child's therapy, and for the therapist to learn about the child's external world, including the relationship with their parents. Reviews have the potential to enrich the treatment through this shared understanding of the child, and align the parents and therapist. However, the interviews also highlighted parental and therapists' anxieties – both conscious and unconscious – that contribute towards therapists' understanding of reviews. The interviews suggest that feelings of shame, envy, jealousy, rivalry and judgment are part of review meetings and need to be taken into account.

4.3.1 Parents' ambivalence about reviews

Perhaps due to its infrequency, the treatment review encounter can be presented as a minor feature of the child's psychotherapy treatment. However, interviews emphasised reviews being rich in feelings, and a site where conscious and unconscious wishes and hopes converge with anxieties:

To have that moment with the actual therapist and to know what is going on, I think it can... it's a mix, I think... something that the parents may want, but also they may feel a bit anxious about. I would say: mixed feelings (Participant 5)

Parents' ambivalence, as discussed in the interviews, was associated with their need for help and the vulnerability this entails. The interviews also raised the implications of this need for therapists:

There's so much at stake, I feel, because for the parents it's your child, it's so important, and it's really... I think it's exposing for the parents as well. If there's something wrong with my child, and maybe because of something that I do, and is this person going to tell me: 'you're doing everything wrong?'. And this can be sometimes... I feel that this is in the open, the parents tell you straight away. You know, there are these parents that are very reactive. Or it can be unconscious. I think... I think sometimes it can be completely unconscious, so on the surface everybody's being polite and listening to each other, but the tension and anxiety is there, so I think you always need to keep it in mind (Participant 5)

Participants reported parental anxieties that are strongly linked to their worries for their child and their need for help:

They're often really concerned about their child and wanting their child to have help, so... it's hearing how the therapy is going and hoping that things are moving on, or being able to talk about it if things aren't, you know, there's still lots of worries (Participant 6)

The need of parents for their children to receive help can be conveyed in very powerful ways in reviews, and can raise the anxiety of the child's therapist:

review meetings can be very anxiety provoking for parents... they might feel as if, you know, they can very easily feel kind of criticised, or that they're not doing a good job, or that the therapist is, like, so much better than them and understands their child so well. And, uhm, so I think it comes from that and I think as a result of that, there can be lots of, uh, projections towards the clinician seeing the child (Participant 1)

The interviews pointed towards parents' powerful thoughts, feelings and fantasies that accompany reviews and how these are understood by therapists: "*what are they [the clinicians] going to say about my child*" (Participant 5); "*for a lot of parents it is tricky to think: 'my child is for 50 minutes with this person... on their own. What are they saying to each other? What is going on there? What is the therapist finding about my, my child?'*" (Participant 5). Comments such as these point to fears of being judged or found wanting; of shame and guilt at the child's problems being attributed to parents; as well as the worries and concerns that parents have for their child and their wellbeing.

4.3.2 The child's ambivalence

The role of the child in reviews was another feature of the interviews. While all participants expressed a reluctance to include the child in reviews, the child's ambivalence about the encounter between therapist and parents emerged in the data and was related to the therapist's own ambivalence:

I try to involve always the child. I say look: this is something that we always do; it is a routine. Because I think [laughs] that it is anxiety provoking for the child as well. Sometimes, like, you know, like, 'am I naughty?' or something and 'are they talking about me?' (Participant 5)

Just as with the parents' anxieties, participants considered that children too can anticipate a critical or punitive outcome to reviews. As Participant 3 indicates, the child's perceived ambivalence about reviews has a bearing on the therapist's understanding of the review:

often I feel like children [laughs] don't really want to think about it or like talk about it much with me, the review... maybe I colluded with that a bit. Kind of not... almost pretending it didn't happen with the child (Participant 3)

Here, participants raised the idea of ambivalence towards the review, which, when felt to be located in the child, can be projected into the therapist, thus potentially influencing their own capacity to recognise the demands of the review. However, despite anxiety about the encounter between their therapist and parents, the interviews suggest that children also benefit from being able to trust that the grown-ups can bring things together for them and their treatment:

I think children want to know that their parents and their therapist talk to each other, and are... in the relationship with each other (Participant 2)

Having this sense of security is perhaps strengthened after experiencing several review meetings, where the encounter between grown-ups does not result in chastisement, but can be felt to support the child and their therapy over time.

4.3.3 The therapists' ambivalence

As already indicated, reviews are often presented as being welcomed by parents and children, but are also approached with caution; an encounter where judgment, shame and other primitive feelings are anticipated. Such ambivalence extends to therapists, who convene review meetings, but also bridle against them:

Well, probably to be honest, the first thing that comes to mind is a feeling of, uhm, slight guilt, that I ought to be doing them more [...] But, I mean, generally I think

they're very useful to do. I mean, they're... really key. But they do take a bit of... a push it to get done. They're extra work in that they're a bit of a shift in the way of working. It's not always, kind of, intuitive to, kind of... person... personally they take a bit of a push to get done (Participant 3)

Treatment reviews fall outside of the usual clinical encounters. As such, reluctance to hold reviews can be inferred from the practical difficulties of arranging them, or in connecting with colleagues in preparation of a review. Yet, even when the benefits of review meetings are acknowledged, the interviews conveyed the difficulties and anxieties inherent to them:

I look forward to the reviews because I think it is a chance to get... to see if it's possible to get some shared understanding. You know, between the therapist, the parent, the parent worker (Participant 6)

I kind of always think that it's really helpful once I... once I've done one (Participant 3)

I probably think about it more than I think I do. Because, once a review is in your diary, you're probably making connections in your mind. [...] So I think when you then know you've got a review in a diary, you're probably being more observant. So... you're almost preparing yourself (Participant 4)

As the responses above indicate, therapists adopt a cautious tone when speaking about reviews, alive to the encounter's potentially disruptive impact on the therapist's work with the child. Therapists, too, are not above feeling judged in reviews:

it feels a bit like, you know, a review of you. Which, I mean, it's not unhelpful, that [it's] a review of you... but they're also assessing whether this is something that they want, you know, it goes kind of both ways (Participant 1)

Interviewees described feeling judged or assessed at reviews, with the pressure leading to feeling like “*you're performing a bit*” (Participant 3); “*I've got to deliver*” (Participant 5); “*you have to quite concretely justify the therapy*” (Participant 3). Reviews can be associated with ‘failing’, which may include: not meeting the significant need of the parents and child, guilt at disappointing parents, shame. The consequence of ‘failure’ was not addressed in the interviews, but may be associated with the premature ending of therapy and thus of the therapist’s relationship with the child.

4.4 Theme 3: Feelings of exclusion and intrusion abound

Psychotherapy offers a separate space for the child to explore their internal world. Interviews pointed towards the value of keeping this space separate from the parent. Yet, for around six months, parents may have been wondering about their child’s psychotherapy, witnessing changes in mood and behaviours at home, adapting to the schedule of treatment. Meanwhile, the actual therapy happens behind closed doors, with a therapist who, more often than not, has only limited interactions with the parents. As a result, parents can “*feel quite separate from what's going on*” (Participant 6). Interviews suggest that parental curiosity about the therapy can be experienced by the therapist as the parent intruding upon the child’s therapy and the therapist’s relationship with the child. Participants explored this through their work with adolescents – which may obviate the need for reviews with parents – or through questions about confidentiality. The parent worker – who has an established relationship with

the parents – was found to play an important role in review meetings in ensuring that a frame is adhered to and to address feelings of exclusion and intrusion.

4.4.1 The therapist as gatekeeper

Allowing their child to begin psychotherapy requires parents to let a stranger enter the relationship between them and their child. As such, parents often get just a little window into the relationship with a therapist when the child is collected from the waiting room:

Some parents, as you know, they do find it quite challenging to be kept out of the relationship. You know, not all, I don't think, but some, might be quite anxious, particularly at the beginning, about letting the child go (Participant 6)

This separation is an important part of the therapy, and parents are provided with their own space with a parent worker in part to mitigate the feeling of being separate from their child and their child's experience in the therapy room. Nonetheless, the review offers parents a chance to ask question of the child's therapist, which, the interviews suggest, has the potential for disrupting the therapy in the therapist's mind:

I find that it can be sometimes unhelpful when I feel really exposed to how... how much the parents need the child to change or how much, you know, how difficult things are at home. Sometimes that puts that kind of pressure on me that, in the therapy, that means it's harder to really stay with the child and what they're bringing (Participant 3)

Managing parents' need and understandable curiosity about the therapy, while also keeping the child's therapy as separate, was a feature of the interviews. Participants

articulated an understanding of reviews as interrupting and intruding upon the therapist's work. This can lead to a tension that clinicians feel they must manage in the review, where *“the parents feel that, actually, they need to know what the child has spoken and talked about”* (Participant 5).

4.4.2 Adolescents and the need for reviews

One of the related issues in the interviews was about whether or not to include patients in the review, which participants agreed was not advisable. This was presented as being for the parents' benefit:

And I think, yeah, parents – it's also giving them the space away without their child so that they really feel that they can ask what they want (Participant 2)

As well as for the child's:

I think it can be helpful [to include the patient], but can also be extremely jarring for them to see you in a different setting. Summarising things [laughs] (Participant 6)

All participants felt that it was preferable to keep the patient and review meeting separate. However, there was some variance when it came to adolescent patients: *“But for some young people – like 16 years old – either you don't have reviews with parents or you will invite them [the adolescent] at the reviews”* (Participant 5). Despite the idea that you would include the adolescent patient, the consensus among participants was that this is best avoided:

Particularly with adolescents, you have to be really, really careful. I've had... I've done review meetings with adolescents and parents and then afterwards, like, deeply regretted it (Participant 1)

One reason given for the reluctance to include adolescent patients in review meetings was related to the therapist's difficulties. Below, Participant 3 reflected on a meeting which was attended by their adolescent patient:

I remember feeling very, kind of: who was I speaking to? Was I speaking... When I spoke about the therapy, was I speaking to the patient? Was I speaking to her mum? Was I speaking to the parent worker? (Participant 3)

Participant 1 felt that, when working with adolescent patients, reviews with the parents could be “*at the clinician's discretion*” (Participant 1) and “*because I've been seeing lots of, like, adolescents... and you don't need to... you don't need review meetings*” (Participant 1). The responses above not only point towards the therapist's role in ensuring that the review can be a space for the parents and therapist to discuss the treatment without the child present, but also highlight the therapists' focus on the patient, especially the adolescent patient, which can trump reviews with parent. However, they may also suggest an unconscious wish of therapists to avoid the review encounter with parents and the feelings this evokes, and to maintain the separation of parents from their child's treatment.

4.4.3 Confidentiality

A question that emerged in the interviews relates to just how much of the clinical material to share with parents. Here, too, therapists play a gatekeeping role – adjusting and deciding

upon the degree of access that parents are granted. Participants highlighted the fine line that therapists have to tread in reviews in terms of confidentiality. Participant 1 commented:

as a clinician you're trying to connect [with the parents], and have this shared understanding. But that can feel like a betrayal to the young person (Participant 1)

Similarly, the wish to present something of the therapy leads to a potential conflict of interest:

I think it is also complicated, because I think you may want to say something to the parents because you think that it is important to give that example so that the parents will understand, but then you disclose something about confidentiality (Participant 5)

The question of how to resolve this dilemma – of satiating parents' understandable curiosity about the therapy while not 'betraying' their patients' confidence – is complex for therapists. Here, parents' wish for inclusion in the treatment in the form of seeking answers can be experienced by the therapist in the review as an intrusion into the child's therapy.

4.4.4 The parent worker's function in reviews

Participants spoke about the dilemma in managing what they experienced as parental feelings of exclusion, and the therapist's feeling of their work being intruded upon. However, reviews also include the parent worker, whose role was identified as supporting the therapist and parent in navigating what can, at times, feel like competing and mutually exclusive wishes:

the parent worker kind of is more responsible for the frame in some ways around... around the child's therapy and when you're the therapist, you're very much kind of in... in that dyadic kind of process (Participant 3)

The parent worker role was presented in the interviews as being responsible for the frame, which involves 'steering' the meeting and giving it structure. This function was valued by participants as addressing the potentially complicated nature of review meetings:

if I'm the clinician doing the parent work, then I would kind of take a bit of a lead and kind of run the meeting. And kind of take charge as to protect the role of the other clinician as the child... as the child psychotherapist. So, they can remain kind of protected (Participant 1)

The idea of the parent worker needing to protect the child's therapist was one that participants returned to during the interviews. Parents' strong feelings about their child and the treatment emerged in the data, which contributed towards participants' understanding of the review encounter as potentially fraught. Here, the parent worker role was seen as being able to "turn down the flow a bit of the parents' need from the therapist" (Participant 3). Parent workers were considered well-placed to do this because of their relationship with the parents:

as the parent worker, I think that you're there in a way to... I think also possibly to reassure the parents, because they know you more than your colleague (Participant 5)

The relationship between the parent worker and the parents in their sessions is an important element of the review meeting, and one which contributes towards the perceived success of the meeting. However, Participant 1 voiced some uncertainty when judging how

active the parent worker should be at the review. Participant 2 also raised questions about rigidity versus structure and how this might be experienced by the parents:

And, you know, there's something about it, that sort... putting a boundary down or something that feels a bit of an impingement, I guess. But it feels, I don't know, the frame feels really important (Participant 2)

Here, the parent worker's role can be understood as akin to a third in the oedipal configuration – a paternal function that mediates and manages the powerful feelings of exclusion and need.

4.5. Theme 4: 'Being aware of what the parent can tolerate'

Participants expressed the challenges of conveying to parents the process of, and the understanding that is achieved through, psychotherapy. Examples were given of poor communication limiting the success of the review meeting, which emphasised the role of sensitivity on the part of the therapist towards the parents and what aspects of the therapy are helpful to convey. Interviews addressed the parent worker's role in the review meeting to help the therapist give an account of the therapy that could be received by the parents. Participants also spoke about the benefits of having two clinicians to navigate the review meeting, and the impact for the parents in seeing two clinicians – a 'clinical couple' – model a way of discussing the child and their treatment.

4.5.1 Difficulties in conveying the therapy

All participants spoke about the challenges involved in communicating what happens in the therapy room to parents, and addressing what change looks like in psychoanalytic psychotherapy, especially when parents feel they need it desperately. Presenting the process of, and changes due to, psychotherapy can feel complicated when development is often non-linear and the language of psychoanalysis can feel obscure to some parents:

Because sometimes children seem to get worse, for example, but actually, we feel that that's because they are making a connection and then finding it difficult, you know, whereas they might have been very withdrawn from the therapist. So the increasing connection can make them feel a bit more... precarious in some way. And then sometimes you know, their behaviour can be a little bit more erratic (Participant 6)

Here, what the clinical couple of the therapist and the parent worker can provide – a way to link up and think about the child and their needs – can be provocative for the parents, who may bring to the review encounter primitive feelings of anxiety, envy and shame that can make thinking difficult. This theme was elaborated by other participants:

When someone gets hold of something about you, and they can communicate it in a really straightforward way so that other people can also get that... Being able to do that can cause a lot of jealousy and rivalry as well (Participant 1)

Building on this, Participant 4 highlighted how the therapist's wish to offer understanding and be a helpful figure can be experienced by parents:

I think some therapists like to feel that they're the expert... Because if the... if the parent then leaves feeling deskilled and leaves feeling as though: 'gosh, you know,

this person, this person that just understood my child, so well. Why don't I understand them that way?'. It then can make the parent just feel really shit about themselves

(Participant 4)

Not only might such a response from the therapist limit parents' ability to understand their child, and hence meet their needs, but may lead to a situation where parents, consciously or unconsciously, respond in a destructive way towards the child and their therapy. In response, clinicians can, as Participant 4 above suggests, lean into their professional identity; however, this limits the chance to join up in thinking about the therapy:

if they [parents] feel that, you know, the, the therapist is speaking in jargon or, you know, sort of language they don't kind of understand it, and that there's, yeah, there's a sort of mis-attunement between the parents and the therapist. And you know, because I think then it can feel a bit opaque and, you know, like: 'we're doing this very special thing here'. And, and, you know, you can't understand it, or you're not part of it, and I think, they've got to believe in it. They've got to believe in the therapy

(Participant 2)

As Participant 2, above, says, it is central that the clinicians are able to convey the value of the therapy to the parents, which requires an awareness of parents' feelings about their child's therapy. Participants emphasised the importance of observing and adjusting their comments to what they feel the parents can tolerate:

I think it's a constant balance between offering lots of information, offering a little bit of information, offering the right type of information; being aware of what... what the parent can tolerate, and what the parent can't tolerate. Being aware of the rivalry,

being aware of... of the shame as well, and that they have come to CAMHS

(Participant 4)

Clinicians' understanding of reviews involves the recognition of a sound grasp of psychoanalytic theory, which can be translated and conveyed at reviews; but also an understanding of parents' state of mind when going into reviews. This is complicated by therapists' wish to provide meaning and understanding – to 'justify' the therapy – which, the participants indicate, may serve to further distance parents from the treatment while also heightening their feelings of anxiety, inadequacy, shame and guilt for their child.

4.5.2 The clinical couple models thinking and linking

The capacity to recognise and disentangle the emotional strands involved in review meetings is a challenging aspect of review meetings – especially so for the therapist, who has had limited exposure to the parents. However, by working in tandem, the parent worker can support the therapist due to their established relationship with the parents:

I think therapists have to be very careful when they talk to the parent... very sensitive when they talk to parents, and I think the parent workers can help them do that

(Participant 2)

Interviews raised how the parent worker supports the therapist in managing the complex interactions between parents and therapists in the review, as well as in communicating the process of psychotherapy:

To try to support that interaction between your colleague and the parents. And to add... because some concepts of psychotherapy also may be new for many parents, so

*when they come from your colleague, then it's... I think it's important for you to say:
'yes, what my colleague is saying, it is true. This happens in therapy for real'*

(Participant 5)

Yet, while the parent worker can facilitate a supportive environment for the parents and therapist, a functioning couple – in the form of the clinical couple – can provoke strong feelings in the parents:

I think the parent worker-therapist relationship is really important. And, erm, so, you know, how you come together. And to think about the child, you know, with the children we see, there's a difficulty with parents coming together to think about the child, so having an experience of that, for the child, and also for the parent, can be really therapeutic. And, erm, it can also be really complicated and lots of things can kind of, you know... There can be attempts to sort of – unconscious often – to sabotage that and to kind of break that relationship (Participant 2)

The capacity of the clinical couple to withstand such unconscious attacks, and hold onto the reason for meeting – to think about the child and the therapy – can have a profound effect on reviews. This function, which resembles Bion's concept of maternal reverie, allows for the projections from the parents, metabolises these, and returns them to the parents in a digested form, thereby allowing for them to be taken in and utilised. The value of this for the infant, in Bion's model, is a feeling of being understood and having one's feelings contained:

The working relationship between the therapist and the parent worker, and kind of... I dunno... Yeah, I think it is helpful for the parent to see that. This... there's a kind of good shared understanding. Yeah (Participant 3)

Across multiple interviews, the value of this ‘modelling’ potential of the clinical couple was stated:

[Colleagues’] respect for one another also models something, I think, for, you know, what would be helpful in thinking about the child [...] so, quite often, I will ask my colleagues: ‘so, what do you think?’, you know, in an ordinary way. But I suppose what you’re actually doing is modelling that sense of: ‘there can be different perspectives here. And all of them are relevant and interesting’ (Participant 6)

Here, the combination of the parent worker and therapist roles was felt to support the review meeting by introducing a third to the encounter that can triangulate the thoughts and experiences of those present at the review, and thereby contain anxieties and promote the integration of differences.

In the following section, I will discuss the themes and sub-themes presented above in light of the literature review and with reference to additional literature as this relates to the results.

5. Discussion

5.1 Introduction

This study set out to explore how child and adolescent psychoanalytic psychotherapists understand treatment review meetings within NHS Child and Adolescent Mental Health Services (CAMHS). Despite being a routine part of service provision – often scheduled termly or at agreed intervals – reviews have attracted little sustained theorisation within psychoanalytic literature. They are frequently mentioned in discussions of parent work (Rustin, 1999; Horne, 2000; Gourbin Riley & Avdi, 2024), yet rarely analysed as encounters in their own right.

The present study invited six ACP-registered psychotherapists to reflect on their experiences of review meetings. Using Reflexive Thematic Analysis (RTA), four themes were identified: (1) Tensions inherent in ‘bringing things together’; (2) Reviews as a site of ambivalence; (3) Feelings of exclusion and intrusion abound; and (4) ‘Being aware of what the parent can tolerate’. The discussion below follows the same thematic structure with reference to psychoanalytic theory, existing research and literature, and considering service context.

5.1.1 A welcome focus on reviews

Before presenting the thematic findings, it is important to note a striking feature of the interviews themselves: participants’ initial caution and uncertainty when asked to reflect on review meetings, followed by a marked engagement and interest in the topic as the interviews

progressed. Several participants acknowledged that they had not given much thought to reviews before, and expressed surprise at how stimulating the interviews were:

I haven't really thought about the topic very much. And there's a lot to think about. I think it's a really interesting area. I really do! (Participant 3)

Thank you. This was great. I never thought about reviews so much before (Participant 4)

Thank you. I think it's been... it's been actually very interesting to think about it [reviews] and you don't get to reflect about it, that much (Participant 5)

[laughs] I've never thought about reviews so much! That's interesting, isn't it, in itself, because we don't necessarily, kind of, like, think about it as a topic. We think about the individual reviews a lot (Participant 6)

Reviews are routine in CAMHS: every psychotherapist is familiar with them, and they occur with predictable regularity. Yet, at a reflective and theoretical level, they remain neglected. Participants' surprise at being asked to think about reviews as a phenomenon in their own right mirrors the scarcity of literature that foregrounds them, as well as the lack of focus on this encounter in child and adolescent psychoanalytic psychotherapy training (Rustin, 1999).

The historical caution of psychoanalysis towards parental involvement may explain this gap. Klein (1932) described dealings with parents as “one problem”, not strictly of a technical nature, but nonetheless a hindrance (Klein, 1932, p. 75) (see also Sherwin-White [2017] for a discussion of Klein's work with parents). She emphasised that parental jealousy, guilt, and rivalry could intrude into the analytic field, advising minimal theoretical

explanation and no disclosure of analytic detail to parents, preferring ‘ordinary psychological means’. Winnicott (1942) similarly advocated keeping psychoanalysis out of parental consultations, while Anna Freud reports the “uneasy” (Anna Freud, 1927, p. 11) feeling of having to meet with parents, who wield the power to grant or prevent their child’s analysis. Despite views articulated by Freud (1909) with Little Hans that prioritised engagement with parents, these early stances enshrined the primacy of the child’s inner world and the sanctity of the analytic setting, while relegating contact with parents to the periphery (Whitefield & Midgley, 2015).

Later authors, such as Rustin (1999), revised this understanding, describing reviews with parents as opportunities to sustain co-operation and integrate perspectives. In this sense, reviews can function to support the ‘working alliance’ (Greenson, 1965 [2008]; Bordin, 1979), which aims to separate the patient’s working attitude towards the treatment from their neurotic transference, and is hence viewed as necessary for the success of psychoanalytic treatment. However, with child and adolescent psychotherapy – which includes the patients’ parents or other adult figures – defining with whom an alliance is formed, or what sort of alliance is necessary, can be a complicated task (Shirk & Karver, 2011). As such, caution has persisted when it comes to conceptualising treatment reviews, which can be experienced as “difficult occasions” (Rustin, 1999, p. 217), with Slade (2008) noting that many therapists avoid writing about parent encounters altogether, finding them ‘messy’ and fraught. Such comments allude to therapists’ potential anxiety when approaching the subject of reviews.

Reviews involve multiple people and relationships; they can be unpredictable and infused with the anxieties of both parents and therapists. As such, they resist neat theoretical framing. In addition, as Goodman (2017) argues in her discussion of ‘childism’ in institutions, there has been a professional tendency to foreground the child at the expense of the parent,

resulting in a relative neglect of encounters – like review meetings – in which parents’ perspectives and anxieties can be expressed (see also Gourbin Riley & Avdi, 2024). The study participants’ recognition that they had ‘never thought about reviews so much’ suggests that reviews are an unexamined aspects of practice, taken for granted yet exerting significant emotional impact.

There are also organisational reasons for this historical neglect. As Moran and colleagues (Moran, Kelesidi, Guglani, Davidson & Ford, 2011) and Deakin et al. (Deakin, Gastaud & Tiellet Nunes, 2012) have observed, CAMHS services are increasingly pressured by outcome monitoring and efficiency measures. These can have implications for the child’s treatment and reviews, where “the need for immediate gratification, little reflective capacity of children and their parents and the search for quick and low cost treatment” can run counter to the psychoanalytic process (Deakins et al, 2012, p. 207). Reviews can thus risk being framed as administrative necessities rather than opportunities for psychoanalytic engagement. This ‘managerial’ framing may discourage clinicians from thinking of reviews as sites of complex, unconscious, processes (see also Norris, 2025).

The participants’ recognition of their own lack of reflection on reviews is therefore doubly significant. It confirms the paucity of literature on reviews, while also demonstrating that clinicians themselves have rarely paused (or been granted the opportunity to pause) to conceptualise them beyond the immediate demands of practice. At the same time, the energy and engagement that emerged by the end of the interviews indicate a latent appetite among clinicians to think about reviews as emotionally and theoretically meaningful encounters.

This finding lends weight to the argument that review meetings warrant study in their own right, rather than remaining in the margins of parent work. It also underscores the value of

psychoanalytic research methods in eliciting reflections on aspects of practice that are routine, unexamined and institutionally under-theorised.

5.2 Theme 1: Tensions inherent in ‘bringing things together’

Participants often began by describing review meetings in straightforward terms, as occasions when different perspectives were ‘brought together’. This accords with Rustin’s (1999) description of reviews as moments that sustain co-operation, bring information from the child’s wider life, and allow parents to test their confidence in therapy. At their best, such meetings “enrich the understanding of both parents and therapist” (Rustin, 1999, p. 217). However, participants also alluded to the quality of treatment reviews as at once integrative and destabilising, with the potential to unify multiple perspectives while simultaneously exposing divergence.

In this way, reviews resemble the unconscious dynamics at play in “Primitive anxieties and the small group: multi-agency working and the risk of collaboration” (Chuard, 2021). In this paper, Chuard reflects on how different perspectives can challenge professionals’ identity in a multi-agency group at an unconscious level:

[...] when there is limited capacity to tolerate and process individual differences amongst the membership, the small group arouses a deeply held primitive fear of psychological disintegration, which has echoes of early infantile experiences (Chuard, 2021, p. 30)

‘Bringing things together’ is rarely smooth, and it can be complicated at reviews by the multiple (and, at times, contradictory) perspectives adults hold of the same child. Rocco-

Briggs (2008) has highlighted this in her work with looked-after children, where foster carers, social workers and therapists frequently clashed in their depictions of the child's difficulties. These divergences can emerge in review meetings in concentrated form, with the therapist exposed to multiple, sometimes incompatible narratives. This recalls Bion's (1979) description of how the encounter of two minds produces an "emotional storm" (Bion, 1979, p. 136); reviews, with several minds, seem to intensify this storm, and 'bringing things together' involves sensitive navigation.

5.2.1 Tensions with the parent perspective

Parental perspectives of the child were vividly described by the interviewees, especially where these were experienced by therapists as an invitation to articulate and collude with a negative picture of the patient. Kenny, Hassett and Pae (2017), in their study "Exploring How Parents Make Sense of Change in Parent-Child Psychotherapy", found that parents' knowledge of their child can help to "shield parents from threats to their identity" (Kenny et al., 2017, p. 84), with the implication that modifying this knowledge in reviews requires sensitivity. Meanwhile, Novick and Novick (2005), discuss parents' priorities in the assessment phase before child psychotherapy, and conclude that:

They [parents] are appropriately motivated by a wish to protect their child, rather than to protect the analyst from criticism or judgment. In this situation, the analyst feels further exposed and vulnerable, prone to invoke his or her own defenses (Novick and Novick, 2005, p. 12)

The above examples suggest a mental relationship of parents with their child, which the present study's participants both recognised and respected. Yet they also indicate how

important parental ideas about the child are to their identity. When Novick and Novick (2005) refer to the “appropriately motivated wish to protect their child”, this may also be understood as a wish to protect a certain mental representation of their child.

Segal (1981) links omnipotent phantasy to the denial of need; whereas thought that is able to tolerate need can allow for external and internal realities, and hence free the individual to think, discern between external and internal realities, and enable experiences that are richer. Similarly, Britton (1992) suggests that new knowledge has the potential to disrupt and disturb the individual deeply, arouse their hostility, threaten their sense of security, reveal their ignorance and expose their helplessness. In experiencing tensions with the parent perspective, participants may be describing feelings associated with significant need; this can be so destabilising that parents cling onto a rigid adherence to a singular perception of the child, which may thus limit their capacity to allow for a new, modified, perception to emerge via the therapy. To mitigate this, the emotional conflict and anxiety associated with a threat to one’s identity – as appears in reviews, where differing perspectives vie for supremacy – must be contained so as to foster “growth in the capacity for emotionally engaged collaboration” (Chuard, 2021, p. 30).

Marks (2020) argues that many parents arrive at CAMHS after demoralising encounters with other professionals and can adopt entrenched defensive positions when engaging with their child’s psychotherapy, seeking validation rather than reflection. Bion, in “Attacks on linking” (1967a), writes:

The internal object which in its origin was an external breast that refused to introject, harbour, and so modify the baneful force of emotion, is felt, paradoxically, to intensify, relative to the strength of the ego, the emotions against which it initiates the attacks. These attacks on the linking function of emotion lead to an over-prominence

in the psychotic part of the personality of links which appear to be logical, almost mathematical, but never emotionally reasonable. Consequently the links surviving are perverse, cruel, and sterile (Bion, 1967a, p. 108)

Parents who may previously have had demoralising encounters with professionals may thus resist the new understanding offered by their child's psychotherapist. In reviews, this can result in therapists feeling pressured into echoing parents' assessments of the child, or lead to a professional "sense of demoralisation about the prospects of fruitful engagement" (Marks, 2020, p. 21). Within the therapist, this may generate what Jacobs (2015) calls 'parentism', which positions the "rescuing and expert therapist, who knows what is best for the child versus the neglectful, destructive, or narcissistically competitive parent" (Jacobs, 2015).

The interviews suggest such fixed positions can be recognised in the use of therapists' language – for example, in an emphasis on safeguarding – which can further entrench identities and split functions. While such an approach may defend against the perception of parental omnipotence in the treatment review situation, it also dampens emotional contact similar to the way that interpretations and their use defensively can protect against the patient's hostile impulses (Strachey, 1934).

5.2.2 Tensions within the clinical couple

The clinical couple – the child's therapist and the parent worker – with its potential for containment and conflict, proved to be a further area of tension in treatment review meetings. As with 'Tensions with the parent perspective', the interviews highlighted a divergence in perspectives based on the roles and identities each clinician brings to the review: the therapist with the child's inner world, the parent worker with the parental reality.

Sutton and Hughes (2005) note that clinical couple is a “particular relationship” (Sutton & Hughes, 2005, p. 173), akin to parents who manage their differences and “operate in complementary ways to act as a couple caring for their child” (Sutton & Hughes, 2005, p. 174). However, this capacity can be fluctuate on a case-by-case basis, with one participant voicing their frustration at a parent worker who ‘didn’t get the parent’, highlighting how divergence in perspective and understanding of a shared case can influence reviews, and unconsciously influence professionals and their interactions (Emanuel, 2002a). This dynamic, as it relates to treatment reviews, did not appear in the literature; however, Feldman (1989) has described the parental couple as a focus of both creative identification and destructive envy. The therapist’s perception of the clinical couple, as experienced in the treatment review, can thus depend upon them broadening their identity to incorporate the shared clinical couple role. The difficulty of this integrating task may account, in part, for the challenges participants reported in arranging contact between colleagues prior to reviews. This requires a modification, as opposed to evasion (Bion, 1967b), of identity, which can be attempted with reference to clinicians’ shared psychoanalytic language and training (Calvocoressi and Ludlam, 2008). In this sense, as emerged in the interview data, reviews can act as a useful tool to ensure that contact between clinicians takes place.

5.2.3 Goals as a way of smoothing over complexity

In response to the tension and concomitant tendency towards splitting in treatment review meetings, goals emerged as a way to smooth over complexity and measure progress in child psychotherapy. Bordin (1979) proposes that the therapist and patient agreeing upon goals – as well as setting tasks and building an emotional bond – is a significant contributing factor in strengthening the therapeutic working alliance (Bordin, 1979). The interview data partially

supports this, suggesting that psychotherapists view goals as offering a structure for reviews over time and for assessing change. Yet, goals can also be experienced by therapists as an imposition on parents. The interviews suggested that the use of goals introduces a tension between change that is alive and progress that can be measured; a tension that therapists are required to mediate in treatment reviews. In terms of the anxiety generated in reviews, psychotherapists may – like the infant who splits experiences into ‘good’ from ‘bad’ as a way to make sense of sensory experience (Laplanche & Pontalis, 1988) – hope that goals can smooth over the potential for tension between competing perspectives in reviews by applying measures that distinguish ‘good’ from ‘bad’, and ‘progress’ from ‘regression’. Yet, the interviews suggested a parental reluctance to engage with goals, which may indicate a wish for a less neat, but more authentic, contact. This is supported by Deakin et al. (2012), in their paper on drop-out rates for child psychotherapy, who found no evidence linking the non-attainment of goals to early termination of treatment, and instead suggest that goals may be better suited to more structured treatment types, such as CBT. Meanwhile, in their study of parents’ and carers’ experience of routine outcome measures in CAMHS, Moran et al. (2011) show that parents prefer a space that allows for ‘open answers’ and comments as opposed to tick box approaches to measuring progress (Moran et al. 2011). These findings suggest that goals and assessment measures are of less importance than the mental approach towards reviews, which:

[...] requires the development of a spirit of enquiry and conditions which provide the security necessary for learning from experience, especially containing anxiety, both organizational and personal (Obholzer, 1994, p. 204)

Urwin’s (2007, 2009, 2011) Hopes and Expectations for Treatment Approach (HETA) offers an alternative method of assessing change in psychotherapy; one that focuses on

parents' and therapists' hopes rather than on rigid goals. Urwin (2007) reports that when goals are used in reviews as a desired end-point, they can "get in the way of thinking about relative progress or difficulties in the present" (Urwin, 2007, p. 139). Among the features of the HETA is the re-framing of goals to articulate hopes, such as wishing for 'less obsessional' play or for a child to be 'generally happier'. When framed as hopes, goals may thus preserve flexibility and enable a way to assess change in psychotherapy.

5.2.4 A shared picture of the child

Participants agreed that reviews are most effective when parents recognise their child in the therapist's account, and the patient (and the treatment) can be brought to life. Mees (2017), in her discussion of the feedback sessions to parents as part of child psychotherapy assessments and state of mind assessments, suggests that both a shared and positive picture of the child, or an appreciation of the parents' parenting, can allow parents to take in and integrate more of what the clinicians offer. This idea was echoed by the study participants. Similarly, Bartram (2003), in one of her case studies, describes parental relief when the therapist's observations matched that of her patient's mother during a review meeting, validating her struggles while also enabling space for new meaning to emerge. Thus, as Bion (1967b) writes:

a sense of truth is experienced if the view of an object which is hated can be conjoined to a view of the same object when it is loved, and the conjunction confirms that the object experienced by different emotions is the same object. A correlation is established (Bion, 1967b, p. 119)

Thus, a shared picture that incorporates parents' perspectives can reduce persecutory anxieties, while allowing for a depressive and mature integration of alternative ideas about their child (Klein, 1958). Approaching this – and treatment reviews – from an alternative theoretical position, Winnicott (1971) suggests 'potential space', a liminal zone between the baby and the mother, or the patient and the therapist. Here, over time, the mother/therapist adapts to the changing needs of the baby/patient in such a way that that the space between the two can incorporate both the individual's needs and external reality; where "the patient cannot become autonomous except in conjunction with the therapist's readiness to let go" (Winnicott, 1971, p. 107). Seen in this light, treatment reviews, which occupy a similar liminal zone and occur at intervals over time, can, with adaptations by the therapist, enable a shared picture of the child patient to develop that represents both parent and therapist perspectives.

5.3 Theme 2: Reviews as a site of ambivalence

Ambivalence emerged as one of the most striking features of participants' accounts of treatment review meetings. Reviews were presented as a mixture of hopes and fears for parents, children and therapists alike, with the data presenting them as opportunities for connection, but also as encounters that disrupted the on-going child's therapy and were coloured by a wish for avoidance.

5.3.1 The parents' ambivalence

Parental ambivalence was palpable in participants' descriptions of reviews, which highlighted 'mixed feelings' – the wish to know about their child's therapy, coupled with an anxiety at what they may discover. This ambivalence, as experienced by therapists, touches upon the range of feelings engendered by meeting the child's therapist and addressing parents' hopes for their child. Thus, therapists were alive to parents' wish for help as well as a potential fear of humiliation. Mees (2017) lists some of responses to hearing from their child's therapist, including: hope; frustration; interest; fear of criticism, guilt, suspicion or anxiety; recognition; reassurance (Mees, 2017, p. 386). Marks (2020) suggests that parents' ambivalence may also be rooted in long histories of 'perfunctory' encounters with professionals. In a similar vein:

Parents themselves have mixed feelings about their primacy with their children, wanting to repudiate how important they are to avoid guilt and simultaneously fiercely protecting their exclusive position as central in their children's lives (Novick and Novick, 2005, p. 6)

Such conflicting feelings can be especially powerful in review situations, where parents grapple with the question of parenting:

Somewhere in every parent still exist the little girl and boy who are convinced that they can never become a proper mother or father. When things go wrong, this little girl in the mother feels found out and projects upon the therapist her super-ego picture of her own internal mother who is going to blame her and take the child away because of her presumption and bad management (Harris, 1968, p. 53)

Thus, when approaching reviews, participants raised the question of whether parents may unconsciously fear that such overwhelming feelings cannot be contained or fruitfully

mobilised, and will be turned against them. The interviews suggested that such an overwhelming array of feelings in parents can engender massive and excessive projection, which touches upon primitive anxieties reminiscent of the paranoid-schizoid position. As such, reviews may be conceptualised as part-object encounters, where the therapist is perceived as all critical. With little hope of an integrated and containing encounter, the parental response of ambivalence – as it was presented in the interview data – points towards a parental anxiety of projections being returned, unmodified, with the result that encounters are consciously welcomed, but unconsciously feared.

5.3.2 The child's ambivalence

Although children were seldom present in reviews, their ambivalence was vividly reported by participants. For some children, reviews signified judgment and danger. Klein, in “Narrative of a Child Analysis” (1961), alludes to the persecutory feelings aroused in the child when the parent-therapist relationship is acknowledged. This is explored by Lynda Miller (1997), where, prior to a review, her 11-year old patient fears that mother and therapist will join together in “poisonous complaints against her” (Miller, 1997, p. 94; see also Bartram [2008]). The interviews raised the idea of the child's anxieties and persecutory fears about reviews and the potential impact of these on the therapist; where projections are unconsciously absorbed by the therapist, who may collude with them by failing to address reviews in sessions.

This not only has implications for the therapist's ability to recognise the reality of reviews with the child, but also for the account of the therapy that the therapist gives the parent. Reviews offer therapists the opportunity to address and contain this ambivalence if it can be

acknowledged rather than denied, and potentially be used to inform the child's therapy, thereby facilitating a shift in treatment, via reviews, from a persecutory and humiliating super-ego, to one that is more depressive and mature (Steiner, 2008).

The benefits of reviews for children were also acknowledged by the interview participants, where the experience of therapists and parents talking can be of therapeutic help to the child. This aligns with Freud's (1923) concept of 'reality testing', and presents reviews as allowing for the reality of a therapist-parent encounter that can be experienced without catastrophe and thus reduce persecutory fears. Furthermore, treatment reviews occur at intervals over time and come to form part of a series of review experiences, each one building upon the relationships formed and perspectives exchanged during previous reviews. In this respect, reviews can become more familiar and less fraught, demonstrating how repetition can foster integration, while offering a "potentially protective connection between the therapist and other important figures in his world" (Crockatt, 2009, pp. 106-7) that can ultimately benefit the child, their parents and the treatment.

5.3.3 The therapist's ambivalence

Therapists, too, expressed ambivalence about treatment reviews, with an understanding of reviews that oscillated between a reluctance to engage with them and a recognition of their value; of reviews as disruptive to the routine of the therapy, but also an invaluable chance to gain a new perspectives of the patient. Such ideas emerged especially in relation to the practicalities of arranging reviews, as well as therapists' feelings of being assessed and needing to perform in review meetings. Such examples recall Sedlak's (2019) ideas on the analyst's super-ego and blind spots. In this context, parental scrutiny appears to activate fears

around inadequacy among psychotherapists, which can be defended against through avoidant measures, such as difficulties in arranging reviews, or difficulties in connecting with the colleague. Brenman Pick (1985) describes how therapists can defend against such anxieties with excessive sympathy towards patients and criticism of others, or vice-versa. However, by working through their own ambivalence of wanting to know and not wanting to know, psychotherapists are well-placed to contain others' ambivalence (Brenman Pick, 1985).

Encountering and exploring such ambivalence is often the work of therapists' personal analysis. As Harris (1968) suggests:

It is important for us as therapists to gain, through our own analysis, enough insight into our own motives, to be in touch with the part of ourselves that does tend to compete with the mother and may unconsciously want to take the child away (Harris, 1968, p. 53)

By conceiving of the treatment review meeting in psychoanalytic terms, and as a psychoanalytic encounter, space can be opened up for psychotherapists to face ambivalence and the anxiety it produces, thereby enabling a more mature, depressive, integration of understanding during the encounter.

5.4 Theme 3: Feelings of exclusion and intrusion abound

Exclusion and intrusion were experienced by participants as two sides of the same coin. Interviews pointed towards parents' feelings of exclusion from their child's therapy, while therapists described feeling intruded upon by parents' significant worries about their child, as well as by their persecutory anxieties, criticisms, and what were perceived as demands for

access to their child's psychotherapy. Adolescents' involvement complicated this dynamic further, while the presence of the parent worker was seen as crucial in mediating this theme.

5.4.1 The therapist as gatekeeper

The data suggest that therapists view parents as feeling frequently cut off from the therapeutic process. The child's sessions are confidential, and participants indicated the need for consideration when deciding what to disclose to parents. This dilemma has a long history in child psychotherapy. Writing of the early stages in the development of child psychotherapy, Ann Horne (2000) suggests that parents' minimal contact with the therapist during the child's treatment may have felt both "condemning and excluding" (Horne, 2000, p. 53) and parents may envy the therapist's role as a rival that takes something away from them. Bartram (2008) reflects on how, in her work with an adopted child, Molly, the positive relationship between child and therapist may, unconsciously, have been experienced by the carer as coming at the expense of the carer-child relationship.

Britton's (1989) concept of the 'third position' helps to conceptualise this exclusion. In the oedipal triangle, the excluded third inevitably experiences feelings of envy, jealousy and persecution. Parents may unconsciously cast themselves in this position vis-à-vis the therapist-child dyad, leading to fantasies of collusion and secrecy (Gvion & Bar, 2014). Horne (2000) notes that parents may envy not just the therapist, but the therapy itself, as if treatment were 'stealing' away their role, or that the child is receiving something which is not granted to the parents.

Such exclusionary feelings extend beyond treatment reviews. Jacobs (2015) argues that psychoanalytic psychotherapy with children has often engaged in 'parentism', a bias towards

framing parents as deficient while idealising therapists as superior caregivers. This legacy, she suggests, has marginalised parents' voices and reinforced their sense of exclusion. It also resonates with Marks' (2020) view of 'perfunctory' encounters with parents, which can lead to a "sense of demoralisation" when faced with parents "who appear angry, inflexible, enmeshed with the child, envious or avoidant" (Marks, 2020, p. 21). Goodman (2017), drawing on the concept of 'childism' (see Young-Bruehl, 2011), argues that clinical culture can privilege the child's internal world and therapy while neglecting the relationship with the actual parents. Reviews, which seek to broaden the understanding about the child, can therefore become sites where exclusion is most acutely felt.

5.4.2 Adolescents and the need for reviews

Therapists experienced reviews with adolescents as a destabilising factor in reviews, and work with adolescents was felt to negate the need for a review meeting with the parents. In the UK, adolescents over the age of 16 who are deemed, based on their emotional maturity, to have 'capacity', can opt to receive treatment without parental involvement (Cregeen et al., 2017). Participants explained this as respecting the adolescent's development and independence from their parents. Yet they also reported finding the presence of adolescents in reviews confounding, adding the complexity of the therapist-patient dynamic to that of the therapist-parent and the therapist-parent worker.

Such experiences resonate with Harper et al. (Harper, Dickinson & Bramwell, 2013), who found that when adolescents and parents were seen together, both parties tended to censor themselves, reducing openness. Coyne et al. (2015) similarly report that parents and

adolescents at joint review meetings felt inhibited when they were seen together, especially in terms of confidentiality and privacy, which lessened communication.

5.4.3 Confidentiality

Klein (1932) was uncompromising in her commitment to the child's confidentiality, stating: "The child who gives me its confidence has no less claim to my discretion than the adult" (Klein, 1932, p. 76). However, it is recognised that such an approach in reviews could feel "both condemning and excluding of parents" (Horne, 2000, p. 53). Managing the question of confidentiality in reviews was understood by therapists as being related to the dynamic of exclusion and intrusion, where the parents' wish for information about the child's therapy could lead to a betrayal of the patient's confidentiality. Lanyado and Horne (1999) comment on the importance of flexibility when deciding what is helpful to communicate from the child's therapy to the outside world, and the child's need for confidentiality. However, in discussing the child's confidentiality, Daws (1986) asks:

how is a responsible parent to evaluate what goes on between a professional and their child, when the professional insists on working in privacy and confidentiality that excludes the parent? (Daws, 1986, p. 103)

The results of this study appear to suggest that this remains a relevant question for child psychotherapy in general, but which is brought into stark relief during treatment reviews. Cant (2005), writing of her work in a therapeutic community, described how child psychotherapists might have to adjust their approach to confidentiality, so as to engage more with the child's external realities:

We have to bring the child ‘alive’ in the mind and imagination of others. This requires our own passion for the work and the child’s struggle, but also, sometimes, more intimate and illuminating details from the therapy that will aid understanding, and convey meaning. Thus the child ‘comes to life’ in the network, and can be thought about more clearly, and with a greater depth and understanding (Cant, 2005, p. 22)

As touched upon in Theme 1 (Tensions inherent in ‘bringing things together’), the capacity of the therapist to bring the therapy alive for the parents and present a recognisable picture of the child is central to reviews. Finding a balance between parental curiosity and maintaining the child’s confidentiality is thus a central task of the therapist in the review as they seek to make the child’s development more present in the minds of parents.

The results, however, suggest other ideas around confidentiality, with participants providing vivid examples of what fears may lie behind parents’ request for details from the therapy, especially in terms of what the clinicians are seeing, discussing and concluding behind ‘closed doors’. Therapists’ understanding of such anxieties thus broadens the question of confidentiality to include parental feelings associated with a judging and punitive super-ego, and attempts by the therapist to maintain the frame and confidentiality as potentially fuelling these feelings. Such anxieties touch upon parents’ unconscious ambivalence toward their child’s therapist and their resistances towards exposing themselves to their child’s therapist (Klein, 1932), as well as potentially reinforcing a “sense of failure and incompetence, and their dread of being despised and humiliated by those felt to be more successful at being grown-up” (Rustin, 1999, p. 216).

5.4.4 The parent worker’s function in reviews

Participants consistently highlighted the importance of the parent worker in mediating these tensions. The child's therapist in treatment reviews can feel buffeted by the feelings of exclusion and intrusion, and how these can coalesce around the question of confidentiality. At their best, the parent worker helps to model collaborative thought that counters a "one-person focus nurtured in child therapists [of] powerful rescue fantasies and less empathy for parents" (Novick & Novick, 2005). Similarly, ensuring a dedicated parent worker and child therapist avoids what Ann Horne (2000) calls the 'split transference', namely the complex transference responses coming from the parents and from the child, while containing tensions arising from parents' difficulties with their child (Dowling, 2019), and "presenting the reality of that person, alongside them, occupying a particular role with prescribed boundaries in their child's life" (Sutton & Hughes, 2005, pp. 180-181)

The results suggest that psychotherapists consider the parent worker as a mediator in reviews, containing parents' anxieties and protecting the child's therapist, who can take "more of a back seat" (Dowling, 2019, p. 89). Sutton and Hughes (2005) frame the parent worker's task as attending to three questions: "what is useful for the child, what is useful and possible for the parents and what is possible for the therapist?" (Sutton & Hughes, 2005, p. 143). This idea of an 'in charge', paternal, parent worker figure finds support in the literature. Whitefield and Midgley's (2015) research on the use of parents' histories in parent work found that younger parent workers more often received childish or unwanted aspects of the parents, who viewed and competed with them more as siblings than as professionals.

Yet, boundaries between the therapist and parent worker were also discussed by participants. These included questions about how much information to share between colleagues. Discussions with a parent worker outside of the review can, as Cregeen and colleagues (2017) suggest, function as a form of peer-supervision. However, when too much

information is shared, it can “become lodged in the clinicians’ minds and get in the way of their unprejudiced emotional availability in subsequent sessions” (Cregeen et al., 2017, p. 141), and thereby hinder the therapeutic work.

5.5 Theme 4: ‘Being aware of what the parent can tolerate’

A final theme concerned therapists’ sensitivity to conveying their understanding of the child and the therapy to parents. Reviews were described as encounters requiring careful calibration, where the quality of the communication risked overwhelming or humiliating parents, or leaving them excluded and resentful, with implications for how therapists experienced reviews. The clinical couple was seen as both protective and potentially provocative, embodying containment yet also inviting envy and attack.

5.5.1 Difficulties in conveying the therapy

Conveying an understanding of the child that has been acquired through psychotherapy is a delicate task, and one which can weigh heavily upon therapists. Complications were highlighted by participants as relating to psychotherapy not following a linear path towards progress. Clinicians were aware of this as an expectation among parents (Miller, 2004), and that temporary setbacks within psychotherapy can be seen as confirmation that progress is “illusory” (Klauber, 1998, p. 95). Such ideas may be framed in reviews as parents’ disappointment in, and frustration with, the therapy, and, by proxy, the therapist. Such ideas can challenge therapists and result in a defensive use of their professional identity.

With reference to Sedlak's (2019) discussion of the super-ego and the analyst's blind spots, exposure to parents' unvarnished curiosity may encourage therapists to respond with their own unvarnished assessment. Similarly, therapists' emotional response to what they perceive as parental frustration, criticism and judgment, can 'mate' with their own self-criticism, leaving them "at the mercy of an analytic superego" (Brenman Pick, 1985, p. 20) and therefore prone to seek refuge in their analytic superiority (Sedlak, 2019).

Such a response was, however, felt to risk heightening feelings of inadequacy among parents – Participant 4 felt that it could leave parents feeling 'deskilled' – while also provoking envy of the therapist's capacity to contain and express their difficulties. As Bion (1967a) writes in "Attacks on Linking":

Should the breast be felt as fundamentally understanding, it has been transformed by the infant's envy and hate into an object whose devouring greed has as its aim the introjection of the infant's projective identifications in order to destroy them. This can show in the patient's belief that the analyst strives, by understanding the patient, to drive him insane. The result is an object which, when installed in the patient, exercises the function of a severe and ego-destructive superego (Bion, 1967a, p. 107)

In such a way, super-ego forces abound in treatment reviews; curiosity and interest, good intentions and understanding, can be imbued with harsh and persecutory feelings and chastisement. In mitigating this, the literature on treatment reviews advise against 'bringing in' psychoanalysis, with Odhammar and colleagues (Odhammar, Goodman & Carlberg, 2019) proposing 'meta-competences' for psychotherapist, among which is the capacity to eschew interpretations in favour comments relating to the child's affect regulation and current emotional and relational concerns. However, such an approach may also be seen as avoiding the rawness of the encounter with parents, and may miss the opportunity to develop

an emotional connection with them and thereby strengthen the therapeutic alliance, as argued by Sutton and Hughes (2005), who present the benefits of well-judged transference interpretations in reviews with parents.

Another route is that proposed by Harris and Carr (1966), who counsel therapists to express:

a genuine interest, conveyed without any claim to ‘magical expertise’, [which] can aid in restoring the parents’ own creativity, putting them back in touch with their own unique knowledge of themselves and their child (Harris and Carr, 1966, p. 289)

Achieving this may be difficult for individual therapists, who can appear to parents to be “omnipotently coping with both them and their child while they struggle to cope with each” (Sutton & Hughes, 2005, p. 180), with study participants emphasising the supportive presence of two clinicians at treatment reviews.

5.5.2 The clinical couple models thinking and linking

The presence of the clinical couple was a central component in therapists’ understanding of reviews, especially in terms of exploring counter-transferential feelings. Reflecting on their roles as both the therapist and the parent worker in a shared psychotherapy case, Calvocoressi and Ludlam (2008) write:

Our joint work and shared reflection helped us in particular to make sense of the way in which anxieties were being processed separately, by the child and by his parents. Our common psychotherapeutic language and training greatly facilitated joint

thinking and the processing of our experience – our ‘countertransference’

(Calvocoressi and Ludlam, 2008, p. 187)

Papadima and colleagues (Papadima et al., 2024) identify three benefits of two clinicians working jointly: containment is enabled; better understanding to help “identify blind spots” (considering the tendency for splitting that can occur when there is heightened emotion) and; avoiding over-identification with either the patient or the parents, and thus enabling a ‘balanced perspective’ (Papadima et al, 2024, p. 481). Sutton and Hughes (2005) similarly observe that concurrent counter-transference experiences, when shared, support the clinical couple’s understanding. Meanwhile, Altman (2004), commenting on the NHS model of two clinicians working together, suggests that: “the emotional containing capacity of the therapeutic team is considerably greater than the containing capacity of an isolated child therapist” (Altman, 2004, p. 204). Calvocoressi and Ludlam (2008) also stress the value of joint work, likening the professional’s relationship to the parental couple (Calvocoressi & Ludlam, 2008). Yet:

For child and parents, the experience of a couple [here: the parent worker and child’s therapist] who can work creatively together on their behalf can be of inestimable benefit. Further, the fantasies that may emerge about the nature of this couple relationship can open invaluable windows into the work, much as in conjoint couple therapy (Sutton & Hughes, 2005, pp. 180-181)

Participants also recognised the vulnerability of the couple. Participant 2 described unconscious attempts by parents to ‘sabotage’ the parent worker-therapists relationship. Such attempts can be related to Bion’s (1967a) “Attacks on Linking”, which Feldman (1989) builds upon, stating:

The understanding of the way the infant's envy becomes aroused by the parental couple, with a violent and disruptive projection into the couple in order to separate them or make them sterile, has illuminated many of the pathological versions of the oedipal situation with which we are confronted in our patients (Feldman, 1989, p. 126).

This places the review encounter in an oedipal configuration. Participants addressed this from the perspective of the parents, yet clinicians' own internal parental couple, and their potential identification "with the excluded party, with the consequent pain, envy and jealousy" (Feldman, 1989, p. 126) this entails, may also influence their capacity to make use of the relationship with their colleague. By withstanding external and internal envy and rivalry, the clinical couple models resilience and the possibility of creative intercourse that allows parents to observe themselves and their child from different perspectives, with the result that they can internalise a benign, and functioning, parental couple (Emanuel, 2002b; Rustin, 2016).

5.6 Strengths, limitations and implications and future research

5.6.1 Strengths

This study has found that treatment review meetings between child and adolescent psychotherapists and their patients' parents are emotionally rich encounters that benefit from a psychoanalytic understanding that can acknowledge and contain anxieties, and thus support patients' psychotherapy. A key strength of this study lies in its originality. To date, no research has explicitly explored how child and adolescent psychoanalytic psychotherapists understand treatment review meetings within NHS Child and Adolescent Mental Health

Services (CAMHS). While reviews are a routine feature of clinical practice, they have attracted little systematic inquiry or theoretical attention. This study therefore suggests an important avenue in the literature by focusing on an under-examined, yet emotionally and organisationally charged, encounter. It contributes to the small but growing body of psychoanalytic research that examines institutional settings, multidisciplinary relationships and inter-subjective processes beyond the consulting room (see Rustin, 1999; Emanuel, 2002a; Sutton & Hughes, 2005; Marks, 2020).

Another strength concerns the study's methodological coherence. Reflexive Thematic Analysis (RTA; Braun & Clarke, 2006, 2018, 2019, 2022) was selected as a method congruent with the psychoanalytic epistemology underpinning the research. RTA's flexibility allows for the integration of subjectivity, emotional insight and theoretical sensitivity – features that compliment psychoanalytic work. Alignment between methodology and epistemology – between a psychoanalytic understanding of unconscious meaning and RTA's emphasis on researcher reflexivity – provides the study with strong internal consistency. My clinical identity as a trainee child psychotherapist has not been treated as a bias to be eliminated, but incorporated as a means of gaining insight that is consistent with both psychoanalytic and qualitative traditions (Carlberg, 2010; Hollway & Jefferson, 2013).

The study's sample and data depth are further strengths. Six ACP-registered child and adolescent psychotherapists participated, all with post-qualification experience within NHS CAMHS teams. This ensured an appropriate level of clinical expertise and familiarity with treatment review meetings as practised in CAMHS settings. Each semi-structured interview allowed participants to explore their experiences and associations of reviews, resulting in engaged and emotionally alive data that allowed for the development of this study's four themes.

My dual identity – as a trainee and researcher – was explicitly considered, recognising the co-constructed nature of qualitative data (Hollway & Jefferson, 2013; Braun & Clarke, 2022). This awareness – encompassing my interest in treatment reviews, as well as my anxieties around evaluation and the wish to ‘get it right’ – allowed an analysis of the data that was grounded in experience and learning from experience, and allowed me to operationalise psychoanalytic concepts such as transference and countertransference in conducting this research.

Finally, the clarity of thematic structure – Tensions inherent in ‘bringing things together’; Reviews as a site of ambivalence; Feelings of exclusion and intrusion abound; and ‘Being aware of what the parent can tolerate’ – offers a conceptual framework that clinicians and researchers can build upon. These themes capture the emotional and relational meanings present in treatment review meetings and offer a language to describe an experience that had previously remained tacit or unarticulated in psychoanalytic training and supervision.

5.6.2 Limitations

Despite these strengths, this study has notable limitations, both methodological and conceptual. Although falling within the recommended sample size for a professional doctorate of 6-15 participants (Terry, Hayfield, Clarke & Braun, 2016), the sample size of six participants is modest. While this enabled the study’s depth, it limited breadth and transferability. In addition, participants were all based in two inner-city CAMHS teams with a result that the data may reflect the culture, ethos and supervision models of those specific services. Psychotherapists working in different geographical regions, in independent practice, or with a greater multidisciplinary influence may express different understandings of

treatment reviews. A wider range of voices – including those of non-psychoanalytically trained clinicians – could reveal alternative or complementary perspectives.

Second, participants were self-selecting, and hence may have been more reflective, confident, or positively disposed towards research. Clinicians with alternative experiences – who may feel more anxious or ambivalent towards reviews, or about being interviewed by a colleague/researcher – may have declined to participate. This self-selection could have skewed the sample toward those with clearer positions on reviews, thereby under-representing alternative perspectives.

Third, my researcher position brings potential blind spots. As a trainee within the same professional community, I was both an insider and outsider, which may have entailed potential blind spots. While my dual position enabled deeper engagement with the subject of treatment reviews, this may have involved some degree of identification with participants or with a shared theoretical background – e.g. a shared understanding of terms such as transference, containment, projection, therapeutic alliance, etc. While reflexive journaling and supervision mitigated some of these risks, some themes may have been unconsciously avoided or muted, particularly around power, evaluation or my trainee status. For example, participants' accounts of guilt, scrutiny and anxiety around feeling judged in reviews may have resonated with my own training experiences, thereby influencing the tone of interpretation.

Finally, the theoretical orientation of this study has been primarily classical and post-Kleinian concepts (Freud, Klein, Bion, Joseph, Britton, Rustin). While this is necessary for conceptual cohesion, it means that less attention was given to other psychoanalytic traditions (e.g., Freudian, Independent) that might conceptualise reviews differently. In this context, Winnicott's (1971) formulation of transitional phenomena and 'potential space' between the

individual and the environment may offer an alternative basis from which to conceptualise review meetings. Moreover, while the study engaged with psychoanalytic ideas about the super-ego, triangulation and the parental couple, it did not examine factors such as class, race, gender, sexuality which will also influence the dynamics of review meetings in NHS contexts – from both a clinician and parent perspective, but also in the interaction between both clinician and parent identities.

In summary, this study's limitations derive mainly from its small, homogeneous sample, my position as a trainee/researcher and the omission of demographic information. However, these boundaries were consciously acknowledged to ensure the study's coherence and scope, and suggest gaps that future research can address.

5.6.3 Implications and future research

This study opens multiple avenues for further inquiry into treatment review meetings as complex, emotionally charged institutional encounters.

Exploring alternative perspectives

Future research into the experience of parents, carers and children and young people of treatment reviews would complement the present study on therapists' understanding of reviews. Exploring these perspectives could reveal discrepancies between psychotherapists' and families' experiences, shedding light on the therapeutic alliance. Such studies might use narrative interviews, focus groups, or mixed-method designs to engage with service users emotional experiences and needs.

Comparative and cross-disciplinary studies

It would be valuable to compare how treatment reviews are understood across different professional disciplines within CAMHS – psychologists, psychiatrists, family therapists, nurses. This could illuminate how psychoanalytic theory and language interact with alternative approaches, e.g. systemic therapy, CBT or medical models. Comparative work might also examine settings outside the NHS, including at schools, charities or private practice, where review structures differ.

An organisational and institutional focus

Building on Emanuel (2002a) and Chuard (2021), future research could explore how institutional dynamics and organisational anxieties shape review meetings and vice-versa. Psychoanalytic ideas that engage with this field (e.g., Menzies, 1960; Obholzer & Zagier Roberts, 1994; Hinshelwood & Skogstad, 2000) could be applied to investigate how institutional defences manifest in review practices – e.g. splitting between clinical and managerial aims, or how ideas around ‘failure’ are projected into review procedures.

Training and supervision

The findings highlight a notable gap in psychoanalytic training regarding treatment reviews. Reviews are often presented as practical necessities rather than as opportunities for psychoanalytic reflection. Further research could examine how training institutions, supervisors and clinical seminars address this topic, and how trainees learn to identify and tolerate the anxieties reviews evoke. Studies might explore how supervision models could incorporate discussion of review experiences, mirroring this study’s own reflexive stance.

The clinical couple and its containing function

Another promising direction for future research is the clinical couple of the child's therapist and parent worker. The study suggests that this professional pair functions as a symbolic parental couple, capable of modelling thinking and containment, but also vulnerable to envy, rivalry and splitting. Future research could use observation or joint interviews to examine how such clinical couples negotiate differences and sustain collaboration under institutional pressure. Longitudinal designs could track how these relationships evolve over time, or throughout the course of a single shared case.

Addressing diversity and cultural context

Future studies could investigate how treatment reviews are influenced by factors such as ethnicity, migration, class or gender – within families and among clinicians. Exploring cultural variations in parental expectations, authority and emotional expression might reveal how unconscious dynamics overlap with broader social narratives. This would extend the relevance of psychoanalytic ideas to contemporary multicultural NHS practice.

6. Conclusion

The present study demonstrates that treatment review meetings, though often regarded as routine and procedural necessities, are in fact rich with unconscious meaning. A Reflexive Thematic Analysis of semi-structured interviews conducted with six CAMHS child psychotherapists indicates that review meetings have the power to stir up primitive anxieties around scrutiny, exclusion, rivalry and judgment among all parties. Reviews test therapists' capacities to both hold on to and, where appropriate, adapt their perspective of their patients. This takes place within a dynamic encounter where therapists can feel challenged and their professional identity threatened by the level of parental concern and need.

Therapists can defend against the anxieties and challenges faced in the context of treatment review meetings in a variety of ways, including: a retreat into a rigid professional identity; with reference to the administrative necessity of the review encounter; and through an adherence to goals and measures that reduce the emotional impact of psychotherapy. However, the review encounter is made all the more fraught if psychotherapists are not invited to consider it through the lens of their psychoanalytic training and their own personal experience of psychoanalysis.

By acknowledging the potential of reviews to generate powerful feelings from which they themselves are not immune, psychotherapists have licence to think about and contain these feelings. This is supported by the collaborative aspect of the encounter, where two clinicians model an integrated and thoughtful approach towards the child's therapy and the feelings it engenders in the parents. In such a way, this study shows that treatment review meetings can foster shared understanding and welcome alternative ways of thinking, and so generate new thoughts, ideas and growth.

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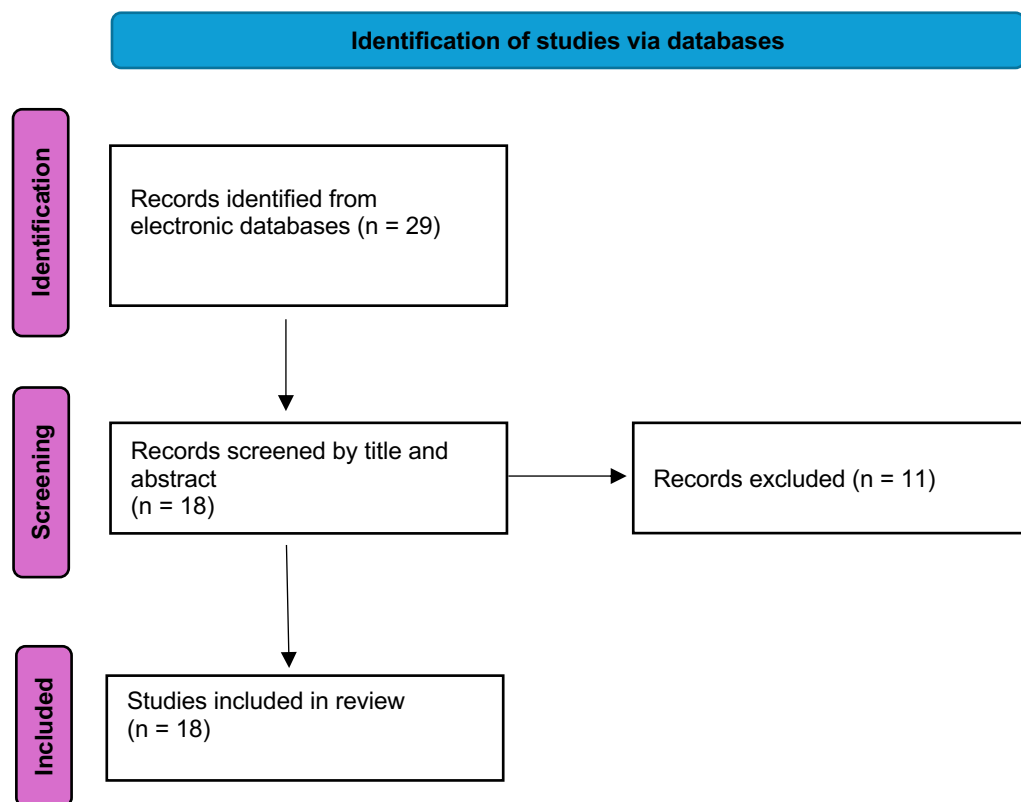
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Appendices

Appendix 1: PRISMA 2020 flow diagram

Search and selection strategy for the identification, screening and inclusion process.

Adapted from: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ* 2021;372:n71.



Appendix 2: TREC form and approval letter

The Tavistock and Portman 
NHS Foundation Trust

Tavistock and Portman Trust Research Ethics Committee (TREC) **APPLICATION FOR ETHICAL REVIEW OF STUDENT RESEARCH PROJECTS**

This application should be submitted alongside copies of any supporting documentation which will be handed to participants, including a participant information sheet, consent form, self-completion survey or questionnaire.

Where a form is submitted and sections are incomplete, the form will not be considered by TREC and will be returned to the applicant for completion.

For further guidance please contact Paru Jeram (academicquality@tavi-port.nhs.uk)

FOR ALL APPLICANTS

If you already have ethical approval from another body (including HRA/IRAS) please submit the application form and outcome letters. You need only complete sections of the TREC form which are NOT covered in your existing approval

Is your project considered as 'research' according to the HRA tool? (http://www.hra-decisiontools.org.uk/research/index.html)	No
Will your project involve participants who are under 18 or who are classed as vulnerable? (see section 7)	No
Will your project include data collection outside of the UK?	No

SECTION A: PROJECT DETAILS

Project title	An exploration of child psychotherapists' understanding of treatment review meetings.		
Proposed project start date	ASAP	Anticipated project end date	September 2025
Principal Investigator (normally your Research Supervisor): Peter Slater			
Please note: TREC approval will only be given for the length of the project as stated above up to a maximum of 6 years. Projects exceeding these timeframes will need additional ethical approval			
Has NHS or other approval been sought for this research including through submission via Research Application System (IRAS) or to the Health Research Authority (HRA)?	YES (NRES approval)	<input type="checkbox"/>	
	YES (HRA approval)	<input type="checkbox"/>	
	Other	<input type="checkbox"/>	
	NO	<input checked="" type="checkbox"/>	
If you already have ethical approval from another body (including HRA/IRAS) please submit the application form and outcome letters.			

SECTION B: APPLICANT DETAILS

Name of Researcher	Samuel Coetzee
Programme of Study and Target Award	M80
Email address	Scoetzee@tavi-port.nhs.uk

The Tavistock and Portman 

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/>

Samuel Coetzee

By Email

07 November 2023

Dear Samuel,

Re: Trust Research Ethics Application

Title: *'An exploration of child psychotherapists' understanding of treatment review meetings'*

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.

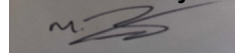
Please be advised that any changes to the project design including changes to methodology/data collection etc, must be referred to TREC as failure to do so, may result in a report of academic and/or research misconduct.

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,

Michael Franklyn

Academic Governance and Quality Officer

T: 020 938 2699

E: academicquality@tavi-port.nhs.uk

cc. Course Lead, Supervisor, Research Lead

Appendix 3: Recruitment information

The Tavistock and Portman 
NHS Foundation Trust

Dear all,

I am about to embark on my Doctoral Research Project as part of my Child and Adolescent Psychotherapy training. I am contacting you to see if you would be interested in taking part.

The project title is: An exploration of child psychotherapists' understanding of treatment review meetings.

I am interested in exploring clinician's thinking and experience of reviews – their function and their role in the psychotherapy process. I am hoping this may also provide clinicians with a space to consider and reflect on this aspect of their work and learn from this for their own practise.

I would like to invite child and adolescent psychotherapists working within Level 3 CAMHS at either the Whittington NHS Trust or Central and North West London NHS Trust to take part in an interview to discuss this aspect of the work. Participants will have at least two years experience within a CAMHS team and have had regular experience of treatment review meetings. Interviews will be guided by me and last around 60. They will take place within your usual place of work and within working hours. If this is not convenient, arrangements can be made for an online interview via a secure video link.

If you are interested and willing to take part, please find attached a participant information sheet for your information.

Kind regards,
Samuel Coetzee

An exploration of child psychotherapists' understanding of treatment review meetings

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 clinicians think about and experience regular treatment review meetings as part of a child's psychoanalytic psychotherapy treatment.

Who is conducting the study?

My name is Samuel Coetzee.

I'm a trainee Child and Adolescent Psychotherapist at The Tavistock and Portman NHS Foundation Trust. I work within CAMHS units in the Whittington Health NHS Trust and the Central and North West London NHS Foundation Trust. This research project is being sponsored and supported by The Tavistock and Portman 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

In addition to the regular parent-work that accompanies the treatment of children and young people in CAMHS, regular review meetings with parents are a core feature of psychotherapists' work in CAMHS, bringing both the child's therapist and the parent-worker together to meet with their patient's parents/carers and speak about the child's treatment.

The importance of review meetings is recognised by NICE, whose guidelines state that: "Healthcare professionals should make all efforts necessary to engage the child or young person and their parents or carers in treatment decisions" (NICE, 2019). As such, review meetings constitute an important part of good practice.

This study aims to explore the perceptions of qualified child and adolescent psychoanalytic psychotherapists (CAPTs) of treatment review meetings with the parents/carers of their child and adolescent patients and thereby better understand the role these meetings play in the psychotherapy process, including the role they play in making a link between psychotherapist, parent and parent worker.

What will participating in this project involve?

The project is an inquiry into clinicians' understanding of treatment reviews. For this you will be invited to take part in an individual interview. Interviews will be face-to-face and be conducted at your place of work during working hours. If this is not possible, arrangements will be made to conduct the interview via a secure online video link. The interview will mainly be an opportunity to explore your experience of – and thoughts and feeling around – treatment reviews. During the discussion I will be interested to hear what you think

Consent Form

Project title: An exploration of child psychotherapists' understanding of treatment review meetings.

Name of researcher: Samuel Coetzee

- I voluntarily agree to participate in this research project.
- I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- I understand that my participation in this study is voluntary and that I am free to withdraw, without giving a reason, at any time up to two weeks after completion of the interview.
- I understand that the interview will be digitally recorded and transcribed as described in the participant information sheet.
- I understand that the information I provide will be kept confidential, unless I or someone else is deemed to be at risk.
- I understand that direct quotes from the audio recording may be used in this research study but will be made anonymous to the reader and held securely by the researcher.
- I understand that it is my responsibility to anonymise any examples referring to cases I chose to discuss during the interview.
- I understand that the results of this research will be published in the form of a Doctoral research thesis and that they may also be used in future academic presentations and publications.

Contact details:

Researcher: Samuel Coetzee

Email: samuel.coetzee@nhs.net

Supervisor : Peter Slater

Email: peter.slater7@btopenworld.com

Participant's Name (Printed): _____

Participant's signature: _____ Date: _____

Thank you for agreeing to take part in this study.

Your contribution is very much appreciated.

Dear....

I am writing to thank you for your contribution to my Doctoral Research Project.

If following taking part there are any issues that are concerning you I hope that you can access the support network around you (colleagues, supervisor and managers). However, if this isn't possible there is a confidential counselling service provided by Whittington Health NHS Trust's independent employee assistance programme or the Central and North West London NHS Foundation Trust's Keeping Well, depending on where you work:

Whittington Health NHS Trust's independent employee assistance programme

An occupational health and wellbeing service available to support staff with all health and wellbeing issues in the workplace and at home.

You can self-refer as follows:

Whittington NHS Trust employees: call 020 7288 3351 Monday to Thursday 9.00am to 5.00pm & Friday 08.30am to 4.30pm or email: whh-tr.OccupationalHealthWellbeing@nhs.net

Central and North West London NHS Foundation Trust's Keeping Well


A support service for staff of Central and North West London NHS Foundation Trust and West London NHS Trust.

You can self refer as follows:

Central and North West London NHS Foundation Trust's employees: call 0300 123 1705 Monday to Friday 9am to 5pm or email http://mailto:keepingwell.nwl@nhs.net/

If you have any questions or would like further information here are my contact details:

Email: sam.coetzee@nhs.net

Telephone: 

If you have any concerns about how the study has been conducted please contact myself, my supervisor Dr Peter Slater (peter.slater7@bopenworld.com) or Lisa Harris, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk).

Kind regards,
Samuel Coetzee

Appendix 4: Developing themes

