Coming into intensive psychotherapy for adolescents and young adults:

An exploration of clinical decision-making

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Abstract

This qualitative study focused on the process of clinical decision-making when making recommendations for intensive psychotherapy for adolescents and young adults. In order to a) learn about which adolescents and young adults come into intensive treatment and b) how they are chosen, the study was separated into two parts. In Study 1, an audit described the population coming into intensive psychotherapy in an adolescent mental health service in a given time period. In Study 2, a case study explored the clinical decision-making process at intake and assessment in the same service. Interpretative phenomenological analysis (IPA), psychoanalytic group theory and thematic analysis were used to analyse the data. The study explored how decisions were made from the point of the referral through to the decision regarding which treatment to recommend and it sought to identify determining factors of the clinical decision-making process. The focus on how a clinical judgement is made, aimed to contribute to the learning about the actual process. The study found evidence for an implicit framework for clinical decision-making about intensive psychotherapy for adolescents and young people. There was consideration of a developmental dimension to the presenting problem as well as the potential impact of trauma. The patient's state of mind was assessed and their motivation was explored. The level of need for containment and the level of intensity needed to challenge resistance were assessed. The quality and level of support from the environment, including parents and network were explored. The study found that the clinicians were looking for movement in the patient's capacity to engage with the assessment process. The research highlighted idiosyncratic features when working with adolescents: the inherent difficulties in the engagement process, the foci on ambivalence and on parental involvement. The study also showed that clinical

decision-making is affected by the clinician's subjectivity, while the team's decision-making is affected by case dynamics, the team's own group dynamics and the service's capacity.

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Chapter 1: Introduction

This is a qualitative study which aimed to ascertain which adolescents and young adults come into intensive psychotherapy and how they are chosen. The study set out to explore the clinical decision-making process when recommending intensive psychotherapy. In order to a) learn about which adolescents and young adults come into intensive treatment and b) how they are chosen, the study was separated into two parts. In Study 1, an audit described the population coming into intensive psychotherapy in a given time period. In Study 2, a case study explored the clinical decision-making process in intake and assessment. Interpretative phenomenological analysis (IPA), psychoanalytic group theory and thematic analysis were used to analyse the data. The study explored how decisions were made from the point of the referral through to the decision which treatment to recommend and it sought to identify determining factors of the clinical decision making process.

Intentions of this study

This study sought to learn about the process whereby adolescents and young adults come into intensive psychotherapy. The researcher developed her interest in this work as a trainee child and adolescent psychotherapist working with this age group. In particular, the focus was on the clinical decision-making process when recommending intensive psychotherapy. Chapter 2 explores the literature relevant to this field of interest, describing the focus of study namely intensive psychotherapy for adolescents and young people as well as the literature on adolescent development and assessment and relevant research. Chapter 3 describes the mixed method strategy used in this study. An audit and a case study supplied the data which were then analysed using thematic analysis, IPA and psychoanalytic group theory. Chapter 4 presents the findings and subsequent analysis of the audit. Chapter 5

displays the findings and analysis of the case study. Chapter 6 offers a discussion of the findings.

Chapter 2: Literature review

Introduction

This chapter aims to outline the field of interest of which this study forms a part. It sets out to describe the history and development of intensive psychoanalytic psychotherapy for adolescents and young adults. This chapter will then describe how adolescent development is thought about from a psychoanalytic perspective and look at the mental health needs of adolescents. This will be followed by a description of mental health service provision and research focusing on psychotherapy for adolescents and young adults.

A review of clinical case studies and psychoanalytic theory will outline the thinking about the assessment process. The particular focus of this investigation being the clinical decision-making process involved in the recommendation for intensive psychotherapy, background literature to the clinical decision-making process from referral to recommendation will be explored.

1) Intensive psychotherapy

The following review will outline the history of intensive psychotherapy for adolescents and young adults, what its aims are and what challenges it may face.

Freud's first psychoanalytic case was Dora, a young adult aged 18, however his focus at the time was not on the particularities of treating adolescents but on transference, dream interpretation and the importance of early sexual development. Before the Second World War the link between adolescence and psychoanalysis was slow to evolve (Jennings, 1990). Deutsch and Aichhorn developed psychoanalytic thinking about adolescence in Vienna but worked mainly within the

sphere of education. Anna Freud, following her father, initially believed that an upsurge of drive energy during puberty weakened the ego by introducing an imbalance between ego and id (Perret-Catipovic and Ladame, 1998). Low frustration tolerance and rigidity of defences were then seen as contraindications to psychoanalysis with its original focus on neurosis as an expression of internal conflict. Anna Freud (1958, p. 261) described adolescence as a 'neglected period' and said the 'analytic treatment of adolescents is a hazardous venture from beginning to end, a venture in which the analyst has to meet resistances of unusual strength and variety'.

Laufer established that a disorder in adolescent development requires psychoanalytic treatment (Perret-Catipovic and Ladame, 1998, Laufer, 1965). This was the beginning of psychoanalysis for adolescents at the Brent Centre. Intensive psychotherapy as a model has evolved from the psychoanalytic model of five times weekly sessions over a number of years. When working with adolescents and young adults intensively i.e. more than once a week, different services use different models. This review does not intend to equate these models nor discuss their differences, but describe the range of work undertaken intensively with this population within the psychoanalytic field. In some services a young person might be seen for psychoanalysis five times a week, in others it may be three sessions a week of psychoanalytic psychotherapy provided by child and adolescent psychotherapists.

Intensive psychoanalytic psychotherapy for adolescents is provided within CAMHS services up to age 18. Young people over the age of 18, commonly called young adults, can be referred to adult services. There are a number of services working specifically with adolescents and young adults across this age limit. Psychoanalytic psychotherapy for adolescents and young adults has a long history

at the Tavistock Clinic, as well as institutions who work specifically with this age group, such as the Brandon Centre, the Brent Centre and Open Door.

As Shaw (2014, p. 394) describes, intensive psychotherapy is thought to provide the additional continuity of sessions, and therefore the 'additional continuity of the experience of having an object available'. This is thought to be necessary to allow the patient to 'identify with this new object', and 'assimilate it into their ego structure'. Shaw argues that some patients have 'extremely fragile ego resources' and may 'be destructive of authentic contact with their objects', this in turn can have an impact on the process of assimilation. He thinks that in once weekly treatment this 'assimilation process' would not be sufficiently supported (Shaw, 2014, p. 392). Wilson (1987) describes the Brent Centre approach of either weekly or twice weekly psychotherapy or psychoanalysis. While he does not describe intensive psychotherapy offered at the service considered in this study, there are some generalizable parameters. Wilson (Wilson and Smith, 1997) argues that intensive psychotherapy is the most comprehensive and intensive endeavour to reach back to past experience and to provide the opportunity to re-experience it, understand it and find alternative solutions and adaptations to the painful and conflictual feelings the patient may struggle with. Blos (1962) argues that intensive psychotherapy treatment implies that resistance and transference are the object of systematic investigation or interpretation. Intensive psychotherapy aims to restore a lost or disrupted continuity in ego experience (Wilson, 1997, Blos, 1983). This in turn then 'promotes the process of individuation, establishes firm ego boundaries, stabilizes the distinction between self and object and enhances the faculty of reality testing' (Blos, 1967, p. 166). Wilson (1987) argues that intensive treatment sets out to support the young

person to negotiate their adolescence more adequately and find a pathway towards a more confident sense of themselves as an adult.

Psychoanalytic psychotherapy, with its focus on finding meaning, thinking and development, is thought of a helpful treatment for the challenges in adolescence, for example the rapidity of change and the fluidity of the personality. At the same time, coming into intensive psychotherapy can be a difficult process for the young person for these very reasons. This is a period of life when the idea of embarking on a dependent relationship runs counter to the adolescent developmental task of separation and individuation. Adolescents who struggle with these difficulties may require considerable internal and external support at a time when they simultaneously work on separating from their external family (Waddell, 1999). Wilson (Wilson and Smith, 1997) describes the conflict between the adolescent developmentally striving for autonomy and independence versus letting themselves achieve the degree of closeness and dependency necessary for treatment. A young person may have mixed feelings about being encouraged to develop a relationship which might evoke regression and dependency. Laufer (1997) emphasises that psychotherapy can be challenging for adolescents who can feel compelled to regress, deviate and change their minds. Working with adolescents requires particular efforts by the patient as well as the therapist, since adolescence, by definition, entails a process of moving against regression (Kohon, 2014).

2) Adolescent development from a psychoanalytic perspective

Freud (1905) described the changes that occur during puberty, in particular the reworking of infantile conflicts after significant biological change. He identified the establishment of healthy genital sexuality as the primary aim in adolescence. Anna Freud wrote about the apparent contradictions in the mental life of the adolescent

(Sandler and Freud, 1983), highlighting physical changes as well as psychological factors and the ego's struggle to survive intense forces from the id. She suggested that while the foundation of neurotic development is laid in infancy, it is the experiences in the second decade of life which determine how much of the infantile conflict will be retained and will therefore affect adult mental health (Freud, 1993, Midgley, 2013). Anna Freud felt it was important to distinguish between ordinary 'Sturm und Drang' and pathological development; she also highlighted the importance of supporting parents to help their child through this period of development. In the 1950s, however, the thinking about adolescent disturbance being treatable began to change.

The following section will discuss psychoanalytic thinking regarding adolescence since that time, one strand focusing on the rapid changes that take place during this time of development, one on the developmental tasks involved, and one on the necessary internal prerequisites for the young person to be able to manage and develop in this time of emotional, physical and intellectual upheaval. These different ways of thinking about development and internal dynamics complement each other and represent different dimensions of the developmental dynamic of the adolescent process.

One group of theorists has focused on the impact of physical development, in particular sexual development. Laufer (1997) sets out the particular challenges for young people in this age group; to come to terms with a maturing body, to come to terms with what one might want and what one's conscience allows one to live with and to establish a sexual identity. Laufer (1996, p. 513) states that 'it is during adolescence that certain creations of the mind become interwoven with past experiences, and it is this combination of the past with more immediate fantasies of

adolescence that ultimately establishes pathologies'. Laufer (1989) suggests that the adolescent is then left with the feeling that the body is the source of their abnormality or hatred, no matter how much they try to find those sources outside themselves. He argues that an adolescent who is experiencing a breakdown has lost touch with his own mental life and is responding to creations from his own mind (Laufer, 1997). Laufer conceptualises adolescent psychopathology in terms of a breakdown in development, what he calls a deadlock or a foreclosure (Perret-Catipovic and Ladame, 1998).

Other theorists focus on the developmental tasks of adolescence. Waddell (1999), for example, describes the personality being able to grow to the extent as it can psychically survive the disturbing experience of change and the losses which that entails. Blos (1967) emphasises the process of separation and individuation. Anderson (2000) states how combining both biological changes and shifts from dependence to inter dependence can revive intense and sometime conflicting phantasies and feelings about parental internal figures. Waddell (2002a, p. p191) describes the 'psychic agenda' as the 'negotiation of the relationship between adult and infantile structures'; the 'transition from life in the family to life in the world'; the 'finding and establishing of an identity, especially in sexual terms'; and the 'capacity to manage separation, loss, choice, independence, and perhaps disillusionment with life on the outside'.

Waddell focuses on the internal processes and the adolescent's capacity to accomplish this development. Waddell refers to Klein's descriptions of infantile states and internal objects. According to Waddell (2002b, p. 379), adolescence 'requires a re-working and re-establishing of the earlier emotional gains of the depressive position, in the face of renewed paranoid-schizoid splits'. She goes on to describe

how the adolescent characteristically attempts to bypass the task of working through depressive anxieties, as it involves ‘a re-engagement with the sense of guilt and responsibility for damage done, with fears of loss, with gratitude and sensitivity to others’ (2002a, p. 183). Waddell suggests that the capacity to ‘think about and suffer emotional experiences feeds the mind and promotes growth’, arguing that this capacity is ‘constantly opposed by the intolerance to frustration and emotional pain’ (Waddell, 1999, p. 217).

Waddell emphasises that, in adolescence, projective will predominate introjective tendencies and describes the importance of having an internal container when struggling with strong feelings and emerging sexuality. The lack of an internal container can lead to an inability to think and therefore to develop emotionally. Unable to consider their internal struggles, the young person may then be more likely to act out their feelings, break down, or become arrested in their development. Bertolini, referring to Meltzer, observes that disturbed adolescents fail to find an intimate relationship where they feel understood, rather they feel ‘inadequate and impotent when faced with the upheavals of their physical and emotional transformation and growth‘ (Bertolini, 2000, p. 105). They might struggle to compose their inner experience in a way that they can think about (Bertolini, 2000).

3) Evidence regarding the mental health needs of adolescents

Having outlined some key psychoanalytic theories about adolescence, this section will now highlight the evidence regarding the mental health needs of adolescents. It is well established that the peak onset of mental ill health is 8 to 15 years with half of all lifetime of mental ill health starting by age 14 and rising to 75 % by age 24 (Booker and al, 2012). The following reports highlight the mental health needs of children and adolescents in the UK: NHS England (England, Farmer and

Dyer, 2016) published a report in 2016 stating that ‘one in ten children aged 5-16 has a diagnosable problem such as conduct disorder (6 per cent), anxiety disorder (3 per cent), attention deficit hyperactivity disorder (2 per cent) or depression (2 per cent). This report states that ‘those with conduct disorder are twice as likely to leave school without any qualifications, three times more likely to become a teenage parent, four times more likely to become dependent on drugs and 20 times more likely to end up in prison’(Farmer and Dyer, 2016). The rates of disorder rise steeply in middle to late adolescence. Wollaston (2014) describes that ‘self-harm rates have increased sharply over the past decade, providing indications of a possible rise in mental health problems among young people’.

Across England, CAMHS are struggling with dramatic increases in demand: between 2013-14 and 2014-15, referral rates increased five times faster than the workforce, according to a report by the Independent Mental Health Taskforce in 2016 (Murdoch and Kendall, 2016). 81% of teams involved in peer review in 2013 reported a 50% increase of young people seeking services in 2008 (Murdoch and Kendall, 2016). According to a BBC report (BBC, 2015), Wales alone witnessed a 100% increase in demand for child and adolescent mental health services between 2010 and 2014. At the same time there has been a reduction of the provision of inpatient adolescent units in recent years (supervision communication Emil Jackson 2017). The Chief Medical Officer’s 2012 report also indicates an increase in complexity and severity of problems.

4) Shortage of provision for this age group

There is evidence that adolescents and young adults do not access the support they need and for those who do, the average wait for routine appointments for psychological therapy was 32 weeks in 2015/16 (Murdoch and Kendall, 2016). This

report highlighted the fact that ‘nearly half the children and young people with a clinically diagnosable disorder also had a disorder when surveyed three years later’. The Chief Medical Officer (Davies, 2014) reports that ‘transition from CAMHS to adult mental health services was poorly planned and executed, with poor flow of information, low rates of joint working and poor continuity of care’.

Adolescents are required to transition to adult services when they are 18; however developmentally the adolescent tasks are not considered to be completed until approximately 25. Stortelder et al (Stortelder and Ploegmakers-Burg, 2010) state that during adolescence, the psychological maturation of the capacity for self-agency comprises the central coordination of the functions of emotion regulation, mentalisation and executive functioning. It is only after age the age of 21 that the psychological development of self-agency is completed (Brockman, 2003). Faced with intense emotional situations, young people can struggle since they lack the self agency to stabilise themselves. The adolescent acquires his independence, personal identity and self-agency slowly and gradually. The long-term and late biopsychosocial maturation in adolescence implies that adequate monitoring at a distance by parents and school remains necessary (Briggs, 2002).

According to the CMO report, failure to refer - as a result of perceived high thresholds in adult services - was much more common than failure of adult services to accept referrals. The CMO report 2014 further highlights, that young people should be supported when making transitions between health, education and social care systems. They suggest for these transitions to be ‘safe, understanding and tailored to the young person’s needs’ (Davies, 2014). The Future in Mind report (England, 2015a), published by the Government's Children and Young People’s Mental Health Taskforce, recommended removing the arbitrary cut-off age thereby

increasing the age limit of CAMHS services to 25. This also aims to respond to the understanding that adolescence and early adulthood are the peak age for the onset of mental health problems.

5) What works for whom?

Despite growing evidence of deteriorating mental health in young people (Reading, 2006, Midgley and Kennedy, 2011), there is evidence (Reinecke and Shirk, 2005, Midgley and Kennedy, 2011) that adolescents and young adults are often overlooked in clinical research.

a) Research focusing on adolescents and young adults

The following section aims to describe the field of research within which this study is placed. While there is a growing body of research focusing on children and adolescents (Midgley and Kennedy, 2011), studies on older adolescents and young adults are much less common.

A community-based study (Baruch, 1995) of psychodynamic treatment for adolescents and young adults presenting with multiple difficulties suggested that measurable change took place during the course of therapy in all domains of functioning (Baruch et al., 1998, Baruch and Fearon, 2002b, Baruch and Fearon, 2002a). In a small study Tishby *et al*. (2007) report changes in interpersonal conflicts among adolescents during the course of psychodynamic psychotherapy. Tishby et al report that over time there appeared to be a shift in the relationship with parents, as the young people reported having less angry and confrontational relationships; whilst the relationship to the therapist shifted from the wish to be helped and understood, towards more of a wish to be understood and to be more distant. In a more recent study, Tonge et al. (2009) report on the effectiveness of psychoanalytic psychotherapy for adolescents with serious mental illness, based on a naturalistic

longitudinal study. Midgley and Kenney (2011, p. 240) summarise the findings as showing that ‘those treated with psychodynamic psychotherapy had a greater reduction in clinical symptoms and social problems compared with those offered treatment as usual; however the greater effectiveness of the psychodynamic treatment depended on the initial level of symptomatology’(Midgley and Kennedy, 2011).

Nemirovski and Carlberg (Edlund and Carlberg, 2016) report on the findings from their study into ‘Psychodynamic psychotherapy with adolescents and young adults: Outcome in routine practice‘. They report significant improvement of general functioning and decreased symptom severity upon completion of psychotherapy, as well as a clinically significant improvement in a large percentage of cases. The main limitation of this study was the lack of a control group, partially compensated for by the use of comparison groups and high external validity.

b) Research focusing on intensive psychotherapy for adolescents and young adults

Intensive psychotherapy for adolescents and young adults is mainly explored in individual case study format and the theoretical formulations which evolved from those (Rustin, 2010). Wilson (Wilson and Smith, 1997) observes that it is an individual case by case decision to decide whether the young person will be able to benefit from this type of approach.

There is limited empirical research into intensive psychotherapy for this age group, for example there is some research into the beginning of psychotherapy in CAMHS but it does not distinguish between weekly and intensive treatment. Midgley and Kam (2006) explored referrals to psychotherapy in CAMHS, and found that child psychotherapists often work with some of the most complex cases within CAMHS.

This seemed to depend much more on the ways children reacted to certain experiences they had been through, rather than the nature of the experience itself. Often the referral was based on the length of time the case had been involved in CAMHS without significant change having taken place. The Robertson audit (Robertson, 2007) focused on intensive psychotherapy cases across the three age groups (under five, latency and adolescents) seen by child and adolescents psychotherapists in doctoral training at the Tavistock Clinic. This audit confirmed the complex nature of the majority of cases, and that intensive psychotherapy was not the first treatment which had been tried.

Kennedy (2010) reports on a study in 2004 comparing psychoanalysis and psychotherapy for young adults with personality disorder: 12 of the 19 patients improved in terms of their symptoms, with 10 of the 12 improvers being in the psychoanalysis group, suggesting that more intensive treatment was more successful. Midgley and Kennedy (2011) present some caveats regarding intensive psychotherapy however. One study suggested that receiving more intensive therapy (three to five times per week) rather than once weekly therapy did not improve outcomes for adolescents when the pathology was less severe (Fonagy and Target, 1994), while another study showed that more intensive work could, in some cases, add to the adolescent's sense of ‘stigma’ (Midgley, 2006a).

6) Clinical decision-making at intake and assessment

Having described adolescent mental health needs, and summarised some of the evidence regarding treatment, the following section will focus on clinical decision-making at the beginning of intensive psychotherapy, namely at the intake and assessment stage. It will outline the learning from individual case studies and psychoanalytic theorists about clinical decision-making. How, the section will

address, does the intake team make a clinical decision about psychotherapy and how do the assessor and the multi-disciplinary team decide to recommend intensive psychotherapy?

a) Intake

The term 'Intake' refers to the process of considering the referrals arriving at a CAMH service. Historically, CAMH services evolved from family consultation services which grew after the introduction of the welfare state (Young Minds, 2017). Over time with increasing demand and reduced funding the organisation of CAMHS changed (Kerfoot, 2005). CAMHS is now part of the mental health 'tier' system, tier one meaning early intervention and prevention provided by schools, GPs and associated services, tier two meaning targeted services in a range of different settings for young people with mild to moderate mental health problems, and tier three meaning specialist CAMHS providing services for moderate to severe mental health problems, while tier 4 are specialist day or inpatient services for people with more severe mental health problems (Herts, 2015, England, 2015b). This broad specification is set up differently across the country. The referral process also differs, with some services accepting self referrals, and some only from professionals using published protocol and scoring systems to structure the decision-making process (Williams et al., 2005). Some services offer a single point of access (SPA), while some only accept referrals according to Tier 3 thresholds. The actual intake process in CAMHS varies widely across the country, from separate triage teams, to duty clinicians individually 'intaking' referrals on a daily basis. Some services use the Choice and Partnership Approach (CAPA), an intake and waiting list management system (Robotham et al., 2010), some use the THRIVE framework (Buckley, 2013), another model to conceptualise need and throughput. There is scant literature on the

thinking and dynamics of the decision-making processes involved in these different systems.

b) Psychotherapy assessment

When a referral has been accepted in CAMHS, there may be a waiting list, followed by a generic assessment or, in some specialist services, a psychotherapy assessment. This section will detail the theoretical and individual case study literature about the psychotherapy assessment process. There are different strands of thought about where the focus lies in assessment, and what follows will describe some historical psychoanalytic literature as well as child and adolescent psychotherapy literature on assessment

The following writers focus on their observations of the prospective patient. Garelick (1994, p. 103) advocates exploring ‘the patient’s capacity to tolerate anxiety’ and ‘the stress and inevitable frustration which is part of the psychotherapy process’. Garelick and Schachter (1994, p. 103, Schachter, 1997) suggest looking for ‘the patient's ability to make use of the experience of being understood’ as opposed to enviously spoiling or dismissing it. Valbak (2004, p. 180) describes exploring seven variables, namely ‘psychological mindedness, capacity for self-observation, capacity for empathy, tolerance of frustration, motivation, response to confrontation and ability to contain and work with affect’. Charman (2004) emphasises the importance of exploring psychological mindedness which she describes as the level of receptiveness to linking.

The following writers focus on object relations; that is, how does the patient relate to the assessor? The assessor's experience of the roles they are being cast in will give an indication of the patient's internal objects and their relationships, according to this perspective. Berkowitz (Berkowitz, 2013) summarizes the

parameters: 1. adequacy of general personality functioning, 2. psychological mindedness, 3. ego strength, motivation and affect and 4. object relations. Others mention risk considerations constituting another important parameter. Milton (Milton, 1997) recommends that the patient's and therapist's safety be thought about, as well as the likelihood of the patient breaking down. Milton advocates that the patient needs to experience what the exploration of defences and experience of anxiety might be like, so they can make an informed decision as to whether or not they want to engage with this approach.

The following authors focus specifically on the assessment of children, young people and their families. Historically child and adolescent psychotherapists work with children and young people who have difficulties in the realm of ego development, might behave in complex and / or challenging ways, not use language or express their difficulties in other ways (Catty, 2016). Therefore some of the above mentioned criteria might not apply, for example ego strength, capacity for self-observation and empathy as well as psychological mindedness. There are different strands within the child and adolescent psychotherapy literature on assessment, ranging from a focus on the developmental process to a focus on 'state of mind' (Quagliata and Rustin, 2004). This literature review will not discuss the differences and similarities between Anna Freudian and Kleinian thinking, but instead aims to draw out the salient points pertaining to assessment of adolescents and young people. One strand of the child psychotherapy literature focuses on assessing the patient's development. Anna Freud's diagnostic profile was further developed by Laufer (1965), specifically for adolescents. Holder (1995, p. 332) quotes Anna Freud that, 'unlike in childhood disorders where one or the other area of the child's personality may be affected, in adolescence changes take place along the whole

line', encompassing 'the realm of instinctual drives, ego organization, object relations, ego ideals as well as the field of social interaction'. Holder (1995, p. 340) emphasises that 'the clinical difficulties involved in differentiating between normal, neurotic and developmentally disturbed adolescents are due to these changes to which the adolescent personality is subjected for many years'. Laufer (1965) recommends observing the ego's ability to deal with the new developmentally induced internal demands (i.e. changing one's relationship to the oedipal objects and establishing one's sexual role). He then suggests examining the interaction of the forces which are creating the disturbance, with the aim of determining whether there already is a deadlock or whether the disturbance represents a temporary defensive measure. Green (Lanyado and Horne, 2006, Lanyado and Horne, 2009) recommends for the assessor to ascertain how the developmental process might have gone awry, and what the required developmental tasks might be.

Wittenberg (1982, p. 140) advocates looking directly at the child and adolescent experience within a family framework. She suggests using three questions: 'who has the pain, what's the attitude to the emotional pain and what's the attitude to getting help'. The young person is viewed within their family and their social context. Quagliata and Rustin (2004) describe the aims of assessment as being to establish network support, to describe the patient's state of mind, including external and internal factors, to clarify action needed from other agencies and the multi-disciplinary team (MDT), to describe the patient's likely capacity to make use of treatment and to recommend intensity, to establish a base line of clinical description, offer a therapeutic experience which provides containment and sustains hope, and to ensure an adequate time frame allowing for the process of working through.

The following writers focus on the assessment of adolescents specifically. Waddell (1999) describes the process that the young person would commit to. She states that the assessment sessions offer 'an opportunity to engage in a thinking process; to explore the degree of motivation in seeking help; to deal with the impact of beginning to look at private or hidden things; and to develop the capacity to sustain the scrutiny, to bear the possible discovery and to risk change' (Waddell, 1999, p. 220). She states that the assessment seeks to ascertain the young person's introjective capacity and their capacity to think. Anderson (2000, Morris et al., 2009) explains how in adolescence unbearable feelings are often followed by action and focuses on the assessment of risk. Wilson (1997, p. 17) outlines possible contraindications when considering intensive work for adolescents, raising the importance of reflecting on 'questionable' motivation, the fear of dependency as a young adult and the precarious capacity to tolerate painful feelings or control impulses. Bronstein and Flanders (1998) argue that the adolescent patient's ambivalent feelings are very strong and need to be considered first and foremost. Bronstein and Flanders (1998) suggest that the adolescent patient entering treatment might struggle with the paranoid and persecutory anxieties raised by the idea of accessing help. They cite a number of individual cases where the adolescent patient seems to have experienced treatment in very paranoid terms, as if 'being taken over' (1998, p. 33). They link this fear of being taken over to the adolescent's experience of puberty where they might have felt taken over by changes in their bodies. Bronstein and Flanders (1998, p. 34) argue that the anxiety about treatment is a 'fear of being passively overwhelmed due to the threatened loss of an omnipotent defence which had been established to cope with adolescent change'. They therefore recommend not making a recommendation before a decision is clear,

so that the young person does not come into treatment in a passive or compliant manner.

c) Formulation

One of the aims of assessment is that of making a formulation and a recommendation (Lemma, 2003, Quagliata and Rustin, 2004). Sim et al. (2005, p. 291) state that the formulation fills 'the gap between diagnosis and treatment and can be seen to lie at the intersection of aetiology and description, theory and practice, and science and art.' Psychoanalytic literature focusing on object relations as well as psychoanalytic literature focusing on developmental profiles is relevant to this field of interest.

Hinshelwood (1991, p. 168) suggests thinking of the material as 'pictures of relationships with objects'. He describes three areas of object relationships; the current life situation, the infantile object relations and the relationship with the assessor. The tools used to develop an understanding of these 'pictures' are observation, transference and countertransference. Garelick (1994, p. 113) suggests examining the patient's 'ability to contain affects' and 'holding the therapeutic experience in mind'. He also argues in favour of monitoring what happens both within and between sessions, the way in which the patient manages the gaps between sessions giving important information when making a judgment about frequency.

Nancy McWilliams et al (Huprich et al., 2015, McWilliams, 2011) developed the PDM, a psychodynamic diagnostic system embracing psychoanalytic concepts covering all ages. The new edition PDM-2 will contain further developments on adolescent diagnosis and formulation. Wallerstein (2011) describes the PDM's aim to aid diagnosis, formulation and treatment planning.

In the child and adolescent psychotherapy literature a formulation includes object relations thinking (Waddell, 2003), the developmental trajectory (Laufer, 1965) and considering the young person's family and environmental set up. When thinking about parameters for the recommendation of intensive psychotherapy, the literature recommends the following: Wittenberg (1982, p. 140) suggests that 'the rigidity of the defensive system and the fragility of the underlying structure', plus whether the patient is able to 'contain anxiety over time', will indicate the type of external support needed and the frequency of sessions. Intensive psychotherapy in itself can be destabilising and environmental support is important to help maintain the commitment to therapy. Green (Lanyado and Horne, 2009) argues that a decision about frequency will be based on an overview of the child's and adolescent's overall functioning. She describes how the assessor looks for a marked curtailment in the patient's capacity to relate to others in a satisfying way or to feel comfortable within themselves. According to Green, the sense that the patient's future emotional development is in jeopardy is an indicator for intensive treatment. Green describes assessing the levels of stuckness, whether the difficulties are long-standing or of a particularly intractable nature.

d) Clinical judgment

How do the team and the assessor make this clinical judgment? The literature highlights the importance of the analytic frame, reflection on the part of the assessor and the team, and the ability to bear uncertainty. Crick (2013, p. 204, Pérez et al., 2015) argues that clinical judgment is a 'subjective judgment', detailing how 'it is to do with a person's capacity to bring observations made available through their receptivity and intuition, together with their experience, expertise and knowledge, and to arrive at a judgment that has confidence and authority derived from a secure

professional identity'. Crick suggests projective identification as the tool to explore one's thoughts and feelings about the patient and the experience of being with them, and describes the importance of then submitting these observations to careful examination and discussion with colleagues. Crick also refers to the tension between needing to make a decision and the pressures of the system, advocating (2013, p. 206) that clinicians exercise Keats' idea of 'negative capability', of being capable to remain in doubt rather than reaching for certainties.

Waddell (1999) argues that the assessment of adolescents poses particular difficulties. She (2002b, p. 380) refers to Bion's (1979) idea of the 'emotional storm' created when two people meet, stating that the 'observational skills involved in exploring the specificity of the physical and psychical world of these particular 'creatures' and the conditions of their particular habitats challenge the clinician in complex ways'. She describes the 'ever immediate, quasi psychotic modes of mental functioning which are developmentally characteristic of the adolescent years'. The task of assessment is 'a severe test of analytic observation, impartiality, insight, judgment and interpretative restraint'. Waddell (2002b, p. 382) therefore issues a word of warning: clinical judgment can be 'a very blunt instrument: weighted with preconceptions, skewed by first impressions, distorted by aspirations and, all too often, loaded with disappointments'.

7) Summary

This chapter has offered a brief overview of the literature to prepare the field of exploration. The main points highlighted are the shortage of treatment provision for adolescents and the need for research into what works for whom in this age-group. Intensive psychoanalytic psychotherapy has been described as one potentially effective treatment for this patient group, although there is very little systematic

outcome research to support or counter this view. **This may be partly due to research into psychodynamic psychotherapy being underfunded (Midgley et al., 2017), as well as partly due to the difficulty of undertaking empirical research in the complex area of intensive psychotherapy.**

Case studies and psychoanalytic theory do however describe the potential for meeting adolescents' mental health needs through intensive psychoanalytic psychotherapy. This review further detailed the clinical literature concerning the assessment of adolescents for psychoanalytic psychotherapy and regarding which adolescents might be suitable for intensive psychotherapy. There is case by case research into how intensive psychotherapy comes to be recommended, and how the decision to choose between a less intensive treatment and other treatments is made. The literature suggests it is advisable to ascertain the young person's level of developmental functioning, their capacity to contain anxiety, and their ability and willingness to engage in a thinking process as important factors to consider during assessment.

It has become clear that intensive psychotherapy is a limited resource; moreover, it is currently unknown for whom it is most effective. This review of the literature suggests that there is scant empirical evidence about who gets referred, who is recommended for intensive psychotherapy treatment, and who benefits from it. Furthermore, we do not know which adolescents access intensive psychotherapy, nor how they are selected. It is also not empirically evident how decisions are made about who should be offered this type of therapy, given it is a limited resource.

Historically this may be partly due to the debate about case studies versus, and in addition to empirical studies (Rustin, 2010). Further to the contemporary debate about case studies please see Chapter 3 Section 3.d.iv.

Secondly there is the difficulty of how to measure outcomes in the most disturbed cases in a meaningful way. The current measures might not necessarily capture improvement. On the ground there may also have been a somewhat self destructive hesitancy to collect data, the focus on the clinical work being preferable to the data collection effort. This schism has been addressed in the child and adolescent psychotherapy training with the increased research focus. Thirdly there may be concerns about getting too far away from psychoanalytic thinking, there may be some tension between wanting to be transparent and accessible and at the same time retaining the specialism. Historically child and adolescent psychotherapy's strength has not been in making implicit thinking explicit and talking outside the field. There may be tension in the psychotherapist straddling and managing the two identities of researcher and clinician. This may be partly due to the psychotherapist being trained to question and reflect, not to focus on certainties but to remain uncertain (see also Chapter 2 Section 6. d).

This study therefore aims to find out which adolescents are offered intensive psychotherapy and how are they chosen. Study 1 aims to answer the first question by exploring an audit of intensive psychotherapy cases at one large inner city clinic. Study 2 then explores two dimensions of the decision-making process: what processes and dynamics are involved in clinical decision-making at intake and assessment? On what basis do intake teams and assessors make the clinical decision to recommend intensive psychotherapy?

Kennedy highlights that when new research is planned it is important to consider the complexity of the area of investigation. This author (2010) asserts that most interventions in Child Mental Health are generally multi-dimensional, complex

and influenced by myriad contextual factors. This study aims to respond to this request by exploring how decisions are made from the point of the referral through to the decision about which treatment to recommend. Furthermore it seeks to identify the determining factors involved in the clinical decision-making process. By focusing on how a clinical judgment is made, the study aims to contribute to the learning about the actual process, starting with the beginning of treatment (Midgley and Kennedy, 2011).

Chapter 3: Methodology

Introduction

This study sought to find answers to two questions: Which adolescents and young adults were offered intensive psychotherapy within a large, urban CAMH service? How is the decision to recommend intensive psychotherapy made? The second question consists of two parts: What processes and dynamics are involved in clinical decision-making about intensive psychotherapy at intake and assessment? On what basis do intake team and assessors make the decision to recommend intensive psychotherapy?

The following chapter will describe the methodology used to achieve these aims. The first was considered best approached by undertaking an audit, as this would help to develop an understanding of the characteristics of this population, the presenting problems, and their journey into intensive treatment. Study 1 aimed to describe the population who undertook intensive psychotherapy over a given time period. The data gathered were mainly in the form of descriptive statistics. In addition, responses to one open question were analysed using thematic analysis. However, this did not provide an answer to the question about how the adolescents were chosen. Study 2 therefore aimed to find out on what basis a recommendation

for intensive psychotherapy was made and how this took place. The methodology chosen for Study 2 involved a case study of the intake and assessment process in an inner city clinic, and the method of data collection used was observation and interview.

The methodology was chosen to throw light on the decision-making process from different perspectives and directions. The approach used was qualitative, drawing on Smith et al.'s (2009) work on IPA and the researcher learnt from Reid, Flowers and Larkin (2005) when defining and redefining the interview schedule. However, this is not a standard IPA study as only four interviews were used and, in addition, extensive data from different sources and perspectives were drawn upon. For the observation part of the study Hinshelwood's and Skogstad's (2004) as well as Rustin's (2010) thinking about psychoanalytic observations were instrumental when planning and undertaking the research. In addition to IPA, the researcher used psychoanalytic group theory to analyse the data (Hinshelwood and Skogstad, 2000).

This chapter will be structured by following Study 1 and Study 2 from the planning to the analysis stage.

1) Setting up the study

a) Rationale for choosing the research question

As described in the literature review (Chapter 1), there is limited empirical research on intensive psychotherapy for adolescents and young adults. It seemed important to understand more about the process of deciding which adolescent and young adult should be offered intensive psychotherapy, as this is a rare resource. Those in the patient group over 18 constitute an under-served group which is positioned between CAMHS services and adult services. This study therefore also has a meta-aim to highlight the importance and complexity of this work.

Furthermore there were also local reasons for undertaking this study. As a child and adolescent psychotherapist in doctoral training in the clinic working with adolescents and young adults, the researcher was well placed to focus on this area of provision. At the same time, this also involved a degree of personal subjectivity, which will be discussed below.

b) Research design – the clinic

The research took place in a clinic which is part of a larger CAMHS service in an inner city setting. The study setting is both a clinic and a training institution. It is unique in that the work covers standard CAMHS work with adolescents as well as work with young adults between the ages of 14 and 25. This model is based on the assumption that adolescent development continues until the mid-twenties. A range of treatments is provided by the multidisciplinary team, from weekly time-limited to ongoing weekly psychotherapy, parent work, family work, cognitive behavioural therapy, a young people's consultation service and intensive psychoanalytic psychotherapy. In this study, the term intensive psychotherapy refers to psychotherapy which takes places two or three times a week for at least one year. The clinicians who provide intensive psychotherapy are child and adolescent psychotherapists and supervised child and adolescent psychotherapists in doctoral training.

In order to capture the breadth of thinking and wealth of experience in the clinic, it seemed appropriate to employ a mixed method strategy. Study 1, an audit of intensive psychotherapy cases, aimed to show which adolescents come to intensive psychotherapy. Study 2, a case study of the intake and assessment process, aimed to show how the decision to recommend intensive psychotherapy is arrived at, and on what basis. It was thought that this would be a good starting point to explore the

young person's journey into the service. Observations of intake meetings, and interviews with senior assessors and one treatment psychotherapist, were chosen as methods of data collection for Study 2. A series of observations of the intake team meetings was thought to lay the groundwork for the research into the group's decision-making process. Secondly, it was thought that interview data would provide insight into the decision-making process during the psychotherapy assessment. Thirdly, it was felt that interview data from a child and adolescent psychotherapist working with a patient intensively (in this case a child and adolescent psychotherapist in doctoral training) would provide data on how this process was accomplished once the treatment had been set up.

The title of the study covers adolescents and young adults. This title has been chosen as the cases in this study cover the age spectrum from adolescents to young adults (14 to 25). Different parts of the study covered different age groups and some overlapped. Firstly the audit covered all intensive cases which included some younger adolescents. Secondly during the intake team observations all referrals were discussed covering ages 14 to 25. Finally the cases discussed in the interviews were mainly older adolescents and young adults.

2) Study 1 - Audit

The first aim of this study was to understand more about the characteristics of this population, their presenting problems and their path into intensive psychotherapy. Therefore an audit of the young people, who took part in intensive psychotherapy at the clinic, was the first step and initial focus of Study 1. The findings from the audit will be presented in Chapter 4.

a) Aims of Study 1

The audit aimed to answer the following questions:

- What were the characteristics of the adolescents and young adults coming to intensive psychotherapy?
- What was their journey into treatment?
- What did the intake and assessment processes consist of?
- How was intensive psychotherapy set up in terms of network, supervision and parent work arrangements?

b) Audit as research tool

The standard definition of clinical audit, endorsed by both the National Institute for Health and Care Excellence (NICE) and the Healthcare Commission, is ‘a quality improvement process that seeks to improve the patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structures, processes and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual team, or service level and further monitoring is used to confirm improvement in healthcare delivery’ (NICE, 2017a). The purpose is ‘to improve services to patients by a formal process of setting standards, gathering data to find how the service is performing in relation to them and changing practice as a result’ (Goldfried et al., 1999, p. 1400). An audit aims to empirically inform discussion about current practice and what can be learnt from it. The interest in gathering data to describe this, responds to calls from political and research domains for accurate, up-to-date data on CAMHS in order that services can be planned and run with clarity (Wollaston et al., 2014, Furber and Segal, 2012).

Punter (1995) argues that the basic philosophy of monitoring activity, its cost and effectiveness, has much to commend it. However, the means by which this is

achieved are contentious. He places emphasis on process rather than outcome and he sees this as the most effective way to improve a service. Thambirajah (Thambirajah and Winkley, 1993) suggests that audits into the psychotherapy of children and adolescents are a vehicle for learning about multidisciplinary work and exploring the assessment process in more detail.

c) Sample

Study 1 was based on intensive adolescent cases seen in the clinic during the period between January 2009 and December 2012. The child and adolescent psychotherapists who worked with the patients intensively during this time filled in questionnaires, answering questions about their patients' treatment.

d) Conducting Study 1

The National Institute for Health and Care Excellence (NICE) defined principles for best practice in clinical audit (NICE, 2002, Harding, 2014) which set out five stages in the audit cycle: 1) preparing for audit, 2) selecting criteria, 3) measuring performance, 4) making improvements, and 5) sustaining improvement. Stages 1-3 were carried out during this audit, while plans to carry out stages 4 and 5 were considered.

Ad 1) this audit built upon a previous audit of intensive cases seen by child and adolescent psychotherapists in doctoral training (Robertson, 2007) which had been undertaken in the same Trust. The Robertson audit did not look solely at adolescent cases, but focused on children and young people seen in CAMHS up to age 18. Its results can therefore not be directly related to this audit, although the audit explored comparable topics and similar themes emerged. The time period for this audit was chosen to represent a cycle of intensive work, assuming some cases would be completed within this time. This audit formed the beginning of the audit cycle. In the

time period from Jan 2009 to Dec 2012, seventeen cases were seen intensively in the clinic.

Ad 2) the criteria and questions were developed with reference to the Robertson audit. The questions were then reviewed by the lead for child psychotherapy, the lead of the research department and lead clinicians in the teams. Please see Appendix 2 for a full list of the questions. The researcher asked some closed and some open questions. These focused on the characteristics of the adolescent patient, for example their education, employment, family background. Further questions explored the referral and previous treatment. The questions then focused on the assessment and treatment process in the clinic, including parent work and network. There were also questions about outcome measures and the clinicians' perspectives on change. A series of questions explored mental health diagnoses and payment by result clustering (PbR)[1].

Ad 3) each clinician and their respective patient were identified by the head of department as having been seen in the specified time period. The clinicians were given the forms to answer online, referring back to their files. All the clinicians agreed to participate and completed the questionnaires retrospectively. The data presented is reported by the therapists, based on the therapists' observations and the patients' communication to the therapist (as understood by the therapist). The researcher reviewed the forms by going through the respective files.

The third stage of the audit cycle involved an evaluation of the findings. The data were mostly analysed using descriptive statistics. Summaries about the sample,

[1] Patients over 18 need to be clustered for PbR purposes in this clinic. Clustering refers to an assessment of need and severity of mental health difficulties for over 18s. The clustering describes the severity of difficulties the patients contend with and the ways in which they might be limited by them. The clusters range from non-psychotic (1 to 8) to psychotic (10 to 17) Gateway, N. P. (2016/2017) *Mental Health Clustering Booklet*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499475/Annex_B4_Mental_health_clustering_booklet.pdf..

and simple graphs - designed to illustrate the findings - were used to form the basis of the analysis. One of the open questions generated data which were analysed using thematic analysis (Braun and Clarke, 2006). Braun and Clarke (2006, p. 5) state that 'through its theoretical freedom, thematic analysis provides a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex, account of data'. After immersion in the data set, three themes were defined and named, and the sub-themes allocated.

The data collected in the audit were reported to senior management and the research department, and were then discussed in a small supervision group. Some of the findings describe the processes within the department, while some highlight possible consideration for adaptation. The findings are presented in Study 1 (see Chapter 4) and then further discussed in the Discussion Chapter (see Chapter 6).

Ad 4) and 5) The remaining parts of the audit cycle - that is, of potential changes as well as a repeated audit to review the development - have yet to take place, but will be carried out following the completion of this dissertation.

e) Ethical considerations

Trust ethical approval was granted, and the research department lead was involved in the preparation and evaluation of this audit. No identifying staff or patient information is included in this write-up. The information collated in the audit was anonymised and the cases numbered. The forms were held in locked cabinets and destroyed after the information had been deducted. Identifying information was removed from all documents prior to data analysis.

3) Study 2 - Case Study

Study 2 aimed to find out how the decision is arrived at to recommend intensive psychotherapy for adolescents and young adults. It was decided to undertake a case

study of an inner city clinic consisting of the intake and assessment process at the clinic. The methods of data collection for the case study are observations of intake team meetings and interviews of assessors. The approach is broadly qualitative, focusing on meaning-making and using some principles of IPA for the data analysis of observations and interviews as well as Bion's group theory for the observations of the intake team. The findings from the analysis of both observations and interviews will be presented in Chapter 5.

a) Aims of Study 2

Study 2 aimed to find answers to the second research question: How is the decision arrived at to recommend intensive psychotherapy for adolescents. This question consists of two parts:

- What processes and dynamics are involved in clinical decision-making about intensive psychotherapy at intake and assessment?
- On what basis do intake team and assessors make the decision to recommend intensive psychotherapy?

b) Participants

Having discussed with both supervisors how best to undertake this case study, it was decided that the sample would consist of intake team observations and interviews with assessors and one psychotherapist currently providing intensive treatment. It was decided to observe the intake team on two occasions in order to learn about clinical decision-making at intake. The intake team consists of senior team members of all the teams of the department, representing child and adolescent psychotherapy, psychiatry and clinical psychology. This is a multidisciplinary team consisting, at the time of this study, of a psychiatrist, two trainee psychiatrists, two

psychologists (one being also a psychoanalyst), a child psychotherapists (also a psychoanalyst) and an administrative assistant. This team meets weekly to screen referrals and make recommendations about possible treatment approaches.

The intake team decides whether the referral is rejected, or referred to another service for a generic assessment or for a psychotherapy assessment. When an assessment is offered, the young person will be given the opportunity to 'opt in' and take up the offer of an initial appointment within a given time-frame. Should the referral be urgent, an appointment will be offered immediately. A generic assessment may be undertaken by clinicians from various disciplines to determine whether the patient may benefit from a psychotherapy assessment or from a different treatment (for example cognitive behavioural therapy, short-term psychoanalytic psychotherapy, consultation, family focus). Sometimes the young person will be referred for psychotherapy and/or the intake team will consider a psychotherapy assessment. This will then aim to ascertain whether psychotherapy is the appropriate approach and, if so, what frequency would be most useful.

In order to learn about clinical decision-making in assessment it was decided to undertake interviews with senior assessors and a child and adolescent psychotherapist currently providing intensive treatment. Should an assessment for intensive psychotherapy be considered, the assessors are likely to be senior child psychotherapists, although this is not always the case. Sometimes a young person will take part in an assessment with a junior member of the team and then be considered for intensive psychotherapy. Sometimes an increase of intensity will be considered later on, then a decision will be taken in supervision and by the multidisciplinary team.

All the clinicians in the intake team, two senior assessors as well as a child psychotherapist in doctoral training were asked to take part in this study. Should a young person be considered for intensive psychotherapy on account of their work in weekly psychotherapy, a senior psychotherapist would have been involved in the supervision of the case and the subsequent clinical decision-making. It was therefore decided that clinicians with this role in the clinic would represent 'a variety of positions in relation to the research topic' (King, 2010). There were three senior child and adolescent psychotherapists in the clinic at the time. One of the senior psychotherapists was also the supervisor for this study, so it was decided to ask the other two senior clinicians. Both clinicians were child and adolescent psychotherapists and psychoanalysts. One of the two clinicians took part in two interviews about two cases respectively.

The researcher initially chose to interview a treatment psychotherapist, in this case a child and adolescent psychotherapist in doctoral training, the purpose being to investigate the process of coming into treatment. However, when analysing the data, the investigation narrowed down further to the clinical decision-making process. It was decided not to include the experience of moving into intensive psychotherapy, as it did not directly pertain to the topic of decision-making. The interview with the treating psychotherapist however provided some important insights into the process of coming into intensive psychotherapy and therefore informed the researcher's analysis of the data.

c) Data collection

i) Psychoanalytic observations

The observations of the intake meetings were made drawing on the principles of 'psychoanalytic observation'. Hinshelwood and Skogstad (Hinshelwood and

Skogstad, 2000, p. 210) detail the following aspects of observation in psychoanalytic practice: observing with 'evenly hovering attention' and without premature judgment; careful employment of the observer's subjective experience (sharpened by personal analysis), the capacity to reflect on the experience as a whole, and recognition of the unconscious dimension. Rustin (1998b, p. 110) describes the method further, suggesting that the observer needs both to have in mind 'a range of conceptions and latent expectations, by which they can give coherence and shape to their experience, and to remain open-minded and receptive to the particular situations and events'. He argues that the observer will not know whether any of their preconceptions will fit, but instead needs 'to hold in mind a loose cluster of expectations and conceptions, while remaining open to the experiences of the observation as it develops' (Rustin, 1998b, p. 110).

Skogstad describes the theory and practice of psychoanalytic observation, writing: 'The main research instrument in psychoanalytic observation is the mind, the mind of the observer and the collective minds of a study or research group' (2004, p. 80). In this study the collective minds were made up of the researcher's supervisors as well as of psychoanalytic theory and IPA which were used to analyse the transcripts of the observation. Edwards (2009) describes the three ways in which the observation is experienced: while observing, when writing up and when discussing and reflecting.

ii) Semi structured interviews

In order to learn about decision-making in assessment it was decided that the researcher would interview senior assessors. When planning the interviews the researcher was influenced by a range of data collection methodologies. First and foremost the researcher followed interpretative phenomenological analysis (IPA)

guidance, this also being the main method of data analysis. According to Smith et al., 'IPA requires rich data', these authors suggest that 'participants should be granted an opportunity to 'tell their stories, to speak freely and reflectively and to develop their ideas and express their concerns at some length' (2009, p. 56). The researcher's planning of interviews was also influenced by Hollway and Jefferson (2013) who invite the researcher to question whether they know if everything relevant has been covered and to consider what assumptions have been made about the effect of the interviewees' motivation and memory. They stress the importance of considering the effect of the interviewer on the interviewee in their answers.

Rustin (2010) argues that the main problem with interviews is that the responses can be artefacts of the questions that the interviewer is offering. He suggests a process in which the subject reflects freely on their experience, supported by prompts from the researcher in order to elicit what the subject thinks, feels and remembers of their experience, not what they construct in their minds as they try to answer the questions. Leuzinger- Bohleber's (2003) recommendations on using semi structured interviews for psychoanalytic research also influenced the researcher. These authors suggest that after the first interview the researcher records his or her impressions, for example on psychodynamics and hypotheses, while taking into consideration countertransference reactions. They further recommend identifying psychodynamics and hypotheses about the researcher's countertransference reaction in the data analysis (Leuzinger-Bohleber et al., 2003).

The researcher developed her ability to conduct interviews, learning from her own experience which was recorded after each interview. This recording included

reflections on how to ask the questions, as well as the researcher's emotional responses to the answers.

d) Rationale for methodology of data analysis

i) IPA

Interpretative phenomenological analysis was chosen to analyse the observations and the interview data. IPA is recommended to help explore the experience and meaning of phenomena. The researcher wanted to capture the quality of the actual experience of the intake team observations and the interviews with the assessors. Initially, grounded theory was considered, but then the researcher was influenced by the thinking of Dean Whitehead (2014) who wrote *'Grounded theory might (have) help(ed) develop a theory, being constructivist in its approach... Phenomenology, the philosophy underlying IPA reveals meanings that appear 'hidden' or identifies the impact of a phenomenon, rather than making inferences.'*

According to Reid, Flowers and Larkin et al (Reid et al., 2005) an IPA study is concerned with the phenomenological aspects, the focus being exploring 'experience in its own terms (Smith et al., 2009)(Smith et al., 2009. It does not set out to prove a hypothesis, but is characterized by a 'bottom up' approach. It attempts to provide detailed insight into the subjective world of the participant through the reflected personal experience of the subject (Smith et al., 2009). Husserl's 'back to the things themselves' provides guidance for IPA researchers (Reid et al., 2005).

The following constitute the three pillars of IPA:

- Phenomenology - the study of structures of experience and consciousness - in this context supports the exploration of processes, both between people and

within people. Phenomenological thinking was applied when paying attention to the intake team's experience of the referral and the associated circumstances, the intake team's reactions to the referral, the assessor's preconceptions and their experience of the patient and their interaction, the interviewer's experience of the observations and interviews. A phenomenological perspective was also applied to the process of data collection; for example, Rayner (1992) and Schlesinger (1994) advise how to listen, not in identification with the speaker but in order to hear meanings between, within and behind words.

- Hermeneutics - the theory and methodology of interpretation – here refers to the exploration of the researcher's fore-understanding and the importance of attending to each new phenomenon.

- Idiography is concerned with the particular as opposed to the generalised. Smith, Flowers and Larkin (Smith et al., 2009) advise the analysis to be thorough and systematic, paying attention to the detail and the depth of analysis, and to keep in mind that a phenomenon has been understood from the perspective of a specific person in a specific context.

ii) Psychoanalytic group theory for data analysis

Study 2 aims to answer two questions; what processes and dynamics are involved in clinical decision-making about intensive psychotherapy at intake and during assessment? On what basis do intake team and assessors make the decision to recommend intensive psychotherapy?

While the researcher used IPA as method of data analysis, her thinking was also informed by psychoanalytic group theory. Psychoanalytic group theory helps gain an understanding of the processes taking place in a group and is therefore used to analyse the process of decision-making in the intake team. Using psychoanalytic

theory as part of the research methodology was one way in which the researcher made use of her professional subjectivity.

Bion's (1961) group theory and Armstrong's (2010) and Hinshelwood's (Hinshelwood and Skogstad, 2000) theories on observation in organisations were used to analyse the observation data in order to learn about the processes and dynamics involved in clinical decision-making. Bion, Armstrong and Hinshelwood's thinking is further detailed in the discussion chapter (Chapter 6). Skogstad (2004) and Hinshelwood and Skogstad (Hinshelwood and Skogstad, 2000) highlight the difference between observing organisations versus an individual in treatment, emphasising that in this type of observation the observer is akin to a researcher using psychoanalytic ideas.

In the findings and discussion chapters the two methods of data analysis, IPA and psychoanalytic group theory will come together when considering the results.

iii) What is the relationship between phenomenology and psychoanalysis as theories and methodologies in this context?

A philosophical debate exists about whether psychoanalysis is philosophically related to phenomenology. Lohmar and Brudzinska (2012) describe how psychoanalysis as a science of human experience is related to the exploration of the phenomenological understanding of human experience. Both phenomenology and psychoanalysis are 'disciplines of reflection', and both deal with 'intersubjectivity, the body and temporality'. Moreover, both are 'advanced primarily as methodologies or techniques' (Throop, 2012, p. 93). In terms of this study the following similarities between the theories and the techniques can be found:

IPA refers to Heidegger's thinking about fore-conceptions. Heidegger states that there always is a 'fore-conception' (Heidegger, 1962) and suggests making the 'scientific theme secure by working out the fore structures in terms of the things themselves' (Smith et al., 2009). There are parallels in psychoanalytic thinking in terms of theory and technique: for example, the psychoanalytic clinician aims to move back and forth between what he or she observes and what his or her preconceptions may be. In terms of technique phenomenology emphasises observation and 'bracketing'. In psychoanalytic terms one might understand 'bracketing' to be something akin to Bion's (1967) encouragement to work 'without memory and desire'.

There was a certain amount of overlap between these theoretical positions and that of the researcher. The researcher was conscious of there being a limit as to how far it is possible to apply psychoanalytic theories to data analysis of interviews and observations. Midgley (2006a) highlights how helpful psychoanalytic concepts can be when interviewing and analysing data. However he also questions the extent to which the actual analysis of the data can be undertaken from a purely psychoanalytic standpoint; for example he wonders whether only sufficiently analysed researchers could apply this methodology. It is important to highlight the difference between a therapeutic relationship and the relationship between the object of research and the researcher. Groarke (2008), when discussing infant observation, emphasises the importance of not drawing conclusions from observed data about the internal world of the object of observation. He underlines the difference between intersubjective clinical facts and observable facts. Hence in this context psychoanalytic theory informed the researcher's thinking and IPA provided a structure to analyse the data. **This will be further discussed in Section g.ii) on countertransference.**

e) Generalisability

The following will describe the researcher's thinking about generalisability. On the one hand, using the structure of IPA for data collection and analysis enhances this research, as it creates an environment for potential generalisability. The IPA framework slows down the data analysis process, so the data can be examined more closely and this in turn provides a structured space for reflection. The phenomenological method also fosters the development of concepts and frameworks. This process makes 'the research process accountable and transparent, lessening the risk that findings merely reflect the clinicians' prejudices' (Rustin, 2016, p. 190). In addition to the research methodology the researcher also used supervision and the process of presenting findings in an informed environment to advance reflection.

On the other hand this study is situated in a very particular context, therefore the transfer of learning has to be approached with caution. The contemporary debate about the value of case studies, helpfully informs the thinking about generalisability. Hinshelwood (2010) asserts that observations of subjective phenomena are in principle generalizable. Midgley (2006b) suggests systematic replication to explore what can be transferred and what is different. He argues that series of observations can be used to infer basic principles that are suspected to be an integral part of the phenomena (Midgley, 2006b). Following this argumentation the researcher suggests that the learning from this study can be applied to organisations of a similar kind, i.e. multidisciplinary teams in mental health organisations and further as a model which can be adapted to other settings.

f) Conducting Study 2

i) Observations

The observations of the intake meetings took place in two consecutive weeks. The researcher consulted the team lead as to whether she could observe the meeting and two dates were then agreed. The team members were informed of the researcher's arrival. The members of the team knew the researcher as a child and adolescent psychotherapist in doctoral training and they were familiar with and supportive of the task. After the observations notes were written in as detailed a way as possible, including what the researcher 'saw, heard and felt' not including interpretations (Skogstad, 2004).

ii) Interviews

As the clinicians expressed an interest in this research project, the researcher discussed the nature of the project with them and allowed space for questions and clarifications. The researcher undertook a pilot interview which took place at one of the interviewees' house. Following this, the interviews then took place in a closed room at the clinic over the space of one hour respectively. One of the senior child and adolescent psychotherapists was interviewed twice and one once. The interviews were recorded and transcribed by the researcher and these materials were held securely to ensure confidentiality.

g) Ethical considerations

The research proposal was cleared by both the UEL ethics committee and by the Trust's research department (NHS research study reference 14/EE/1294 and R&D reference 148664). Consent was sought from the intake team members and the interviewees who were given information sheets describing the process and the procedure for recording (see Appendix 3 and 4). A pilot interview took place as part

of the preparation. After completing the data collection the researcher sought consent from the interviewee to include the pilot in the study. To protect anonymity and avoid harm, no identifying staff or patient information is included in this write-up. The transcripts of observations and interviews were anonymised, held in password protected digital files and destroyed after the information had been extracted. Identifying information was removed from all documents prior to data analysis.

i)The researcher's own subjectivity

King and Horrocks (King, 2010) helpfully discuss personal reflexivity**.** The researcher struggled with her own subjectivity both on a personal and a professional level. Both the observations and the interviews took place while the researcher worked at the clinic as a child and adolescent psychotherapist in doctoral training. The researcher was aware that the context within which the research took place, the participants' roles, her own role and the relationships with other team member affected not only her thinking but also what took place during the intake observations and the interviews.

The researcher found she was initially somewhat hesitant to form opinions during the research because it seemed somehow inappropriate to be considering the dynamics within a team which included the researcher's supervisors and consultants. One of the interviewees had also supervised the researcher's clinical work and there was some awareness of the need to keep these aspects of the relationships separate. The process of developing both professional and personal distance was helped concretely by changing the team members' names, as well as by gaining temporal distance from the experience and also developing confidence in thinking after qualification. During the interviews the researcher noticed that she initially felt drawn towards her own agenda, her own thoughts about the assessment

process. The researcher also wondered about the observed group members' and the interviewees' experience of being the object of a trainee's research project. It is possible that the interviewees might have related differently to the researcher because she was a trainee. However the researcher was mainly aware of their wish to support the study and the researcher's interest. The fact that the observations were planned might have had an impact, namely that the group may have behaved slightly differently than when not under observation. This raises the question of how and to what extent the researcher and the team as well as the assessors might have been stymied by the experience of being the observer and being the observed. **Smith et al (2009) argue that in order to gain access to the insider's perspective on the phenomenon, the researcher also has to use their own conceptions. The researcher's own thinking is required in order to make sense of the other's personal world through a process of interpretative activity. Smith call this a 'two-stage interpretation process, or a double hermeneutic' (see also Anthony Giddens (1976)). In this case the researcher was trying to make sense of the assessors' and the intake group's thinking and group dynamics while at the same time the participants were trying to make sense of their tasks. Also in terms of psychoanalytic theory Hinshelwood (2010) states that in psychoanalytic research the instrument of observation is as much a subject as the field of observation (see also Section g.ii). This 'double hermeneutic' is an inevitable part of IPA and psychoanalytic research.** When interpreting the transcripts the researcher aimed to apply her professional understanding and to retain a detached perspective. The researcher repeatedly tried to get away from any prior understanding and experience and confront the data with

an open mind, **applying Nancy McWilliams' (2013) 'disciplined subjectivity'.** The supervisors helpfully reminded the researcher to write in the spirit of curiosity.

ii) Countertransference

Countertransference, one of the pillars of the psychoanalytic method has a long initially contested history. The thinking about countertransference evolved from whether it could at all be useful, to conceptualising different kinds of countertransference and how to best make use of it. While Freud (1957) thought of countertransference as an experience one should try to abstain from, Heimann (1950) first named countertransference as a potential indicator of an aspect of the patient's experience. This way of thinking of countertransference was then hotly debated over the next fifty years. Racker (1988) explored different types of countertransference, and more recently Spillius (Spillius and O'Shaughnessy, 2011) spoke about the different elements of countertransference. In the context of this study the question arises whether the researcher's countertransference is too subjective to be considered empirical data.

There are two strands of argument about the subjectivity of countertransference. Both Sternberg (2016) and Hinshelwood (2010) highlight the subjectivity of the therapist's experience and how this is where its very value lies. Hinshelwood (2010) asserts that psychoanalytic research is inherently subjective, as both the instrument of the observation as well as the field of study are subjective. The field of this study being the clinical decision making process of the intake team and the assessors, the observations are inherently subjective for both the objects of study as well as the researcher who undertook the observations and interviews (see also Section g.i).

Secondly the issue of the researcher's countertransference is related to the question of the relationship between psychoanalytic research in the consulting room and using psychoanalytic concepts and methods in research (see also Section d.iii). Holmes (2014) asserts that careful reflexive exploration is necessary, that countertransference is only one of the sources of data that the researcher will explore. In this study the researcher used her countertransference to inform the process of data collection and analysis. For example, the researcher used process notes in addition to tape recordings of the interviews to provide accurate and reflected material (Kegerreis, 2016).

4) Analysing and managing data

Smith, Flowers and Larkin (Smith et al., 2009) provide helpful guidance on how to undertake an IPA study. The researcher immersed herself in the original data by transcribing the interviews. It was a slow process but one which did come to life and the researcher can even still hear the interviewees' voices. The researcher read and reread the transcripts and started making notes alongside them.

a) Gathering associations and developing themes

Associations were gathered by writing down thoughts next to the transcript. The themes then evolved from working over the associations, while still following the transcript line by line. Following the guidance in such a concrete way helped to keep the experience alive. Kirkham and Smith (Kirkham et al., 2015) state that IPA requires close interpretation on the part of the researcher. This means making sense of the phenomenon experientially and then connecting the interpretation back to relevant and resonant theoretical and/or empirical work in the discussion. '*A distinctive feature of IPA is its idiographic commitment whereby the lived experience of the particular individual retains a central role throughout the research process….'*

They recommend to '*dig deeply into how you have made sense of your participants making sense of their experience*.' (2015, p. 30)

Subsequently the original data were numbered - captured in columns between associations and themes - in lines, in order to be able to quote from the relevant section. During this process of analysing words and sentences for their meaning and content, the researcher was aware of her countertransference. What the researcher made of what was being said was coloured by her preconceptions and expectations of what the interviewees and the observed team had said. Braun and Clark (Clark, 2014) advocate that an IPA theme should capture and illuminate a pattern of meaning in the data. The researcher was wondering was she just allocating themes according to what she had expected? How were her preconceptions impacting on her experience of the data? After this initial analysis the researcher put the first transcript into a table, with exploratory comments on one side and themes on the other.

b) The big muddle

The next step in the process was to take out the themes collated in the left column and to cut them into lines. IPA recommends cutting up the themes to aid abstraction, and this indeed helped to get away from preconceptions as well as the actual data in their original form. There now was a little mountain of pieces of paper. The researcher then laid out the themes in different groupings. It seemed hard to find a piece of paper big enough to contain all the themes. This of course mirrored a parallel process in the researcher's mind; having cut them all up, they had now become a big jumble of ideas that seemed hard to hold in mind all at the same time. The researcher contended with a lack of confidence and not trusting the process enough, while putting the pieces of paper on a large roll of wallpaper on the floor.

The next step was to read the themes again and then put them into groups on the page. After this, they were regrouped and regrouped. The researcher became interested in this process, creating a shape and then taking it apart, and this helped her think about the themes and how to cluster them. As the themes were cut up into little pieces, the researcher felt less preoccupied with her expectations and better able to open up a larger space in her mind. Some sense of the themes emerged, and some unexpected directions evolved. By the next interview the researcher started from scratch, and it felt like a whole new set of ideas. This process was performed with all four interviews and both intake observations. Rigorously following the IPA steps helped the researcher not to feel influenced from one set of data to the next.

c) Finding superordinate themes

Together, the themes of the different interviews and observations seemed like an utterly unwieldy mess. Having derived exploratory themes for all of these different pieces of activity, the researcher returned to the literature to think about how to bring them together. At this stage, one of the recommendations had been to set up a new document for each emergent theme; however, this was decided against as it seemed that the themes were still too numerous and too descriptive; similarly, the text was extremely dense and the associations already abstracted. The team, interviewees and the researcher shared a professional language which was quite different from interviewing someone whose language would have to be decoded. However, each theme potentially harboured sub-themes, and it was therefore important to decode the language.

Subsequently, all exploratory themes were collated in a new document and then cut into pieces. While they were spread across the floor, the researcher looked

at the themes across all the interviews and observations, before deciding to describe a thematic structure for each interview and observation. This latest collection of themes was cut up again and spread out on a roll of wallpaper. The wallpaper now seemed to predicate a longitudinal process. The researcher tried out three dimensional presentations of the thematic material to counteract this. Through this process of repeatedly putting together and taking apart, themes gradually started to emerge and a superordinate theme finally came to light. Slowly, a number of themes started to fit the developing range of superordinate themes. At first the researcher developed the themes separately and also analysed the data from the two datasets (interviews and observations) separately. Subsequently, however, it was decided to draw the themes together and explore clinical decision-making across both datasets. Eventually, the researcher decided that the processes were too different to be compared in this way, and a decision was taken to explore clinical judgment in two parts - the intake team and the assessors.

The psychoanalytic interpretation of the findings was undertaken in two ways. Firstly, as the researcher is a psychoanalytic psychotherapist, psychoanalytic thinking permeated the analysis and provided the background to the structural framework of IPA; secondly, the researcher used psychoanalytic group theory specifically when analysing the excerpts from the intake team observations (for results see Chapter 4 and the discussion in Chapter 5).

d) Writing up

During this process the researcher realised that the original research question needed to be refined. There was a wish to return to the interviews and ask the questions differently or with more detail. Subsequently, a narrative was written for the themes relating to the research question, all the while refining the themes in mind

and on paper. Again, the researcher was forced to confront the difficulty of becoming detached from the data and from the experience of having worked in the service.

At first, the process of assessment was described in order to analyse how a clinical judgment is arrived at. The focus was developing themes and then returning to the respective case, a process which entailed honing in and out. Finally, the researcher went back to the drawing board and re-thought the research question. In supervision it was acknowledged that the first draft of findings focused mainly on a description of the process, and that the themes needed to be further abstracted and the analysis developed. The first part of the question - what processes and dynamics are involved in clinical decision-making about intensive psychotherapy at intake and during assessment - explored two different processes, namely intake group thinking and the assessor's experience. Hence it was decided to develop themes for the first part of the question separately for the two datasets of observations and interviews. The themes relating to the second part of the question – on what basis is this clinical decision about intensive psychotherapy made? – are brought together in a single set. Clinical decision-making was now thought of more abstractly from the researcher's overall experience and then aspects of this experience were analysed. In this way the themes were reformulated and restructured. At the same time, the original text was revisited with the aim of not becoming too far removed from the original data. In Chapter 5 the findings relating to the first question - what processes and dynamics are involved in clinical decision-making about intensive psychotherapy at intake and assessment - are presented separately. The data for the second question - on what basis is the decision made to recommend intensive psychotherapy - are brought together in a single set of findings.

Chapter 4: Findings from Study 1 - Audit

Audit of adolescents and young adults in intensive psychotherapy in a large, inner-city adolescent mental health service

Introduction

Chapter 2 outlines the gap in empirical research about intensive psychotherapy for adolescents. There is scant empirical evidence about who gets referred, who intensive psychotherapy treatment is recommended to and who benefits from it. We do not know which adolescents access intensive psychotherapy, nor how they are chosen. It is also not empirically evident how decisions are made about who should be offered this type of therapy, given it is a limited resource. Study 1 and 2 therefore aimed to answer a number of questions: what are the characteristics of the adolescents coming into intensive psychotherapy and how is treatment set up? What processes and dynamics are involved in clinical decision-making about intensive psychotherapy at intake and assessment and on what basis is a recommendation made?

This chapter focuses on the first question. An audit was undertaken to show which adolescents came into intensive psychotherapy, what their journey was into treatment, what intake and assessment processes consisted of and how intensive psychotherapy was set up in terms of network, supervision and parent work arrangements.

For the purpose of the data analysis in this study, the audit results were grouped into three areas of interest. Group one covers personal details, living arrangements, education, employment and family history. The second group of questions consists of those about referral, assessment and history of previous treatment and diagnosis. The third group explores the determining factors for the

treatment recommendation. Were the sessions increased, was there a change between the assessing and treating clinician? Here the audit also inquired about supervision arrangements and parent work. The data analysis is presented as numbers of cases with percentages in brackets. Each case represents 5.88% of the sample.

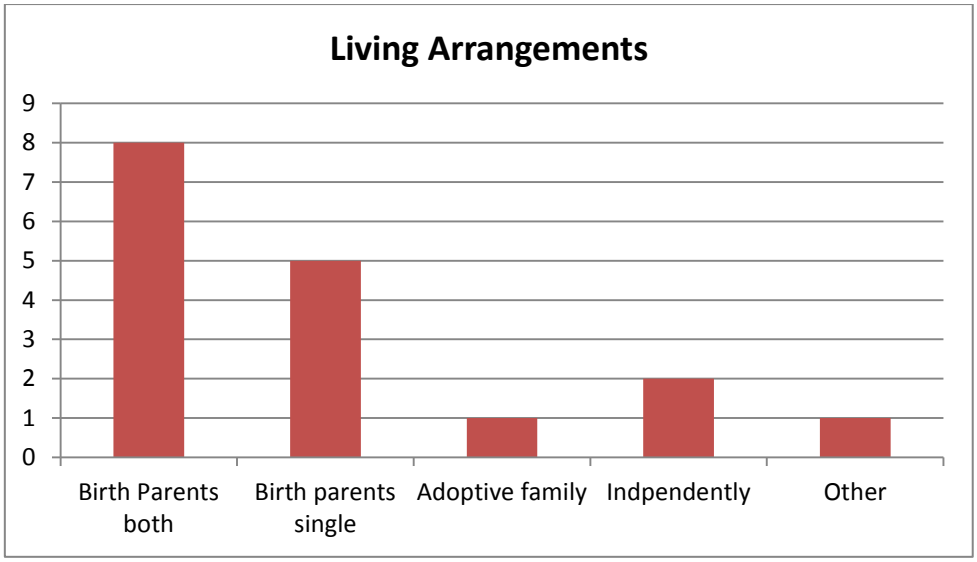
1) Results

a) What are the particular characteristics of the adolescents and young adults who come to the clinic?

The first cluster of questions helped establish a picture of the population who took part in intensive psychotherapy at this clinic over a four year time-period, from January 2009 to December 2012. During this period 1098 referrals arrived at the clinic. 17 of these were selected for intensive psychotherapy. Descriptive data about gender, age and ethnicity for those who went into intensive therapy were gathered, but also about living arrangements, family background and whether the patients were in work or education. The audit comprised 13 young women between the ages 14 and 23, with the average age being 18.69 years. There were four male patients between 17 and 20 years old, with an average age of 17.75. The average age of males and females combined was 18.47. Of these, 12 were White British, one White Other and four Black Minority Ethnic. The local census of 2013 estimated that nearly 34% of the population are from a black minority ethnic group (BME) background (Camden, 2015). The audit therefore showed a slightly lower percentage of 24% BME than average in this locality.

Graph 1

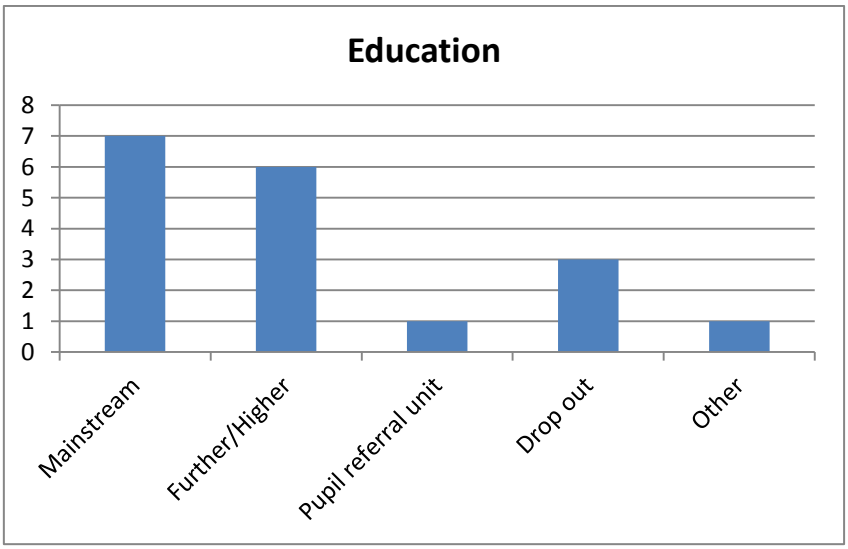
This graph shows the patients' reported living arrangements.



Eight patients (48%) lived with both birth parents, five with single parents, two independently and one with their adoptive family.

Graph 2

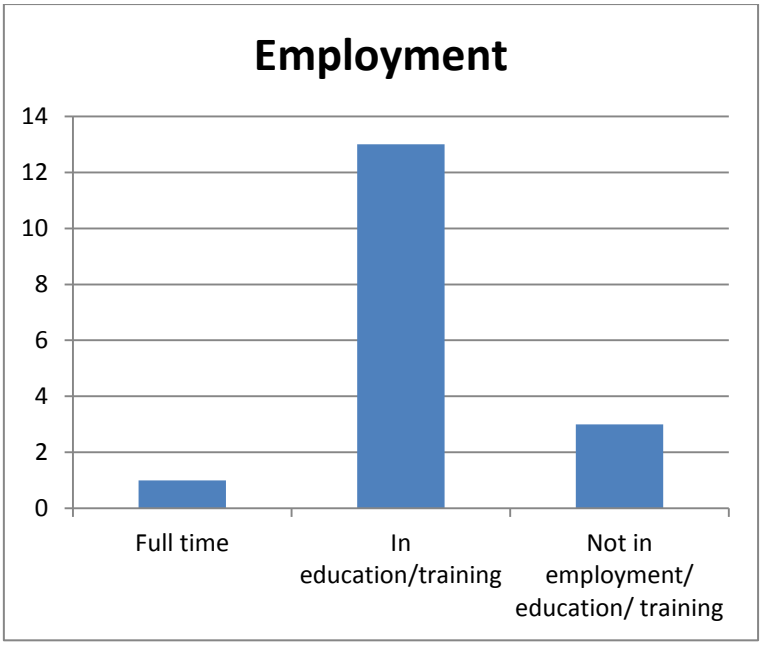
This graph provides information about the educational background of the patients.



13 (78%) patients were in mainstream and/ or higher education. Three patients had left school early and one attended a pupil referral unit.

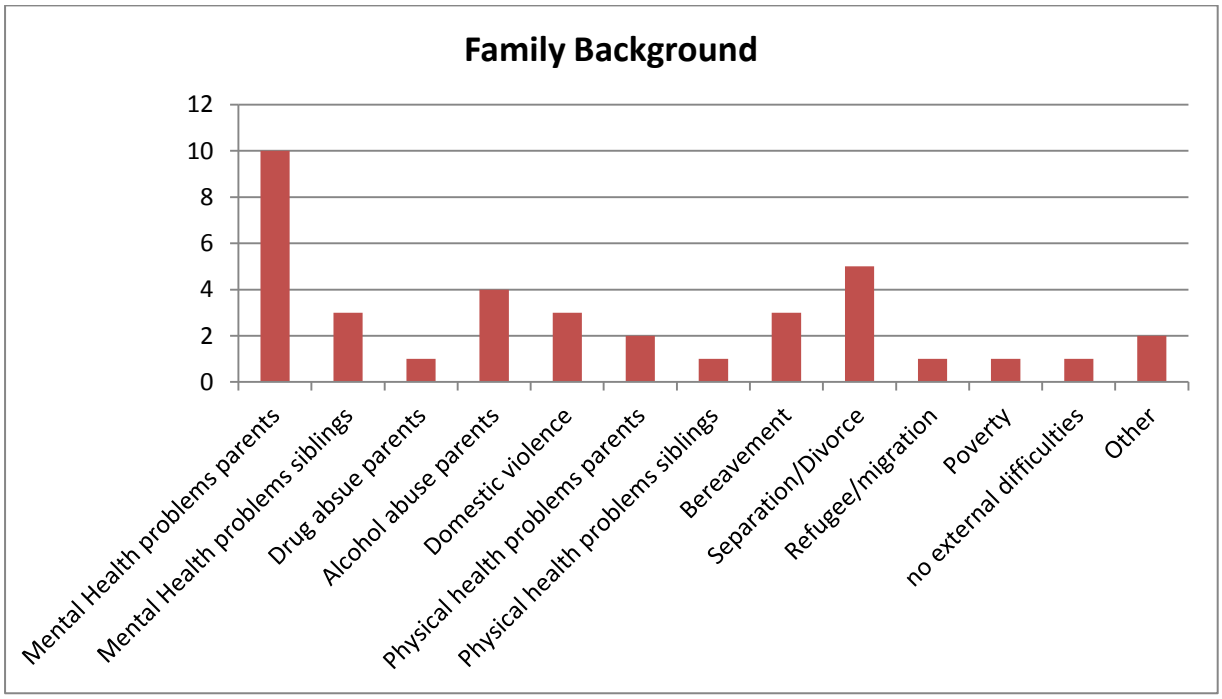
Graph 3

This graph shows whether the patients were reportedly in education or employment.



Graph 3 shows that 13 (78%) patients were involved in education, training or work.

Graph 4 gives information about the patients' reported family backgrounds.



Graph 4 shows that ten patients (60%) reported parental mental health problems according to their therapists' reports. The therapists also reported a series of further

external difficulties, and only one patient did not have external difficulties according to their therapist.

b) What is the journey into intensive psychotherapy?

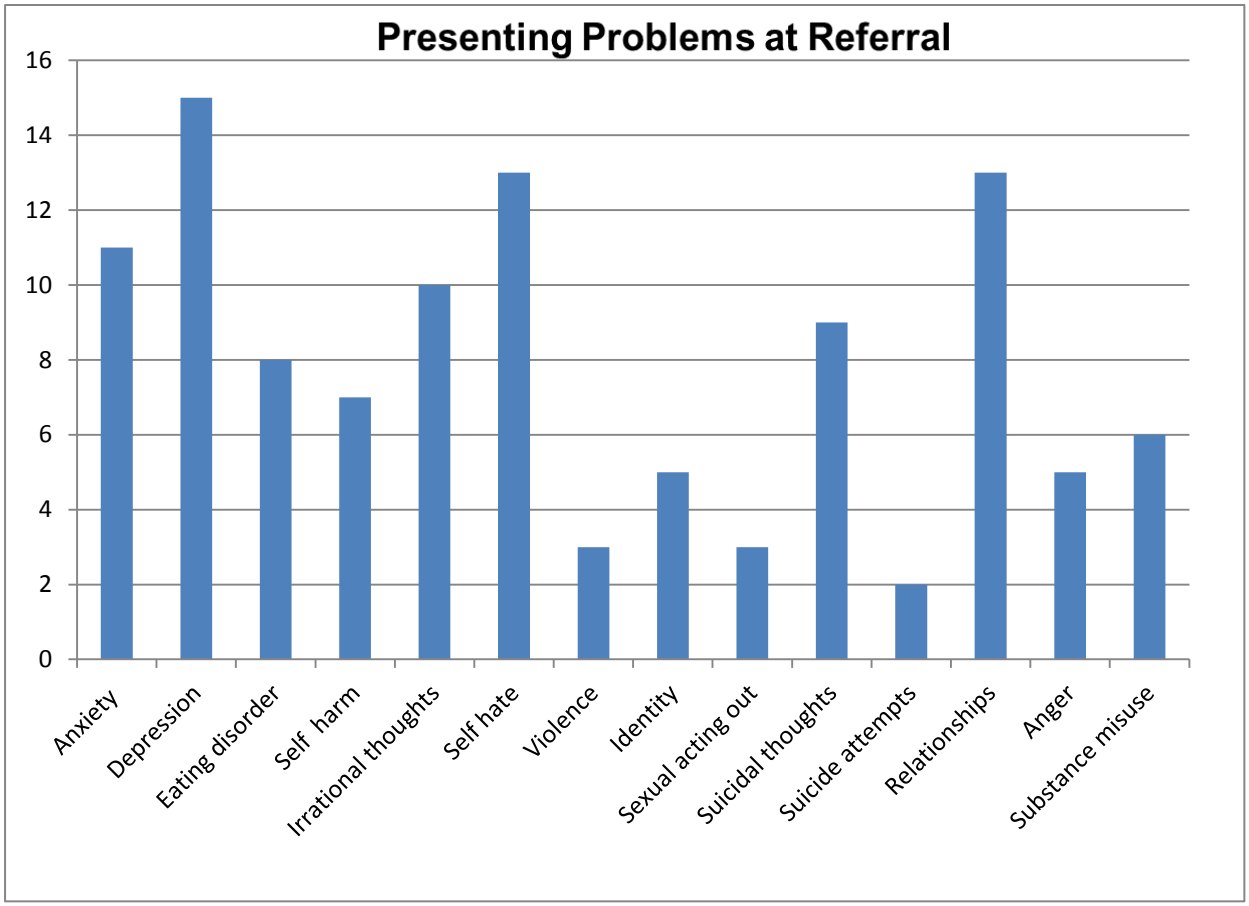
In the second cluster of questions, some of the parameters of the process regarding coming into treatment were explored. The audit focused on the referral background, presenting problems at the time of referral, treatment history, other professionals involved, diagnoses and Pbr clustering.

12 (72%) patients were referred specifically for psychotherapy, while three had referred themselves; the remainder were generic referrals. This process had changed in recent years, as from 2008 onwards referrals from outside the local borough have needed to be initiated by a professional. Since then, only adolescents and young adults in the local borough can self- refer.

The presenting problems section (see graph 5) shows that many patients had a number of concurrent difficulties.

Graph 5

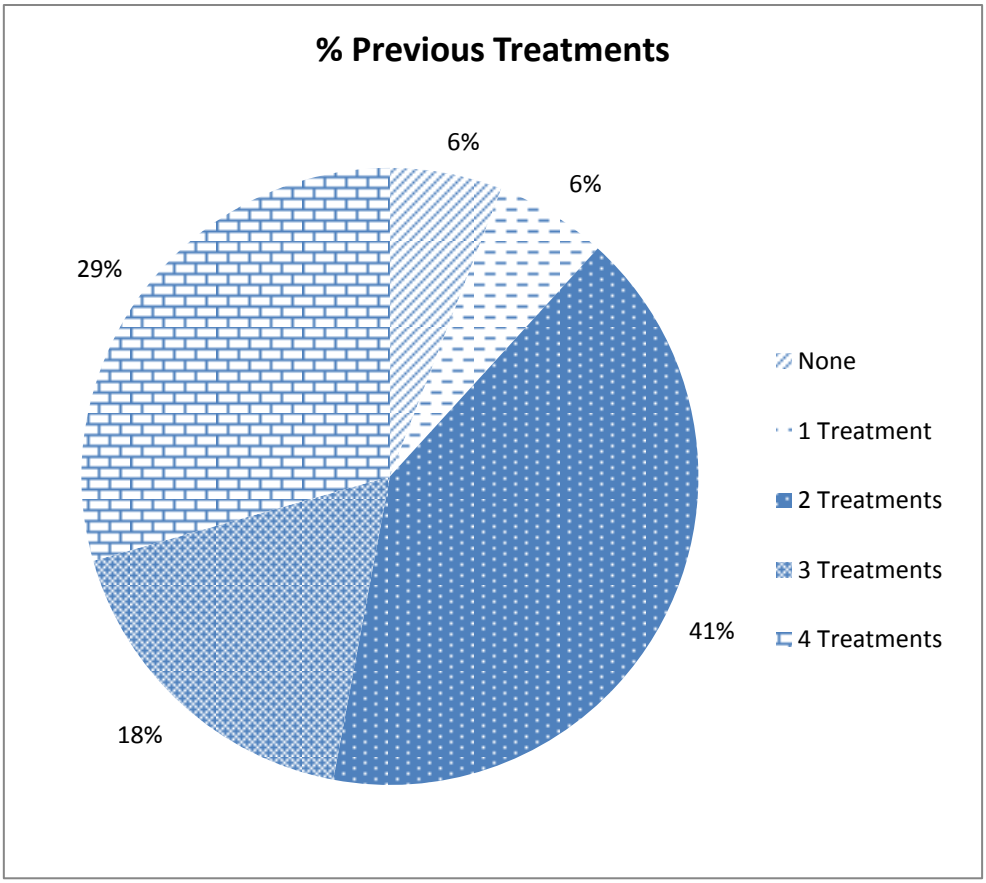
This graph shows the reported diversity of presenting problems at the referral stage.



This graph shows that, according to their therapists' reports, not a single person presented with just one presenting problem. Two patients (12%) were rated for 10 or more out of 15 problem areas. 14 patients (84%) had depression, anxiety and relationship problems, nine patients had suicidal thoughts, eight patients were scored for eating difficulties disorders, five patients for anger and three for violence. The patients had an average of nearly 6.5 (6.47) presenting problems.

Graph 6

This graph shows the previous treatments that the patients had reportedly had.

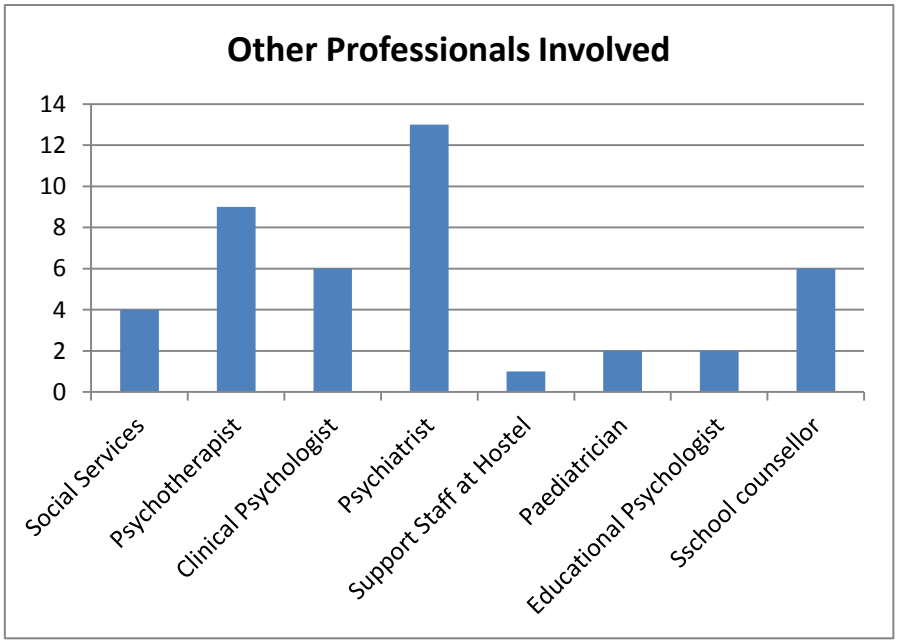


For purposes of illustration, figures in this graph total 100% and some have been rounded up from 5.88% per person.

Graph 6 shows that, as reported by the therapists, only one patient (6%) had had no previous treatment, five patients (30%) had had inpatient treatment, eight patients (48%) had previously been in receipt of medication and ten patients (60%) had had previous treatments.

Graph 7

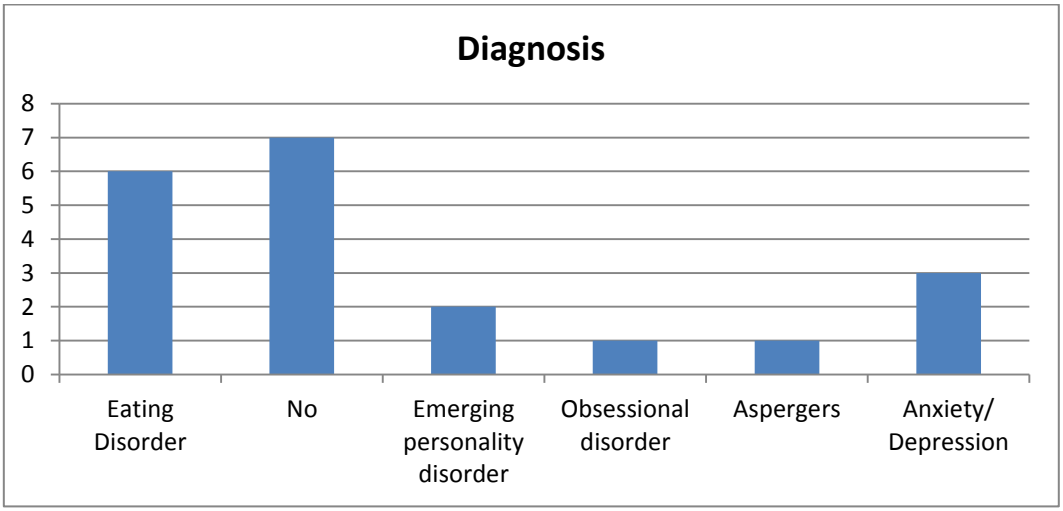
This graph shows the reported diversity of professionals involved.



According to the therapists' reports, 13 patients (78%) had had psychiatric input at some point. The audit questions did not distinguish between previous and concurrent psychiatric involvement and concurrent psychiatry involvement. Every patient had from one to five professionals involved, historically and currently.

Graph 8

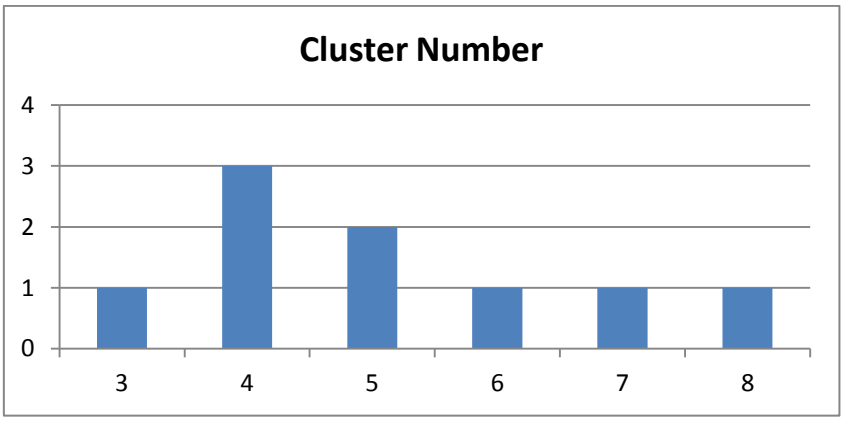
This graph gives some information about reported diagnoses.



Graph 8 shows that, according to the therapists' reports, seven patients did not have a diagnosis on the basis of the assessment while ten patients (60%) were given a diagnosis at this stage.

Graph 9

This graph shows the distribution of cluster numbers (PbR).



Nine of the over 18 year old patients (90%) had been clustered. The clusters all ranged in the non-psychotic field, starting from one patient rated as three (moderate severity), three patients as four (severe) and two as 5 (very severe). However, there were also three case respectively which were rated as 6 (overvalued ideas), 7 (enduring non-psychotic disorder high disability) and 8 (chaotic and challenging disorders). This suggests a considerable level of need and severity of difficulties.

c) Intake and Assessment

The third cluster of questions looked at the circumstances surrounding the clinical decision- making process. 15 cases (90%) were referred for psychotherapy by their original referrer, for example their GP, psychiatrist and university counsellor. One young person was referred for a generic assessment. None of the cases had been referred for intensive treatment.

At intake, the assessments were allocated according to information gleaned from the referral regarding severity and complexity. 13 cases (78%) were assessed by a child and adolescent psychotherapist (frequently an experienced child and adolescent psychotherapist at senior level), one case (6%) was assessed by a trainee psychiatrist, two (12%) by a psychiatry consultant and one (6%) by a clinical psychologist. In 12 cases (72%) there was a change in clinician between assessment and treatment.

d) Clinicians' recommendations

The audit explored the recommendations made by the assessing clinicians. The clinicians referred to the following as being indicators for a recommendation of intensive psychotherapy:

a) case complexity including severity and longevity: for example considerable personality difficulties, excessively harsh superego, high degree of isolation, somatisation, poor self - image, long standing difficulties and previously recommended intensive treatment.

b) risk: for example psychiatric breakdown, refusal to enter inpatient treatment, inability to tolerate gaps between sessions and acting out (sexual acting out, self - harm and suicidal ideation).

c) factors apparent in the relationship between patient and assessor: for example 'difficulties with thinking', capacity to use psychotherapy.

In eight cases (48%) the treatment modus was changed to intensive by increasing sessions. This may mean that the patient was seen on a weekly basis at first, but it could also indicate that the sessions had been planned to slowly increase from the outset. The data from this audit does not show in which cases the increase

had been planned from the outset and in which cases the increase took place due to the recommendation changing during treatment.

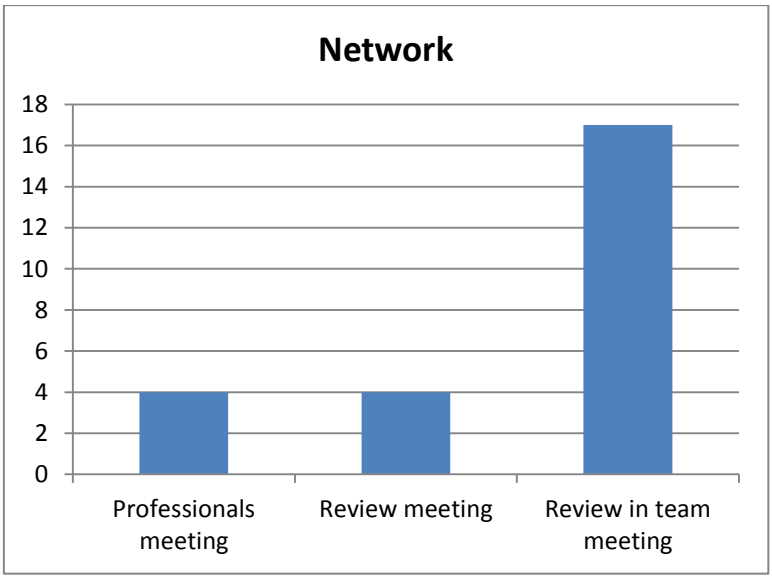
e) External parameters relevant to setting up treatment

The following section will show how intensive psychotherapy was set up in terms of professional network, supervision and parent work arrangements. All three aspects were reported on as being elements of intensive treatment. This information was of course not available at the beginning of treatment, but only in hindsight. However, the findings will be presented here in order to illustrate how both professional network and engagement with parents are important parameters that influence the clinical decision-making at the beginning of, and throughout, treatment.

i) Professional network

Graph 10

This graph gives some information about the network involved.



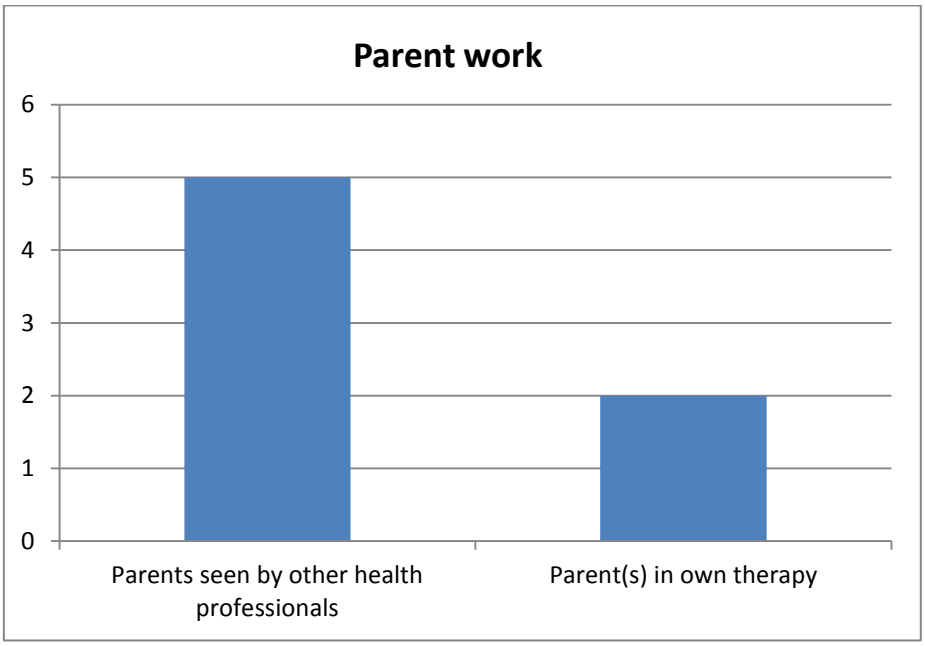
All cases were reportedly regularly reviewed in multi-disciplinary team meetings. In four cases specifically arranged review meetings and professional meetings took place. The audit also enquired about the internal holding framework

for the intensive treatment. All cases had weekly ongoing supervision for one year. In 14 cases (84%) supervision was ongoing until the end of treatment. The clinicians all described supervision as very helpful in terms of reflecting on the dynamics of the case, the therapeutic relationship and technique.

ii) Parent work

Graph 11

This graph gives some information about the reported parent work involved.



In 7 cases (42%) the parents were reportedly either undertaking parent work or were receiving their own therapy. Parent work is provided by another clinician to the parent in regular sessions alongside the patient's treatment to support the therapy. According to the therapists' reports three patients' parents were either unavailable or lived at a great distance. In one case, it was not recommended by the referrer to involve the parents while in another the parents withdrew; in three cases the patient did not want the parents involved. In two cases it was not clear why the parents were not involved other than that the patient was a young adult.

2) Discussion

What might the results suggest about which adolescents come into intensive psychotherapy, what their journey into treatment entails, what the intake and assessment processes consist of and how intensive psychotherapy is set up in terms of network, supervision and parent work arrangements? The following discussion takes each of these in turn.

a) Which adolescents and young people come into intensive psychotherapy?

Firstly, it is apparent what a rare resource intensive treatment is, considering that only 17 (1.54%) of the patients referred to the clinic were seen intensively. The first group of results provided a profile of this cohort, the majority living with parents, in education or work. The first three graphs can be understood as demonstrating that the patients had a certain amount of external stability, being largely engaged in education and employment, and having outwardly stable living arrangements. Only 4 cases (24%) had social services involvement. This picture highlights one of the factors, namely external stability, which might be considered as protective when considering intensive psychotherapy. Study 2 will explore how the patient's external support and their internal capacity are assessed.

This audit, however, revealed a mixed picture as some patients had very little outside stability and the intensive treatment might have been undertaken instead of inpatient treatment. In six cases inpatient treatment had been offered before. In two cases the patient chose intensive instead of inpatient treatment. This also raises the question as to whether intensive psychotherapy can be considered a viable alternative to inpatient treatment.

Looking more closely at the patients' family backgrounds it becomes apparent that there was significant disturbance in the patients' immediate environment.

Research suggests that mental health difficulties in parents are highly correlated to mental health difficulties in children (Rouf, 2014, Siegenthaler et al., 2012). This outcome echoes the outcomes of the Robertson audit (2007), which highlights the complexity of intensive cases: that is, a third of the cases were not living with their birth families and a high proportion of the children in treatment were living in families who had a range of serious difficulties. A direct comparison between these two audits is not possible however, as this audit focuses only on adolescents and young adults (up to age 25) while the Robertson audit focuses on patients' aged up to 18. However it is clear that both audits unearth the themes of complexity and family difficulties. Indeed it would be interesting to consider whether there were similarities in the kinds of difficulties experienced by those young people whose parents also had mental health problems. However, from the given data it was not possible to draw conclusions about this.

b) What is the journey into intensive psychotherapy?

In an audit of psychotherapy in CAMHS, Kam and Midgley (2006) consider the hypothesis that psychotherapy might be seen as the treatment of last resort. This audit suggests that this might have also been the case for this cohort, since it shows that in 60% of cases the patients had undertaken treatments previously. An audit carried out at the Brandon Centre (Baruch, 1995), a community-based psychoanalytic psychotherapy service also targeting young people up to the age of 25, showed that the target population are young people who predominantly fall within the clinical range, and that young people usually present with more than one diagnosis and multiple problems. The Brandon Centre has a self-referral system, while the clinic under observation in this present study mainly has a GP referral system. It is plausible to suggest that some of those young people accessing the

service via self-referral might be those most open to undertaking treatment, and this might be an interesting area for further research.

From the data, a mixed picture emerged: the analysis showed that the PbR (payment by result) clusters indicated some rating of mental ill health. However as only half the cases were clustered, this number cannot be taken as representative. Based on the reports completed by the psychotherapists, the majority of patients had a range of mental health difficulties, their problems were long-standing and they had received numerous previous treatments. At the same time only 60% of patients had been given a formal diagnosis. Using diagnosis as a measure for mental ill health with this age group raises complex questions. Might the low level of diagnosis be an indication of less complexity? Alternatively might this be based on the thinking in this service that diagnosis may be inaccurate and/ or unhelpful for adolescents and young adults who still have considerable development ahead of them and should not be given the message that their difficulties are permanent? Bell (2010, p. 15) argues that psychoanalytic thinking does not generally think of patients having a number of illnesses, but rather 'only one illness which expresses itself in different ways, and which is inseparable from his character'. Further research could helpfully explore and describe psychoanalytically informed 'diagnoses' and which of these might be best treated with intensive psychotherapy.

It is noteworthy that about one third of patients had eating disorders. Intensive psychotherapy is not the first treatment choice for eating disorders, with NICE Guidelines (NICE, 2017b) recommending family therapy and CBT. However it may be that this treatment was chosen for this cohort due to the simultaneous presence of a number of difficulties (as described above see graph 5).

c) Intake and assessment

The audit described how intensive psychotherapy is set up at the clinic, namely assessment, involvement of the multi-disciplinary team (MDT), professional network and parent work.

After intake an assessment takes place, the decision about whether the patient remains with the assessor for ongoing treatment or not depends on the patient's needs, as well as logistical determinants, for example the availability of specific treatment options. Sometimes it is decided to start intensive psychotherapy in stages, starting weekly in the first instance; sometimes, the intensive work evolves out of weekly ongoing psychotherapy.

The audit covered determining factors for intensive psychotherapy. While these are based on the clinicians' descriptions, they nevertheless give a flavour of the factors considered. While some of the determining factors were descriptive, others were quite vague for example 'the capacity to make use of' and 'not being able to think'. These descriptions might be indicators for a recommendation for intensive treatment or they might, in another case, be considered a contra-indication. The clinicians' descriptions were solely derived from the relationship in the consulting room whereby the clinician observes and explores the patient's and their own experience of being with the patient in the room. These considerations are therefore highly idiosyncratic to the respective case and its development throughout the assessment. The subjectivity of this process raises a number of questions which will be considered in Study 2. All psychotherapists reported regularly taking their cases to team meetings and/ or review meetings. Ultimately the recommendation is made by the MDT.

d) External parameters relevant to setting up treatment

i) Professional network

This audit highlights the fact that a significant professional network had been involved for the purpose of containment the treatment in most cases. The professional network consisted of professionals involved within the organisation and those in outside agencies. A large number of patients had a number of other professionals involved in their care, some historically, some currently. The data gathered is not conclusive on this point since it does not distinguish clearly between historical and current involvement; however, it points to the importance of considering the involvement of outside agencies. In cases with limited parental involvement it is often external agencies that provide the parental functions of supporting the treatment in conjunction with the intensive treatment team (clinician, supervisor, MDT). This is similar to the outcomes of the Robertson audit (2007) which found that the families of the children in treatment had contact with a wide range of professionals both within and outside the clinics where the children were being seen.

ii) Parent work

This audit explored some aspects of the set-up of the intensive treatment for this cohort. Intensive treatment was set up as a holding framework, with the clinician holding the patient, the supervisor holding the clinician, the parent worker holding the parent, and the team holding the case including parent worker and supervisor. It is interesting to note the relatively low parent involvement: in seven cases (42%) parent work was reported on, which seems a small number considering the level of complexity of the cases and the reported levels of parental mental health problems. By comparison in the Robertson audit (2007) 88% of parents took part in parent work

and 71% were seen on a monthly basis. Robertson (ibid) states that a large proportion of child and adolescent psychotherapy trainees listed the support of parents as one of the factors that helped intensive work. While a direct comparison of the Robertson audit with this audit is not possible due to different age ranges and the Robertson audit including younger children who might have had more parent involvement, one can nevertheless infer that parent involvement is an important factor to be considered and one which could helpfully be investigated further. The Beedell and Payne (1988) and Rance (2003) audits similarly highlight the importance of the involvement of child and adolescence psychotherapists in parent work.

There may be a number of reasons why less parent work took place in this cohort. While parents are involved regularly to some degree in the assessment process for children up to age 16, after this age the adolescent can only be encouraged to agree for their parents to be seen. And while there may be exceptions to this if there is very serious risk involved, a proportion of adolescents might be reluctant to have their parents involved in their treatment.

On the other hand this relatively low figure might also indicate a raised level of disturbance in the respective families, and that, as a result, some parents struggled to engage with treatment. From a service perspective one might wonder whether facilitating access to services for parents could be a focus point. It could be helpfully explored whether parents were offered support and did not take it up, or whether and why it was not considered an appropriate offer. It would also be interesting to explore the link between case complexity (see point 1) and parents being involved in parent work.

The audit leaves many questions about the actual treatment unanswered; for example, what actually happens in treatment between the therapist and the patient?

How do the parameters designed to support treatment impact on the process? Furthermore, it might be fruitful to explore whether a tighter network and more parent support leads to better outcomes.

3) Limitations

The cohort was small and the findings provide only an impression of what an adolescent population entering the service in the given time period looked like. Unfortunately, the audit did not include data on the other 1081 patients who did not receive intensive psychotherapy. Therefore the characteristics of this small sample cannot be compared to the characteristics of all the patients referred in that period. The data is collected from the psychotherapists only and therefore gives only one perspective. It is taken retrospectively, which means that the therapists' views on presenting problems, clustering and diagnosis might have been affected by the experience of working with the patient. Follow up audits would help determine whether these findings can be generalised and a comparative analysis could take place. Little statistical analysis was possible, unfortunately, as the numbers are relatively small.

In hindsight, the researcher could have focused on the decision-making process in more detail in order to learn more about the choice between weekly and intensive psychotherapy. The researcher would also now phrase the questions more clearly; for example, whether other professionals were involved in the past or now. The audit raises many points that would require further data in order to provide definitive answers. The audit as seen here does not contain all the data which had been received. Some of the answers to the open questions (see Appendix 2) were not included as they were considered not relevant to the purpose of this study.

4) Conclusion

Plans were made in the clinic to attend to stages 4 and 5 of the audit cycle. When repeating the audit it would be helpful to include the following:

- an audit of the intake process
- the correlation between parental mental health and adolescent mental health
- outcome measures

This audit described the adolescent population offered intensive psychoanalytic psychotherapy in one clinic over a given time period; it also detailed some of the circumstances of the clinical decision-making and some parameters of the intensive treatment. The focus now shifts to how the decision to recommend intensive psychotherapy is made, bearing in mind that the audit did not detail the clinical decision-making process within the multi-disciplinary intake team (an exploration of this process will be part of Study 2).

Chapter 5: Findings from Study 2 - Case study

How is the decision to recommend intensive psychotherapy to an adolescent patient made?

Introduction

This chapter will present the findings from Study 2. As outlined in Chapter 2, there is a dearth of empirical research about intensive psychotherapy for adolescents; thus there is scant empirical evidence about who gets referred, who intensive psychotherapy treatment is recommended to and who benefits from it, nor do we know which adolescents access intensive psychotherapy and how they are chosen. It is also not empirically evident how decisions are made about who should be offered this type of therapy, given that it is a limited resource. In Study 1 an audit showed which adolescents were referred for intensive psychotherapy and what their

journey into treatment was. Study 2 then aimed to find out how the decision is made to recommend intensive psychotherapy to adolescents in one particular service. The findings are organised to shed light on two components of the research question:

- What processes and dynamics are involved in clinical decision-making about intensive psychotherapy at intake and assessment?
- On what basis is the decision to recommend intensive psychotherapy made?

A number of themes emerged from the observations of intake meetings and interviews with assessors. Some of the themes bring aspects from the intake observations to the fore while others focus more on the interviews with assessors. In addition the themes sometimes overlap or feed into each other. Excerpts from the observations and interviews will evidence determining factors of the clinical decision-making process to recommend intensive psychotherapy for adolescents. A discussion of the findings in Chapter 6 will highlight discrepancies and gaps of the research.

This chapter begins by considering the processes and dynamics involved in the clinical decision-making process and then setting out the factors which had been considered during these processes. Section I will evidence aspects of clinical decision-making at intake and assessment separately, while in section II themes from observations and interviews will be shown together.

When considering intake process results, the referred young person will be described as the ‘young person’; when presenting assessment results, the young person will be referred to as the ‘patient’. The clinicians who took part in interviews will be referred to as assessors.

Code for letters:

Intake team:

B- Chair, consultant clinical psychologist and psychoanalyst

Dr T- Consultant psychiatrist

N – Consultant child and adolescent psychotherapist and psychoanalyst

Dr D – Trainee psychiatrist

C - Consultant clinical psychologist

Interviews:

N1 and N2 - Consultant child and adolescent psychotherapist and psychoanalyst interviewed about two assessments on two occasions

P – Consultant child and adolescent psychotherapist and psychoanalyst

Y – Trainee child and adolescent psychotherapist

1) What processes and dynamics are involved in clinical decision-making about intensive psychotherapy at intake and assessment?

The following section presents the findings in answer to the question: What processes and dynamics are involved in clinical decision-making about intensive psychotherapy at intake and assessment? The findings are presented in two parts. The first part will focus on clinical decision-making by the intake team and the second on clinical decision-making during assessment.

a) Dynamics of clinical decision-making at intake

The following section will use an excerpt of an intake team discussion to demonstrate how a decision was made by the team. This decision does not concern a decision whether or not to refer a young person to intensive treatment, but rather to whether and how the young person could be supported to find their way into treatment.

'B, chair, reads the referral from the CAMHS psychologist. The young person is not sleeping, and the mother had asked for the referral. The young person is living

with the father, but letters should please be addressed to mum. Mother has apparently been unhappy with CAMHS. The referral continues by stating that ADHD is not the issue. Dr T, psychiatrist, says that mum has therefore asked for this service. Dr T adds that the psychologist said that ADHD is not the issue, 'so they won't get it from CAMHS, when that's their bread and butter' (Obs.1, p. 6, l.30ff).

Could it be the case that Dr T took sides by inferring that this is something CAMHS should have done? Might he have identified with an elevation of this service, or a denigration of the CAMHS service? Could this have been a way of avoiding thinking and avoiding retaining a questioning attitude towards the psychologist's clinical decision? The group seemed to move between different modes of functioning. The 'them' (CAMHS) and 'us' dynamic could have been a response to the information about the conflict between the CAMHS clinicians and the mother, and this might have encouraged further splitting in this case. There may also have been internal group pressure to split in an attempt to avoid the inherent pain and conflict related to the waiting list (see Section 2.d.i). The pressure of the waiting list and the training needs had come to the fore during the discussion about the previous referral. It is not directly apparent from this excerpt whether there is pressure from the waiting list or training needs (see Section 2.d). However, the underlying dynamics evolved not only from the referral but also from the context within which this referral was considered. This was the ninth case to be discussed and the fourth of six new referrals during this observation.

'C, *consultant clinical psychologist*, *mentions another ADHD request, referring to an earlier conversation. Dr T: How about their ADHD? This sounds like bad practice'* (ibid). Dr T was wondering about the appropriateness of the referral and the dynamics between the family and CAMHS. This brief exchange also shows the team

grappling with the dynamics of the referral; might the referral constitute a countertransference reaction of the referrer: Might the referral have been seen as a solution to the difficulties between the referrer and the family? Would taking on the case encourage an unhealthy separation in the system, within the family or for the young person? Might it be more helpful to support CAMHS to retain the case and attend to the dynamic? What might this process say about the young person's motivation? The intake team unpicked the referral to explore what the motivation might be and whose it is (the theme 'wish to change' is further considered in Section 2.a).

'Dr D, trainee psychiatrist, returns to the young person's needs, 'she needs an outreach team and a drug service. There might be a lot going on. We don't know what other drugs she might be taking. Mother seems aggressive with CAMHS'. B, chair, reminds the team that the question is where to locate it, what's the address/ GP?' (ibid)

B returned to a logistical question: Is this even a case for this service? This comment can be understood literally on a logistical level as well as on a metaphorical level: Can this case be held in the service? The team members held different concerns. Sometimes it seems that there was a pattern as to who held the logistical concerns and who held concerns about emotional need. However, this pattern was subject to change and group members seemed to take on different stances depending on the dynamics at the time. It could be seen as part of B's role as chair to consider the logistical question. However, in this example, B's response might have also indicated a hierarchical dynamic in the intake team; in this case her comment set a boundary to Dr D's exploratory comments.

The chair, B, and the consultant child and adolescent psychotherapist, N, then pulled the group back to task. '*N returns to the young person, wondering how much she might want help. B says that it looks like the young person herself asked for help. Dr D argues that if she gets here, then that is a solution already. B says that it looks like the psychologist sent a letter to the GP, but the closing summary does not seem to be attached'* (ibid). B's comment seemed to be an expression of the need for more information. This raises a question about the need for more information and what this might mean in this context. In this case it seemed important to have access the closing summary to understand the process of the previous treatment (see a different example of this in Section 2.d.i).

'*Dr T wonders what their opinion is and what did she do in terms of education. She lives with dad, but mum's address is given'* (ibid). Dr T now developed the quest for further information about the young person's living circumstances and their history. Might knowing whether a young person is in education be used as an indicator of external stability? Might there have been an unconscious bias at play? Might the team members have been looking for answers to a somewhat incoherent picture? It may also have been a comment designed to slow down the decision-making process. And perhaps the ebb and flow of the discussion represented a general ambivalence about taking on referrals, related to concerns about the waiting list and trainee availability (see Section 2.d).

'*N, consultant child and adolescent psychotherapist, suggests maybe mum needs to be seen*' (ibid). N might have had in mind that the mother could provide more information, but may also be saying that seeing mother could throw light on the family dynamics and the dynamics of the referral. N might have been wondering who

actually held the motivation in this case and what this mother's request might have indicated about the service the family had received.

'B says she will ask for her to opt in. Dr T asks does she want to see us, she didn't want to see the CAMHS psychologist, she only attended 6 out of 18 sessions' (ibid). B seemed to reach her decision on the basis that the young person was asking for help in the referral, and the fact that N suggested the mother could be involved. The above extract indicates that there might be a functional hierarchy regarding the decision-making; in this instance, it was the consultant child and adolescent psychotherapist who made the discerning comment by requesting to involve mother in an initial exploration. The chair made the clinical judgment to proceed to the next stage in this case opting in. It could also be the case that this decision was taken because there was a question about the previous treatment this young person had received and a wish to be seen to offer a better one. Dr T and Dr D's requests for further information were indirectly responded to through a decision to invite the mother. Maybe Dr T's reservations (the initial splitting and the observation about attendance) informed the decision to offer opting in. The young person was asked to make the first move and express a more subjective desire to change rather than being offered an appointment straightaway. This highlighted the importance of the young person asking for help themselves not solely through the parent. On the other hand, it may be that these reservations were not explored further due to a wish to avoid conflict, or to speed up the decision-making due to time pressures.

This excerpt showed how the above decision was taken: the clinicians were 'taking in', i.e. absorbing, the impact of the patient and their predicament on paper. They then interpreted the data according to their experience and training. The

clinicians used their professional perspectives to explore the referral and weigh up a range of factors. The team developed their thinking about whose need and motivation was expressed in the referral, and why it had been made now. The team did this by exploring the young person's predicament and their external set up. In this excerpt the young person's relationship with other services also gave an indication about the dynamics of the case. It is not clear whether there had been inconsistency in the service the young person had received and/ or whether there was a dynamic in the family that found expression in the treatment the family had received.

There was a dynamic to how thinking evolved in this group: While developing a clinical decision the group operated with each clinician holding a particular view pertaining to their background. At the same time they questioned one another, and, as individuals, they made interpretations or questioned the material. Sometimes the clinicians held opposing views; however, presenting different polarities seemed to develop the thinking process. The team discussion involved a to-ing and fro-ing, as well as a speeding up and slowing down, as part of the process, as the thinking developed. This ebbing and flowing might have also been an expression of the underlying dynamics, in this case an expression of splitting, potential disagreement and professional differences. As discussed in Chapter 6, Section 2d, every profession may be inclined to respond to group dynamics in their own particular way.

There was also a dynamic based on tasks (see Section 2.d below): The intake team aims to decide whether to take on referrals and what treatment direction might be appropriate, while they also manage the waiting list and allocate cases to trainees. From this small sample it seemed that the team carefully weighed up the multiple, often contradictory, tasks. At the same time there appeared to be a dynamic based on hierarchy. The clinicians took part in this meeting in their professional

capacity as well as their role within the organisation. While there is no organisational hierarchy in the intake team, it seemed that, functionally, different members' opinions carry different weight. It therefore appeared that there might be a range of sometimes competing hierarchies related to clinical thinking and different professional viewpoints. These observations do not provide sufficient data to make definitive statements about hierarchy; however, further research could helpfully explore these dynamics.

b) Clinical decision-making during the assessment

The following section presents findings regarding what has been learnt from the interviews about clinical decision-making about intensive treatment during assessment.

i) Countertransference

The clinician's countertransference as well as observations of the patient, reportedly provide the clinical data on the basis of which a clinical judgment will be made. The assessors reportedly have had an experience of the patient on paper and now meet the patient's level of disturbance, psychic pain and developmental need in the room. The '*assessor develops a picture of the patient's life: what they do, what they don't talk about, what they think of themselves*' (N1, p.11, l.2). The assessor experienced the patient's account of her history/ life/ parents and what place they took and/or saw themselves taking. What were the functioning and less functioning parts of the patient? '*Just because it looks like an intensive case, it isn't when you are in the room with someone*' (P, p.2, l.30ff).

The assessors described their experience of the patient on a factual level, but also on an experiential level, in terms of what the patient evoked in them. The assessors reported that they experience and observe the atmosphere in the room. P

(p.3, l.44) and N1 (p.11, l.5) concurred that '*the assessor will be interested in what's not talked about, what's omitted.'* The assessor was '….*not systematically questioning, but (having all the areas of interests) in mind*.' The assessor observed the manner in which the patient conveyed his/ her feelings and thoughts, for example: '*The patient needed to tip it out: they might not yet be able to stop and reflect'* P (p.9, l.13). This assessor referred to an evacuative quality to the patient's communication. P thought that the assessor might have to '*initially absorb anxiety for the patient to keep functioning*' (p.5, l.22). P reiterated the importance of the '*patient having the experience that the assessor was able to take in and bear'* (p.7, l.47). Here, the assessor described her understanding of the patient's need judged by the impact the patient had on her. P advised to '*make use of the maternal function'* in addition to '*retain(ing) analytic capacity'* (p.2, l.14). Y described the assessor will be '… *tracking the mood, tracking where things change*' (p.6, l.43). P stated that the clinician needs to observe themselves in terms of '*acting in, they might be at risk of repeating past experience during the assessment*.

At the same time this assessor reported thinking that the fact of her own feelings changing might suggest a change in the patient's feelings. '*He could listen to me and there were also moments when I felt a bit more sympathetic, as I had said he had been telling me about the abusive mother, and of course I had felt some sympathy, but I had not felt really sympathetic, or engaged with him*' (N1, p.3, l.41ff). N1 seemed to express that initially she felt quite distant from the patient; however, throughout the sessions she started to experience the patient differently. This is not to say that the assessor needs to feel sympathetic or warmly towards the patient, but that the assessor takes an interest in their emotional response to the patient and wonders what this might say about them and their internal object relations. N1

described the assessor becoming aware of tension within the patient. '*It seemed there was a push towards treatment and a pull away. In the third session there seemed to be a turning point. The patient was almost becoming more connected to the idea of treatment'* (p.4, l.51ff). N1 described how her feeling differently about the patient matched the atmosphere in the room changing as the patient slowly became more engaged with the idea of treatment. Assessor N2 described an emotional experience and how she wondered about its meaning. N2 had anticipated withdrawal but then experienced the patient making use of the contact with the assessor. '*This was the interesting contradiction, I almost hadn't expected that she would come back and that she would take the initiative*' (p.5, l.24).

ii) Considering a formulation

The assessor's formulation emerged as a related subtheme. The patient will leave the assessor with impressions from which she aims to gauge the patient's internal object relations. The assessor might ask herself: Who am I to the patient now? What sort of an object does the patient experience me as? How is the patient relating to me and how do they expect me to respond to them? Does the patient have me as a benign figure or as an intrusive one in their mind? These physical and emotional impressions will form part of the emerging hypotheses. The following excerpts, which will look at what the assessors made of their experiences of being with their patients, demonstrate this process.

Assessor N1 reported experiencing the patient as '*quite demanding*.' The patient also took '*the position of being the patient (the ill person to be treated)*' (p.1, l. 42) '*It wasn't easy to feel sympathetic towards him, if I remember rightly he presented as this quite tough demanding person. There was this feeling that he had battled his way in. That we weren't interested in seeing him*….' (N1, p.2, l.10). Y

described the '*patient was always wanting to be in charge, pushing all the time and filling up the room. He talked in a very explicit manner, as if needing to make an impact*' (Y, p.3, l.25). The assessor might be interested in what the patient is projecting into them and what they might expect to meet in the assessor. Assessor N2 said she looks for '*the impact the patient had on the therapist*…. *It wasn't difficult to be with this patient in the room. He wasn't hostile at all, quite polite and friendly, but he was extremely controlled'* (N2, p.3, l.20 -26). *'This patient kept everything to himself, at the same time he attended all his sessions*' (N2, p.7, l.28). What might this say about the patient and the way he relates to her objects? N2 proposed the following hypothesis: '*Maybe it was partly that he evoked activity and hope in someone else/ me … there was some hope around, even though he didn't express it. But it wasn't the kind of case where maybe one can't do anything at all'* (N2, p.10, l.45ff). This assessor seemed to base her recommendation partly on her experience of the patient's capacity to evoke some hope and perhaps a sense of agency projected into the assessor. The assessor sought to weigh up the quality of, and balance between, the patient's life and death drives.

Assessor P described how she felt very aware of the '*patient's high level of anxiety about the extremity of her state of mind.'* She then observed how she thought that '*the patient certainly wanted me to feel anxious. There was a very powerful maternal transference'* (p.4, l.13). This experience seems to have aided the assessor in devising their formulation.

A picture of the patient was emerging for the assessors through their observations and experiences with the patient in the room. The assessors then formulated hypotheses about the patient and their internal world. The assessors developed these hypotheses within themselves (with their internal team, supervisor/

theory), by reflecting in weekly team meetings throughout the assessment and by testing them with the patient when formulating links and interpretations. The assessors continued to refine their working hypotheses internally, as well as with the MDT in regular meetings, using the team for the purposes of reflection – as it were for 'external' reflection, '*I discussed him in the team, to have some idea of what others thought about him*' (N1, p.7, l. 7). This process in turn supported the multi-disciplinary team thinking 'within' the assessor.

2) On what basis is the clinical decision to recommend intensive psychotherapy made?

a) Indicators for potential suitability

The themes listed below emerged in answer to the question about the basis on which the decision is made to recommend intensive psychotherapy. This section will explore indicators in the referral and the assessment experience that might suggest suitability for intensive psychotherapy.

i) A 'wish to change'

The 'wish to change' appeared as a recurrent theme throughout the observations and the interviews. The assessor explored the patient's interest in coming to an understanding of their predicament and their wish to change. Assessor N2 said she always wondered 'w*hat are the patient's reasons for treatment? Does the patient have a future perspective?'* (p.4, l. 30-36) Assessor P described how she looks for '*her patient's wish to get better.'* (p.10, l.12ff). P described that she explores evidence of the patient *'helping themselves and asking for help. Do they want to get some understanding?*' This appeared to be a reference to the patient's wish to consider the meaning of their difficulties with the assessor.

It seemed also that the assessors were interested in the patient's preoccupations pertaining to liveliness and hope; equally they were curious about the patient's destructiveness too. This included destructiveness expressed in active physical destructiveness as well as in pervasive flatness. The assessors appeared to be trying to understand the relationship between these conflicting aspects. The only concern the patient had was '… *that he was so stuck, and his contemporaries were all about to finish their A levels and be off to university.'* At the same time '*It didn't have the regressive pull that some adolescents have, where you feel they convey they just want to be in a (an inpatient) unit and someone should take care of them. … (They) give you very much a sense that they have handed everything over about their lives to someone else who should pick it up. …(it seems) that the gaps over the weekends would be too long for them, and that they can't activate themselves enough for anything*' (N1, p.8 l. 20ff). Is the patient determined to remain in the predicament they have created for themselves? Is there also a wish to change? Can there be some awareness of both? (See Section 2b below and Chapter 6, Section 2b) These questions take time to be considered and answered, even tentatively. To what extent might the patient have a 'wish to change' will be part of the decision-making process.

ii) Being 'right for therapy'

'Being right for therapy' was a recurring theme during the intake observations. This section will explore how this theme can be conceptualised and the manner in which it is assessed. What follows is an extract from the first intake team observation:

'B, chair, reads out the referral. This young person was seen as a 13 year old. B asks the administrator to get his file. N, consultant child and adolescent

psychotherapist, points out that the referral mentions no suicidal thoughts at present but the young person had attempted suicide twice age 16. There is also no mention of the family. N wonders what might have happened when he was 16' (Obs.1, p.5, l.20 – 25).

The child and adolescent psychotherapist tried to get a sense of how this young person's mental health had developed by pulling the facts described in the referral together and wondering about the gaps as well as about the meaning of the information given. It seemed that a suicide attempt was considered an indication of a crisis in development and hence an expression of great emotional need. Here the clinicians tried to ascertain whether anything about the young person's apparent need might throw some light on whether they might be able to engage in psychotherapy (intensive or otherwise). What might the meaning behind the suicide attempts have been? What had the circumstances been around them? What might these say about the patient currently? N also stressed the importance of the family and network around the young person as a crucial factor when considering a recommendation.

'*B and Dr T, consultant psychiatrist, notice that the name on the file differs from the name on the letter. B wonders whether the young person had changed his name and then adds that there is no mention of that either. Dr T wonders whether he wanted to be someone different'.*

Some clinicians made interpretations and others asked open questions as if to facilitate the thinking process. Both types of comments furthered the team's thinking. *'B - possibly having considered Dr T's comment- states that it is unclear whether he would be right for therapy'* (Obs.1, p.5, l.25-30).

What might ‘being right for therapy’ mean? In this observation a lot of the meaning of what the clinicians were saying was implied rather than stated plainly. For example, the clinicians sometimes made statements or asked questions without stating their own opinion. There did not seem to be an expectation that these questions and statements would be answered directly. However, they nonetheless had an impact on the individuals as well as on the group atmosphere. The individuals seemed to think about what they had heard, and the questions and statements which they then voiced triggered further thought. B wondered whether this young person struggled with developing her identity, and also wondered whether the amount of confusion in the referral indicated confusion within the patient. B also referred to the fact that there was no mention of a family. This could be understood in a number of ways: was B suggesting that the family not being mentioned might be an indication of a lack of internal and external family? The importance of considering the external environment will be discussed in Section c. It is possible that B meant that this patient did not seem to be sufficiently stable. By this, B might have been indicating that psychotherapy can be a challenging experience which requires a certain amount of stability within and around the young person. Perhaps B was concerned that psychotherapy would be unsettling for the young person and that there might not be sufficient support available. It could be that B was pointing out that the potential lack of family involvement and the young person’s apparent intrapersonal instability both indicate that this young person would benefit from a different kind of support in the first instance. This discussion highlights some of the themes arising during intake thinking: the team aims to identify suitability by trying to imagine what the young person’s difficulties might be from the referral; the team considers how the information has been conveyed and what is missing, what the

meaning of the provided information could be and what the gaps might indicate. 'Being right for therapy' is used as indicator for psychotherapy when considering a referral. The emerging picture is then measured against the concept of psychotherapy. Would this approach be helpful for this young person? The following sections explore this in more detail by focusing on particular aspects of the treatment.

iii) 'Can they be held?'

The theme of 'being held' is related to the assessment of potential suitability and emerged from both intake observations and interviews. The data analysis highlights that the idea of 'being held' implies a question about containment. Would psychotherapy provide containment for this patient and their predicament? The research brought the potentially difficult juxtaposition of a patient's complex presentation, the rigidity of their defences and risk elements to the fore as emergent themes to the concept of 'being held'. The clinicians weighed up these elements by observing the patient and their development during the assessment. The following section presents extracts from the interviews to evidence this kind of thinking.

- 'Severity of symptoms'

The assessors discussed a number of cases which stood out for their severity and complexity. It seemed that a common theme for considering intensive psychotherapy was the severity of the symptoms and the related anxiety. The severity of the patient's predicament might manifest in how stuck they seem: for example, P described how the trauma seemed to be locked in physical symptoms. Assessor P outlined '…*it was a mind-body cross symptom, the anxiety was experienced physically,'* (p.3, l.39) *'…deep down there was a fear of madness but this was displaced into physical worry*' (p.12, l.10ff). P described the patient

expressing '*unthinkable and unspeakable emotion of fear, loss and guilt. A chilling triumph of the cognitive over the emotional had taken place.'* Assessor N2 described a patient's history of severe depression and suicidal ideation. The patient could not talk about her development nor her difficult emotional experiences. While she seemed to have some outside life (some relationships), in most areas of her life she needed to be '*activated'* (p.1, l.45). She seemed '*cut off and wanted to keep aspects of herself secret'* from the assessor. The assessors wondered whether their patients would be able to shift, and what might be possible considering their current presentations. In this cohort severity and complexity were present in every case; however, this might not always be the case. Sometimes a less complex case might be considered for intensive psychotherapy because they have been able to make use of weekly treatment but require increased intensity (as discussed during the intake observation, see Section 2.b.i).

- 'Rigidity of defences'

This related theme was raised repeatedly throughout the interviews. All assessors described rigidity in their patient's defences and a concern whether the patient would be able to reflect on these. *'The patient had a clear story that he obviously had told many times before'* (N1, p.1, l.20-25). The assessor was concerned that she would be unable to effect much change in this patient's narrative. It seemed (p.2, l.25) that the patient *'was just demanding therapy, which had been recommended. It wasn't easy to think with him about it….This patient was demanding change but would he be able to change?'* (p.3, l.20)

The patient was *'pretty stuck, also stuck with his physical health, feeling (that) he was terribly damaged'* (*p.8, l.26). 'He needed to receive intensive psychotherapy and really change some of her more intellectual defences. It was the way in which he*

had organised himself, in terms of how he told his story' (p.5, l.4). This highlighted the following considerations: Can the patient acknowledge other perspectives? Can the patient express insecurity in relation to himself and also regarding having treatment? Can the patient bear not knowing where treatment might take him? Intensive treatment was considered here due to the rigidity of the patient's internal world. The assessor indicated that once weekly engagement might not provide a strong enough framework to work on this patient's defences and insufficient containment within which this patient could be held as he might relinquish his defences. The question as to whether the patient might feel overwhelmed as he might begin to acknowledge his feelings was implied. Here the assessor referred to the patient's ability to bear anxiety, to his internal capacity to bear strong feelings. This will be further illustrated in Section 2. In another case rigidity of this kind might be thought of as contraindicative, due to the risk of breakdown. Such an assessment will depend on a combination of factors as well as the assessor's subjective response.

N2 described how '*This patient was facing a life-long illness. Intensive psychotherapy was recommended to encourage a large developmental move against great resistance'* (p.8, l.9-13). *'My feeling was that with once a week, it would be very hard to access it. I thought it would be very difficult to get to a deeper layer' (*p.5, l.20ff). Here, the choice to offer intensive treatment was taken as a result of how buried the patient's feelings seemed to be, and how inaccessible they seemed to remain when the patient was seen only on a weekly basis. The thinking was that *'…intensive psychotherapy would help get more into his inner world, and I felt there was something quite secretive and secret going on, something quite destructive, that one wouldn't get hold of otherwise*' (N2, p.8, l.49ff). The patient *'…liked the status*

quo… that was my concern about once a week (therapy), that he would do something, and appease everyone a bit' (p.4, l.22). Here, the assessor also referred to the impact of the treatment on the system around the patient. There was an idea that in this case weekly treatment would potentially collude with a system that maintained the patient's defences. *'So I thought three times (a week) would be an opportunity to move things on. And yet I also felt uncertain whether he would allow that to happen' (ibid).* The assessor wondered *(p.8, l.46) 'Could he allow himself and others to know more about what was going on? It may be that he wouldn't allow the higher intensity to really open things up*.' (p.10, l.23ff) '*So I felt the main work would be to see whether one could get him interested in taking responsibility for himself. Moving into adulthood that's where he was really stuck. And I didn't think that would be possible with once a week'*. (ibid) The assessor had experienced the severity of the patient's symptoms and the rigidity of the patient's defences and felt that only a more intensive framework would provide sufficient containment to stand up to this. The assessor was wondering whether this patient could become interested in his own predicament, and whether he would move beyond a desire for symptom relief. Would this patient be able to make even the slightest change to the predicament he presented with? The assessor seemed to suggest that engaging with intensive treatment would indicate a step towards life. It seemed that on some occasions the decision might remain ambiguous; i.e. the patient will be given an opportunity to engage and it will remain to be seen if they will accept the recommendation, and if they do accept it, what use they will be able to make of the treatment. The themes of movement and engagement will be further explored in Section 2.

- Considering 'risk'

Observation, assessment and anticipation of risk constitute another dimension of 'being held'. Considering risk - observed and anticipated - reportedly forms part of the clinical decision. Here the risk to the patient of not having treatment was explored. '*I thought that this would turn into a very chronic depression. He also described himself as diagnosed with depression and he felt that this was absolutely right, but had already resigned himself to that. He was functioning at a very low level. (*Without treatment*) … he would have a very reduced existence*' (N2 p.9, l.44ff).

Having observed the patient's risk to herself and others throughout the assessment, the assessor was better able to make a prediction about how the patient might manage in treatment. What might the risk be of undertaking intensive treatment? Would the patient be able to manage the potential emotional turmoil? Would treatment of a lower intensity be more helpful at this point? To weigh up these concerns the assessor might consult the MDT in weekly team meetings, as well as request a psychiatric assessment alongside the psychotherapy assessment.

Assessor N1 described this patient as having a '*complicated presentation'* and having had *'a history of inpatient admissions and a severe physical condition, so I was quite concerned about possible risks and not sure whether he would be held in psychotherapy' (*p.2, l.5ff).

Whether a patient can be 'held in psychotherapy' referred in this instance to the patient's risk to herself, and the assessor seemed to be referring here to the potential for risk to escalate during intensive treatment. While this patient would require intensive psychotherapy in order to provide containment for the complexity of his presentation, this needed to be weighed up against the potential for regression and the risks which might arise due the demands of the intensive treatment. The risk of

further breakdown was a consideration throughout the assessment and a key aspect of the decision-making process.

'… *the psychiatrist also agreed that there is a risk that this young man might get worse with therapy and obviously that was something that I discussed with him*. *There might be a risk of a self-destructive reaction to change'* (N2, p.6, l.24).

The patient might not be able to bear the idea of change and might attack the process by attacking themselves. Sometimes it can be a fine line between the assessor making a recommendation for outpatient and inpatient treatment.

'*Could he be held in psychotherapy as an outpatient, or does this patient need inpatient treatment?'* (N1, p.1, l.60) Assessor P described how she had tried to ascertain whether the patient could cope with intensive psychotherapy. *'If the patient doesn't really have the ego strength or (psychological) endoskeleton to sustain it, they are more likely to break down if you go straight into intensive*' (p.2, l.36).

Sometimes the patient might need to start with weekly sessions and slowly build up to intensive treatment. This excerpt seemed to highlight a paradox where, on the one hand, it can appear that greater ego strength is required to undertake intensive psychotherapy while, on the other, intensive psychotherapy potentially offers greater containment when defences are lowered and challenged (see Chapter 6, Section 2).

The assessors seemed to weigh up the complexity and severity of the patients presentation and the inherent risks against the patient's evolving (or otherwise) capacity to bear anxiety and ability to make use of psychotherapy. The assessors emphasised that a certain ability to bear emotional pain without acting on it is a prerequisite of intensive work. This will be further explored in the next section.

b) Indicators for internal capacity

The previous section focused on the evidence concerning how the clinicians attempt to ascertain a young person's potential suitability. This section will demonstrate how the clinicians try to discern the young person's internal capacity. The following themes emerged when exploring the basis upon which a decision for intensive psychotherapy is taken.

i) Can the young person 'make use of' psychotherapy?

The research showed that an exploration of the patient's potential capacity to 'make use of' psychotherapy is paramount when deciding on intensive psychotherapy. This section will show how the intake team and the individual assessor attempted to gauge the patient's internal capacity to 'make use of' psychotherapy and how they used evidence of this to make a decision regarding which treatment to offer.

'B, chair, reads out an account of a harrowing journey from a developing country. The young person had been sent to his uncle when he was not yet 5. He endured severe injuries during this transfer. In the care of his uncle's he was also badly treated. The referral then details further trauma throughout his childhood and adolescence. There is silence as B reads this out. All the clinicians are sitting very still in their circle, and there are some sighs. N, consultant child and adolescent psychotherapist, breaks the silence, wondering where the account is from. The others are looking at N. N then wonders whether this young person would be in a state of exploration, or would she need something more supportive' (Obs.1, p.5, l.40 ff).

N was wondering who made this referral, the shock of which conveyed a sense of how unprocessed the trauma might have been for the young person. This young

person may well have been in a rather fragile frame of mind, considering the impact of the trauma. N seemed to express an interest in the young person's current external environment. The referral described what happened to this young person, but did not say much about what this young person's state of mind might be now. In order to contemplate the young person's potential capacity to engage with psychotherapy, the clinicians reflected on a number of interacting internal and external factors. They considered their predictions of the patient's state of mind, the level of trauma they have experienced, how stable they and their environment might be. It seemed that the trauma conveyed in the referral had a considerable impact on the team. There was then a discussion about what support this young person might receive at the moment and the decision was to get further information in the first instance.

*'B, chair, says that it depends on how much work is being done in the young person's current environment. There is some thinking about what support the young person might need to receive currently. Dr T wonders about psychiatric input and medication. B decides that this needs to be discussed with the referrer (*ibid*).* (This is further discussed in Section 3 when exploring the role of external networks). *B tells N that she will contact the referrer for more information. Dr T adds that there may be other agencies involved'* (ibid).

As above (Section 1.a), paying attention to the group's response to the referral might shed further light on the dynamics of the case. It seemed that the group was digesting the material bit by bit, gathering more information before resorting to action. At the same time it is possible that gathering more information was a defensive move. Here, the group seemed more united in their response, although there was some indication of N and B (B addressing N) focusing on the emotional

need and Dr T focusing on waiting list pressures (which may have been a way of expressing a wish for someone else to take this particular case on). It is also possible that resistance to taking on this amount of emotional pain affected the clinical decision-making process.

In contrast, the following referral concerned a young person who had already had some psychotherapy which he had been able to engage with and learn from. In this discussion the focus was also on the frequency of the treatment.

'B, chair, describes the referral of a young woman from another clinic where she had received psychotherapy for one year, supervised by X. It's not clear why she was referred now. She has a history of being left in the care of her aunt who was violent towards her. Her father had passed away and there had been limited contact with mother. She had struggled with aggression and had been excluded at school. Later she began to self-harm and she continues to have difficulties with relationships. Her work place is supportive towards her. B says that the supervisor described her as having made good use of treatment but needing more' (Obs.1, p.1, l.10 ff).

What might 'having made good use…, but needing more' mean? Might it indicate that the young person had been able to stabilise and continue her developmental trajectory? Had she been able perhaps to make changes to her external life as a result? Or could it indicate that these gains were fragile and that she would benefit from a continuation and intensification of the treatment in order to internalise them? Equally, could it be that the young person needed more intensive work to address deeper seated difficulties, or that the referrer idealised the clinic based on a fantasy that they could provide something that the referring organisation could not?

*'N, consultant child and adolescent psychotherapist, asks whether intensive treatment had been discussed. B, chair, says no, not in the referral, and she had not heard from the supervisor. They are wondering what that might be about. There is no answer to this. There is a moment of silence between N and B, during which the researcher wonders what they are thinking' (*ibid).

Were N and B wondering about why weekly psychotherapy had been helpful but not enough? '*N says she will need to be assessed. B agrees and says she will need to opt in. N says there might be an argument that she should be seen intensively, the supervisor had referred her for work with a trainee, but actually the background is very disturbed.'* (ibid) Does this mean that a very disturbed history plus a history of having 'made use' of a psychotherapeutic relationship is an indication for intensive psychotherapy? Considering the cases that the interviewees described and the cases outlined in the audit, this might be an appropriate distinction. However, this is not always, nor necessarily, the case.

Furthermore, in this instance N and B seemed to be considering the impact on the trainee of seeing the case intensively. The capacity of a trainee to manage a case was found to be part of the clinical decision-making process (see Section 2.d.ii). *'N adds that an assessment needs to take place in any case. B says she will be accepted and then have an assessment. N suggests that a senior person should assess her'* (ibid). It is evident that it is generally senior clinicians who undertake assessments particularly when a case is being considered for intensive therapy. N might have been particularly concerned about the young person's level of risk to themselves. In the assessment it will be decided whether this young person would benefit from intensive psychotherapy and whether and how they would manage the higher intensity.

The intake team seemed to make predictions regarding the young person's state of mind and their potential ability to engage with the psychotherapy process. The young person's state of mind will have been affected by their external experiences. The team try to discern the young person's potential internal capacity as well as their broader context and external situation. In the two cases considered here the young people had experienced trauma; however, they seemed to be at different stages of coming to terms with their experiences and as well as having different levels of support from their environment. While, in the first case, the trauma had been ongoing until recently and the young person was possibly unsettled, the other young person had achieved some stability, there was a network around them and they had already evidently benefited from treatment. The team formulated their understanding of each of these young people's past experience and their current situation. Their predicament and the team's understanding of their current state of mind were weighed up against the demands of intensive treatment. In both cases it was B, the team lead, consultant clinical psychologist and N, child and adolescent psychotherapist, who considered the young person's emotional capacity.

From the observations it appears that only young people who were referred specifically for psychotherapy were considered for intensive psychotherapy. Generic referrals were referred for assessment, possibly having a range of treatment options in mind. It would be interesting to follow particular types of referrals over time and observe the process by which decisions about them are made; and it would be interesting to ascertain whether, and to what extent, the referral reasons have an impact on the decision-making process.

ii) Can there be 'movement'?

The assessors aimed to discern the patient's capacity to take part in and 'make use' of this particular way of thinking and relating. The following themes were identified as sub-themes: the patient's ability to engage with, and develop throughout, the assessment. Is this patient developing in terms of their engagement with the assessor and their own thinking about the predicament they find themselves in? The assessors also highlighted the importance of exploring the idea of treatment with the patient. (She) '*arrived as patient … but could there be movement?'* (N1, p.3, l.21). This movement was reportedly measured by observing and experiencing the patient's emerging capacity to engage and to think. The following passage will evidence how the assessors evaluated their experience of the patient and how their thinking affected the clinical decision to recommend intensive psychotherapy.

- Is there a 'capacity to engage'?

Engagement with the assessor and the process were identified as key factors which clinicians looked for when determining whether to refer for intensive psychotherapy. N2 stated that an initial consideration is '*whether and how the patient had made use of earlier treatment(s)*' (p.2, l.7). Having already been considered as part of the intake process, this can now be explored with the patient in person.

The assessors reported that they observe the patient's behaviour and emotional responses to the framework they provide in order to inform their clinical judgment. The setting is reportedly part of this framework and refers to the space that the assessor provides externally, as well as the setting in the assessor's mind. The setting provides something akin to 'laboratory' conditions within which the patient and the emerging relationship can be observed. N1 stated that the setting '… *is an opportunity to test engagement, as it is never clear from the outset whether the*

patient will take to it' (p.10, l.40ff). It is hoped that it will provide some containment and a frame of reference against which the patient's feelings, thoughts and behaviour can be considered. '*I feel they need to have an experience of what treatment might be like*' (N1, p.11, l.1).

The assessors described introducing the idea of an assessment stage. *'This includes* (informing the patient) *that the assessor might not be the treatment therapist*' (P, p.1, l.15). Assessor P emphasised the importance of keeping preconceptions from the referral in check. P warned that '*preconception blocks observation*' (P, p.2, l.7). The assessor reportedly pays attention to her own feelings and prejudices. Assessor P warned that while the assessor will have many thoughts about the meaning of the patient's predicament, for example '*this patient might be high achieving to reassure the parents*' (p.2, l.7). *'The assessor is paying attention in order to notice the unexpected*' (*N2, p.10, l.35).* P (ibid) also stated that the assessor needs to '*hold back therapeutic zeal*.' The assessor attempted to create an atmosphere of observation and exploration. P (p.7, l.46) wanted '*the patient to have an experience that a mind really is meeting another mind.*' The assessor set up an environment which provides an opportunity for the patient to make contact with their unconscious. At the same time, treatment is different from the assessment stage: '*I had said the treatment was going to be different from the assessment. The treatment therapist would probably be very interested in her dreams, but also would not be as adaptive as I had been. A lot more would be left to her*' (P, p.8, l.16ff). Here, the assessor referred to the exploratory nature of the assessment; for example, the assessor might ask more questions than the treatment therapist. From the interviews it is clear that the assessment, as a stage, provides a framework for the clinical

decision-making process. Sometimes it can also be considered as a separate piece of work (P, p.7, l. 10).

The assessors reflected on the patient's response to, and use of, the assessor and the setting. The assessors described being interested in the way in which the patient arrives at the setting, the patient's pattern of attendance and their thoughts between sessions. The assessors reportedly observed the minutiae of how the young person related to the setting. Unique to the assessment of adolescents is the extended time-frame of four sessions.[2] '*…they present so differently from week to week*' (P, p.1, l. 27, 32). A series of sessions reportedly provides the opportunity to observe movement within, between and throughout the assessment sessions. N considered the meaning of the patient's attendance: Might it represent curiosity about the person of the assessor and the idea of treatment? She described a patient who was very depressed and yet she came to the sessions herself. '*She seemed to be taking the initiative'* (N2, p.3, l.11-15). '*This patient attended all her sessions.'* N2 seemed to think the patient could easily not have returned. *'There was no immediate pressure from the outside*' (N2, p.7, l.22ff). Sometimes assessments are shortened: '*I always do four session assessments, unless someone is getting too attached, in which case I might sometimes have said two'* (P, p.1, l.27f). Sometimes, if there is lack of clarity and a clear recommendation cannot be reached, the assessment might be extended. '*In the first sessions he had already decided he wanted more sessions. I felt it was really important not to be pushed - but really to have a bit of time to explore … I felt it was important to be firm and not be pushed into making a decision'* N1 (p.4, l.23ff). Here the assessor clarified not only the impact the patient made on her, but also the fact that the assessment is a co-created process. The patient

[2] Child and adolescent psychotherapy assessments in CAMHS are regularly set up for three sessions in particular for younger children.

expressed his motivation and the assessor felt time and challenge was needed to explore the meaning of this. This assessor was wondering about the meaning of the experience of 'feeling pushed'. Would this patient be able to consider the meaning of 'demanding' something and might his stance shift?

- Can the patient bear 'ambivalence'?

'Ambivalence' emerged as sub-theme of 'movement' in some of the interviews. The following passage illustrates the focus given to ambivalence as an important factor within the clinical decision-making process. Exploring ambivalence is also linked to the next section on 'thinking', as considering ambivalence implies that thinking is actually taking place. This separation between themes is therefore somewhat artificial, and shows how the themes are in fact inter-connected. The assessors described their exploration of ambivalence in different ways, including observing the patient's ambivalent feelings about treatment and the assessor, encouraging expression of ambivalence towards the idea of treatment and the assessor, and challenging the patient's preconceived ideas. The following passage will evidence these findings.

Whilst observing what sort of 'another' the patient was expecting to relate to, the assessor was also observing how the patient did this. N1 said that the assessor fosters engagement by '*really having a bit of time to explore it and see it from one week to the next'* (p.4, l.4). N1 describes a '*patient who, unusually in the first session, already said that he wanted to come more than once a week*' (p.2, l.50–55). The following extract presents a contrast to this: P thought that '*unattended sessions are an important part of the assessment.'* P suggested that the unattended sessions can be understood as a reaction to the therapist. In her experience the *'patient may assume that nothing was happening when they didn't attend, but they are almost*

always having their session in mind' (p.10, l.48ff). The time frame gave an opportunity to observe and think about potential fluctuations of the patient's state of mind, but also movement in terms of how the patient relates to the assessor and the idea of thinking together. *'I never quite knew what to expect, she was dramatically different every week'* (P, p.3, l. 27-29).

This assessor reportedly encouraged the adolescent to explore their feelings about the idea of treatment. N1 suggested '*The clinician needs time to bring (out) different aspects* (with the patient) *and their ambivalence. The clinician needs to work with this in the assessment process, and not settle too quickly on one thing or another*' (p.10, l.23ff). '*He was very clear he didn't want to go on living like this. He didn't enjoy it'….* and *…'there was a bit of movement, he could also acknowledge that it would be quite hard to come three times a week, to open up…. not to know where that would take him…. I thought it was quite important that he would also speak about the other side, that he was actually a bit anxious about the intensity of three times a week'* (N1, p.3, l.40ff). Here, the patient's ability to project himself into the future and to challenge his preconceptions was taken to bode well for his ability to decide that he wanted this treatment. This patient's initial demand for intensive work was considered part of his presentation and it was thought that, given time, the patient could consider his ambivalent feelings and anxiety about the idea of intensive psychotherapy. He was then able to engage in a more realistic manner. This highlights the patient's capacity to allow movement within his rather rigid internal world. *'I think there probably was just enough, I felt there were moments, when I felt I could engage a bit more with him and I actually did feel he really did want to change'* (N1, p.3, l.4). Here, the wish to change seemed to stem from the exploration of ambivalence (see Section 1a 'wish to change'). The assessor's experience and

assessment of this process was of course subjective and also related to the assessor's state of mind (see Section 1.b). The capacity to experience, and also acknowledge, ambivalence was considered a significant emotional development within this assessment. This capacity is also connected to being able to tolerate internal tensions and conflict which will be generated within treatment. It was deemed to be indicative of the extent to which the patient can consider the idea of treatment and their relationship to the assessor. This assessor seemed to suggest that ambivalence needs to be allowed to emerge and be explored in order for the patient to make a decision about treatment. The patient's capacity to experience ambivalence and to explore this with the assessor appeared to be regarded as an indicator for intensive psychotherapy. The theme of ambivalence is also connected to the following theme.

- Can the patient 'bear strong feelings'?

The assessors highlighted their exploration of whether the patient can 'bear strong feelings' during the assessment. The capacity to 'bear strong feelings' emerged as a sub-theme to 'movement'. This theme is also referred to in previous sections when discussing 'severity' of symptoms, and the idea of 'being held' in psychotherapy. The 'capacity to bear strong feelings' is linked to the 'capacity to think' (see below) as the assessors reportedly tried to support the patient to think about their feelings. They described that they assess whether and how the patient experiences emotions and how they communicate their feelings to the assessor.

Some patients may arrive with a considerable amount of anxiety. Assessor P said she *'assesses the patient's capacity to worry and to contain anxiety'* (p.7, l.22ff). The assessor attempted to support the patient to manage this tension. Bearing strong feelings implied some '*ego strength*' (P, p.2, l.34), which involved an ability to

feel challenged and to survive this without feeling overwhelmed by feelings of persecution. The assessor seemed to observe how the patient navigates between their impulses on the one hand and their thinking on the other. '*They realise how ill they are or how they are not the person they thought they were….and whether or not they can bear to explore that in an intensive setting'* (P, p.3, l.2).

Sometimes the assessment sought to increase the patient's concern for themselves. N2 wondered about the system the patient had created for himself *'needing to be activated. Did this leave a possibility of him developing an interest in himself*?' (p.4, l.10ff) *He wasn't really prepared to change and to engage with it further. There was no clear sense of having a future, wanting a future …But he was able to discuss this'* (p.4, l.14 – 17). The assessor wanted to ascertain whether this patient could think about her predicament and how she related to the world. Could she get worried, or at least interested?

At the other end of the spectrum one patient '*had already stripped herself of her defensive carapace quite a bit. So it wasn't like, I felt with every interpretation I would be peeling of her skin, as it were, and she would just pop through it*' (P, p.7, l.22 ff). Here, the assessor described the patient's development in the assessment. There was evidence that this young person had been able to bear experiencing and reflecting on some feelings and thoughts with the assessor. This assessor thought that the patient allowing herself to experience painful feelings with the assessor was an important indicator when considering a recommendation for intensive treatment.

- Is the patient 'able to think' with the assessor?

'Capacity to think' emerged as a sub-theme of 'movement'. The assessors reported on their assessment of the patient's evolving capacity to think. In what way did the patient's thinking develop from session to session? This research has shown

that the concept ‘thinking’ encompasses a patient's capacity to develop curiosity about themselves and their predicament, the idea of treatment and the assessor. It seemed that being able to consider ambivalence towards the assessor and treatment, as well as to bear strong feelings in the presence of the assessor, were seen as emotional achievements. The assessors also described how they attempted to ascertain whether the patient has some potential to develop their capacity for thinking. The patient’s capacity for thinking would be weighed up against other factors, such as the severity of a patient's symptoms and risk (see above).

The patients were offered an opportunity to see whether they found thinking with a clinician about their difficulties helpful. ‘Thinking’ also refers to how the patient relates to the assessor’s observations, linking comments and interpretations. The assessors reported how they observed the patients making use of the assessor associating to and linking diverse experiences. Did the patients have the potential to have an emotional experience, consider it and integrate it?

This assessor focused on whether this patient felt supported, understood and appropriately challenged. Observations of the patient informed the assessor’s decision-making process. ‘*We realised she was very frightened about what would happen. I thought she would be better held in the counselling service in her college than coming to interpretative work* (P, p.13, l.31ff). This raises the question as to what might be meant by the term ‘interpretative work’. Interpretative work implies commenting on unconscious processes and/ or the transference relationship, while a non-interpretative approach would focus on emotional support and conscious processes. The assessors made links and offered tentative interpretations. The assessors described their interest in what impact they had on the patient and whether and how the patient would consider their comments.

For example, did the patient experience the assessor's comments as intrusive and scary, or as containing and helpful (and the spectrum of possibilities in between?). Should an interpretative approach in weekly or intensive psychotherapy be experienced as too challenging, another approach might provide more appropriate containment for the patient.

Moving between what they perceive in their interaction with the patient and what they make of this within themselves, the assessors invited the patients to think with them about the meaning of the patient's communication. The clinicians contemplated hypotheses in their mind and sensitively tested them with the patient. For example, P explored the '*gap between actual age and developmental age*' (p.4, l.4). Here, the assessor was aware of the patient's seemingly delayed psychosexual development; however, when they carefully invited the patient to think with the assessor together about this, '*the patient was not ready to consider this, and retreated'* (P, p.8, l.24). On the one hand, the developmental gap might have been an indicator for intensive psychotherapy, on the other, the patient's response to the intervention may have indicated that intensive treatment would be too challenging at this point. For even though the assessment might suggest that intensive treatment would be indicated – as a means of containing the patient's anxiety – the assessor might nevertheless recommend starting weekly in order to support the building of the treatment alliance with the psychotherapist. For some patients momentary connections may be possible and they might benefit from further help to develop their capacity to think. This might mean starting with a lower frequency of sessions with the potential to increase.

This assessor cited a situation when the patient expressed an interest and the assessor responded with curiosity. The patient subsequently dashed this emerging

hope quickly. '*He also said his dad always becomes excited if he mentions something, but then he drops it and he feels now he definitely cannot do it*' (N2, p.4, l.7 -10). '*He got someone else to say that this would be really good, he went along a bit, but then dropped it.'* The assessor linked the external behaviour to the behaviour taking place in the room and observed what the patient made of this. Might the patient go along with the recommendation of treatment and then drop out? Here, the patient could become slightly interested. N2 (p.3, l.11) 'W*hen one talked straight to him, he seemed to take notice. I felt there was a bit of him that did engage with that. He could smile, when I said to him that I felt nothing was allowed to move. Even though he did not like the fact that he was stuck, he also made it clear that other people had to give him the treatment and help him become active. He was watching it a bit from the outside. And he could kind of look and smile, which I thought was a response*' (p.7, l.22ff). This assessor felt that the patient's response indicated that he was able to consider the assessor's observation and linking. The assessor indicated that this shift in perception and ability to use the assessor in combination with the concurrent rigidity contributed to him considering intensive treatment. The fact that the assessor took the patient's smile as constituting sufficient information will have been based on the countertransference and the assessor's experience of the patient throughout the assessment sessions. The assessor might have considered the risk of acting into the patient's passivity without him having to own his wish for treatment.

iii) Diverging thoughts

'The aim is to see whether the patient can make use of psychotherapy' (N1, p.10, l.45). The assessors had different views on the meanings of, and answers to, this question. In all the interviews the need to understand the various aspects of the patient's internal and external worlds was emphasised. The assessors agreed that

exploring the patient's ability to engage and to consider their relationship to the assessor and the idea of treatment were aims of the assessment. All the assessors used their observations and experiences with the patient to weigh up the patient's capacity against their less available aspects, and attempted to make a prognosis as to whether intensive psychotherapy would be the most appropriate treatment.

However, the assessors described this exploratory process in different ways. While the assessors were looking for some movement, some development within the series of sessions, different kinds of movement were observed: one assessor described movement in the patient considering her predicament, and another patient was able to consider her stance in relation to the assessor. In another case, the emphasis in the recommendation was on the patient's observed capacity to make use of the assessor's links and interpretations. Sometimes decisions might remain ambiguous, and the assessors highlighted the degree of uncertainty nevertheless contained within the recommendation. This small sample showed that the recommendation of intensive psychotherapy can serve different purposes: one patient clearly seemed to be someone who the team felt would benefit from intensive treatment, whereas another – who equally clearly needed treatment –might only be at the very early stages of considering whether they could engage with treatment. While intensive psychotherapy might be the only way to reach them, they may not yet be able to access it. Again, this highlighted the idiosyncrasies of each case and each therapeutic relationship.

However, does this also point to differences in thinking? One assessor focused on developing an awareness of ambivalence. This connected to a potentially destructive dynamic in the patient's mind, something which is frequent feature of adolescent development (see Chapter 6, Section 2b). Another assessor focused on

the patient's ability to bear strong feelings (see Chapter 6, Section 2b). Bearing and considering 'ambivalence' and 'bearing strong feelings' can be thought of as similar in that they both require an ability to consider feeling states and an ability to bear anxiety, internal conflict and emotional pain. At the same time there are also differences: the focus on the patient's ability to contain feelings within themselves and within the relationship with the assessor refers to the patient's capacity to use what the assessor offers. The focus on ambivalence refers specifically to the patient's acknowledgement of their vulnerability, and having ambivalent feelings about the possibility of dependency and intimacy in treatment. The theories underpinning these concepts and dynamics will be further explored in Chapter 6. From this present research it seemed that both foci – exploration of ego strength and ambivalence – form integral parts of the clinical decision-making process.

c) Indicators for sufficient external support

The capacity of the patient's environment to support the work emerged as a central theme during intake observations and interviews. How supported or otherwise is the patient by their family/ carers? Is there a network and, if so, what is the quality of the relationships within that network? Is the patient in work or education? Finding out about the young person's external set-up and their relationship with it reportedly forms an indicator in the clinical decision-making process.

The patient might feel overwhelmed and anxious having started psychotherapy and the assessors pointed out that psychotherapy inevitably leads to some regression. P explained that often a '*therapeutic engagement starts off with making people feel worse, dropping their defences. They realise how ill they are or how they are not the person they thought they were. (It needs to be assessed) whether or not*

they can bear to explore that in an intensive setting and whether they have the external support to do that, which is very important in terms of family circumstances and school' (p.2, l.47ff). Can the patient's environment support the engagement with psychotherapy and the inevitable peaks and troughs of treatment? The assessors seemed to think that there needs to be environmental capacity to support the development of internal capacity (see Section 2.b).

The intake team considered how the young person's external environment was described in the referral. '*There is also no mention of the family. N, consultant child and adolescent psychotherapist, wonders what happened when she was 16'* (Obs.1, p. 5, l.20 – 25). The team wondered about the quality of this young person's external support. The risk of deterioration or regression in treatment might be of particular concern if the patient lacks an external network to help support and contain them. Alternatively, the team wondered who makes up the network around the young person and what support they provide. The following is an excerpt of an observation where this is discussed. *'B, chair, wonders what support this young person is getting at the hostel. Dr D googles the place; Dr T says it's a hostel with some support. There is an air of concern for her. N asks how long she had been in the country.'* '*Dr T wonders about psychiatric nurse input, is the young person on medication? Is the CMHT involved? B says this needs to be discussed with the referrer. B says to N that she will contact the referrer and get more information'* (Obs.1, p.5, l.60ff). Sometimes a network needs to be developed before treatment can be considered.

The assessors tried to get some understanding of the patient's external life and the way in which they position themselves within that. N1 recommended weighing up a range of factors '*Positive factors (were) that she was engaged in college and had some idea of a plan, and was looking for relationships with friends outside….. She*

did relate to herself in a rigid way, but she had a connection to things outside' (p.8, l.1ff). In this case, the patient's relationship to the world outside was considered an indicator for intensive treatment. The fact that there was social engagement might protect the patient from risk to herself should she regress during intensive treatment. However this is not necessarily so, social isolation in a particular case could point towards intensive treatment if there are other balancing factors. It seemed important to have a balance between challenging and supportive factors. The way these factors are interpreted by the intake team and the assessors is of course subjective (see Section 1.a) and b).

i) The parents' role in the process

'*The parents were concerned. I knew she had a reasonably concerned environment which would hold her*' (P, p.7, l.19-21). While one of the aims of psychotherapy may be to develop inner strength (see Section 2) an external structure may be needed to support the therapeutic relationship. This section will focus on the role of the parents in particular.

The parents might need support in their own right and/or to support the psychotherapy. However whether or not to involve them in the treatment can be a complex clinical judgment in itself. Unlike with younger children, 'o*ne starts with the young person, not with the family …, one starts with the young person and what they want, what they feel comfortable with, (this) is essential in the assessments with adolescents*' (N1, p.1, l.29). What role the parents play in the patient's life is ascertained throughout the assessment. How does the patient describe their relationship with their parents? How do parents involve themselves? With some older adolescents, there may a question as to whether the parents should be involved at all. N1 described the benefits of concurrent parent work as being able to

warn parents about potential risk, the ups and downs of treatment and the impact of breaks. At the same time, it very much '*depends on the extent of parental involvement* (in the patient's life). *The tension whether he could be held (in psychotherapy) might have led to the parents but it didn't. The patient felt more like a young adult, or was it pseudo mature?* (N1 p.5, l.25)

Here, the assessor wondered whether it would have been helpful to have the parents involved. The assessor became interested in his/her own thinking process in hindsight: had the assessor acted out by following the patient's apparent pseudo maturity and therefore not involved the parents? (See Section 1.b)

There can be tension between helpfully including the parent and/or risking the patient breaking off by including the parent. P highlighted the importance of negotiating parent work with the adolescent patient and recommended '*if they were 16 or 17 (I) would say to her, I think it would be a good idea if your parents came and saw a colleague. There has been a lot of parental distress and I think it would be good in terms of them supporting you, if they came here and had a session with a colleague or possibly two. I would make it quite clear that it was for the support of the treatment and not for the parent themselves. It also depends how grown up they are; some are like 13 year olds and some seem as though they are 22 and the idea that parents would come is unthinkable'* (p.6, l.17-31).

The assessor may also have considered the patient's development outside of the sessions, i.e. what takes place in the young person's external world during the assessment and how this can be understood. One assessor described how the patient and her family expressed their significant anxiety outside the assessment sessions by involving a range of professionals. This was understood as a need for containment for the family.

When considering involving parents, the following factors were considered: the patient's evolving relationship with the assessor, the patient's developmental needs and the potential risks to the patient's evolving relationship with the institution. The inevitable tensions these evoked were reportedly carefully considered and supported by the MDT.

d) Service parameters

The institution's capacity emerged as a theme in observations and interviews. Waiting list pressures and training needs/training capacity evidently influenced the clinical decision-making process. Recommendations were partly based on a consideration of the service's capacity, as the following section will evidence.

i) 'So many waiting already'

The pressure of the waiting list emerged as a sub-theme during the intake observations. The following passages are extracts from the intake team observations which evidence how the pressures of the waiting list affected clinical decision-making.

This excerpt is taken from a case where some discussion has already taken place,

…'N, consultant child and adolescent psychotherapist, 'it sounds like she would like some help.' N seemed to base her comment on her emotional response to listening to the referral. She stated that not only was there need, but also this patient did seem to want something. The 'want' seemed to refer to 'motivation' as one step up from 'need'. '*B, chair, seems to disagree, Are we the right place? Then she completes her thought process saying, 'Given we do not know much, maybe we do need to see her'.* B seemed to have been influenced by N's clinical authority on the

young person's emotional need. '*N reiterates her argument, 'she cannot be sent anywhere else.'* (Obs.1, p.5, l.20)

Here, N acknowledged that this young person's need is not straightforward. However, she also referred to the uniqueness of the service. Might this have over-ridden the issue of appropriateness? Did the clinician wish to defend herself against feelings of helplessness, deficiency or guilt by highlighting the uniqueness of the service? The clinicians might have used omnipotence to defend against these feelings, following a phantasy that they and their organisation can help with all kinds of difficulties. At the same time, there is the reality of there not being many services for young people aged over 18 years (see Chapter 2), and research which suggests that psychotherapy is often considered to be treatment of last resort (see Chapter 2, Section 5e).

'Now B, chair, articulates what her concern (i.e. whether they are the right place) might have been driven by: 'There are so many waiting in (this area) already' (ibid). It may be that, on this occasion, the concern about where this young person could be seen functioned as a reason not to take them in. It seemed that 'the right place' is a somewhat vague concept and might have opened a space for concerns about the waiting list to be expressed.

There may also have been intra-personal forces at play. For example, had a number of cases already been accepted in this meeting, and had the pressure had been building up on the individual members? These issues may well have been expressed through tension between members of the team. '*At this point C, consultant clinical psychologist, mentions the housing situation'* (ibid). This comment seems to be disconnected, although it could be that C was referring to the instability in the young person's external world, perhaps the comment is an expression of

anxiety about the pressure from the waiting list - projecting the metaphorical service's housing problem into the patient - another reason why this client should not be seen. On the other hand, the clinician may have been expressing concern about the patient and, in this way, been seeking to move the discussion back to a consideration of need. 'B *appears slightly dismissive: 'But there are also other issues'.* Perhaps B responded quickly, as she had expressed the concern about the waiting list, or it could be that she took C's comment as raising the issue of the young person's need again. The debate subsequently moved away from the waiting list pressure. It seemed that there was a pattern to the debate, in that a need would be named and then a constraint would be expressed. This ebb and flow continued.

'N, consultant child and adolescent psychotherapist, then summarises that the patient is saying she wants help with housing and there is a sense of deprivation, given her age.' (ibid)

Maybe N was summarising as a way to move away from the debate and pull together all the known elements about the patient. She did this by refocusing on interpreting the referral data. At the same time, it is possible to think of her comment as holding the pressure of the waiting list and the young person's needs simultaneously in mind. She seemed be referring to the question of whether this clinic will provide a metaphorical home for her.

'*N continues that she had probably not had much in terms of having been in care. She tried a college course but could not sustain it. Dr T, psychiatrist, suggests that the referrer thought of us because she had been here before. B adds we don't know what is going on as this was only on the phone. Dr D, psychiatry trainee, suggests talking to the social worker'* (ibid).

The clinicians generally identified the need for further information before a decision was taken. The process had taken a more pragmatic direction again, involving a third party, another agency. '*N says that probably she is not high priority (for social care)'* (ibid). N commented on the young person's level of need as perceived in the current climate.

'Dr T then wonders whether she could get brief therapy somewhere else. Dr D brings it back to the emotional need by saying that there had been no input since she was thirteen. She didn't have treatment for her previous suicide attempts by the looks of it. Dr T, maybe overriding his trainee's thoughts, wonders aloud about a referral to a different team.'

The debate had once again moved back and forth; however, this time the exchange seemed to have been affected by the team's internal dynamics. The unconscious, and possibly conscious, dynamics between the team members, hierarchies and the culture of the team had a real effect on the decision-making process.

Dr T seemed to reiterate B's earlier comment when she wondered whether this clinic 'would be the right place.' *B replies that they must have discussed that. Then Dr T returns to his thought that this young person's life might be very chaotic and he wonders 'would she be able to fit here'* (ibid). Dr T seemed to be predicting how the young person's mental state might develop. How can 'being able to fit here' be understood? Dr T may have been wondering whether this young person would be able to access psychotherapy, and whether her lifestyle might be too chaotic to manage a commitment to a therapeutic relationship and regular appointments. He may also have been making some prediction of risk. In terms of the team's thinking process, Dr T's comment may have been a reference to the team's difficulty in

working together well at this point. Was this an expression of the team's countertransference to the case presentation? Or was this a projection of how difficult the team was finding it to work together well in this discussion?

This comment moved the debate on to a logistical level again. If this was not the right service, which service would be better suited? *'B suggests asking the referrer 'Why us?' Maybe a personality disorder service would be more suitable. Dr D wonders whether the service should hold her in the meantime. Dr T reiterates his suggestion of a different service; they offer a care co-ordinator.'* Here, as the consultant contradicts the trainee, it appeared that hierarchical dynamics were affecting the decision-making. This seemed to become part of the force driving the decision. '*B closes the debate by saying, we need to get more info or send to an outside organisation'* (ibid).The request for further information might have had a range of meanings. Was there really a need for information or did this request solve the current difficulty of the team struggling to decide? To what extent would further information help to clarify this situation? What kind of information would really be needed?

A number of factors were considered: the patient's need, her external set-up, some prediction of her internal capacity to take part in psychotherapy based on the description of her presentation and history. At the same time, concerns about the waiting list were expressed. It is not clear to what extent concern about the waiting list determined the decision about the young person's suitability. Dr T made the last contribution before B decided.

In this excerpt the child and adolescent psychotherapist's concern about the potential clinical and social need was heard but then outweighed by the sense that there was not enough information and that the social needs predominated. The

process was further affected by the senior member asserting their own views over those of the trainee. Perhaps this decision was influenced by the hierarchy (or dynamics) between the psychiatric consultant and the trainee – i.e. tension between a senior and a junior member of the team somewhat rescuing peers from the larger tension within the group as a whole. It may also have been the case that the dynamics between the different professions determined the outcome. There seemed to be some tension within the team when the concern over the waiting list was being discussed by N and B; it was after this that the psychiatric focus became more prominent. On this occasion B did not echo N's concern, and it is possible that this process led to Dr T's concern being given more weight. The consultant child and adolescent psychotherapist named 'emotional need', but ultimately concern about the potentially chaotic presentation resulted in the case being referred to an outside agency. It is also possible that psychiatry holding the focus on risk determined the decision on this occasion.

From these considerations it is not clear what weight the concern about the waiting list carries and whether this can be generalised. Managing the waiting list is one of a number of potentially competing intake team tasks, and one which therefore impacts on the clinical decision-making process. It is also possible that the concerns about the waiting list are resorted to as a function for other concerns, namely managing a sense of helplessness and/or uncertainty, and the differences between team members.

ii) 'Is there an intensive space?'

Training needs and trainee capacity/availability emerged as a sub-theme during intake observations and interviews. The clinic is a training institution in which intensive psychotherapy is provided almost entirely by child and adolescent

psychotherapy trainees. This means that there needs to, and can only, be a defined number of cases per year treated intensively, which sets a limit to the number of patients that can be taken on for this treatment. The clinical decision-making process is affected by the need to find appropriate cases for trainees. In the following excerpt the intake team considered a referral for intensive psychotherapy. This case was referred by clinician J who felt that the young person had 'made good use of psychotherapy but needed more'.

'This is a patient who was seen for psychotherapy at a CAMHS service and is now referred to this service as he is turning 18. B, chair, is looking at N, consultant child and adolescent psychotherapist. N is shaking her head in thought and says that it sounds like a convincing referral but it is not straightforward' (Obs.2, p.1, l.40ff).

There was a moment of silent reflection on the issues. The thinking space was expanding while clinicians were listening to each other's input. It seemed as if the thoughts were developing by going around in the group; one person made a statement about what they heard and thought and the others developed their thoughts in response, their replies furthering the group's thinking. Silences and pauses seemed to give space and shape to this process. *'B then wonders whether he should be assessed now. She continues that there are a million referrals waiting but this would have to be taken forward clinically.'* B was holding the concern about the waiting list. '*N, referring to the patient's current psychotherapy, suggests that an ending with J might be necessary.'* (ibid) The researcher noted a speeding up/ slowing down experience. Once again there was a sense of going back and forth between different concerns – the clinical need, and possibly waiting list pressures. 'B*, looking at the file, says that he has already ended with J. Maybe he needs to be re-referred in the autumn.'* The researcher noted a sense of worry and uncertainty.

She inferred this from the length of time B and N seemed to consider how to transition this case. It seemed as if the tension was mainly between the clinical thinking about how to plan the assessment and the concern about the waiting list. There was a lull. *'B says that a review is something for the summer (meaning the young person would be held over the summer at the referrer's service). N suggests that he should either be assessed before or after the summer.'* Both options had implications as an autumn assessment would imply a longer wait. It is also in the autumn that the new trainees start their placements every year.

'L, consultant clinical psychologist, says that in some ways we should assess him before the summer. She adds there is an intensive space at the moment isn't there? N replies yes but that she has someone else in mind who asked specifically for a man. B says the patient is only 18 in October. B adds that she will speak to J about whether it is possible to hold the patient over the summer. Dr T clarifies that he is engaged with them. He adds that if he ends now and has an assessment, it is a long wait over the summer. Dr T suggests that while he is a patient at X (the referrer's service) he can just walk in there. He would have a different summer then. B states but he had ended (therapy) and only has sporadic appointments now. She adds that he might need to be re-referred in September' (ibid).

A decision like this would of course also have implications for the waiting list. Again there was a lull while the clinicians mulled the issues over. *'B then says she will call J and talk to her to see if the patient can remain at the (referrer's) service until the autumn. There is a pause and a sense that this has been dealt with for now'* (Obs.2, p.1, l.40 to p.2, l.38).

Here, careful planning involved considering the young person's needs as well as waiting list constraints, training needs, trainee availability and capacity. Another

factor when deciding on training cases is the consideration of risk (see section II.1b). Should intensive psychotherapy be recommended, the risk to the trainee would also be part of the consideration. '… *the case will be monitored and shared by other members of the team, certainly this wouldn't have been a case I would want a trainee to be on their own with*' (N2, p.10, l.10ff). Intensive cases are accompanied by weekly supervision with a senior clinician; however, in this case the assessor highlighted the importance of supervision and regular MDT discussion to support the trainee and their work.

e) How would the patient manage the transition into treatment?

'Transition' emerged as a sub-theme during intake observations and interviews. This also links to the description of careful planning in the previous section. The intake team and the assessor considered how the patient would manage the transition into treatment. Considering and – if appropriate – planning the patient's move into assessment, and from assessment into treatment, formed part of the clinical decision-making process. Should intensive psychotherapy be recommended, the holding of the case by the MDT continues via the assessor regularly becoming the case supervisor and the team continuing to be a reflective space for the treating clinician.

P (p.1, l.20) described how *'the transition to another therapist needs to be communicated at the beginning of the assessment.'* The patient might have a range of phantasies about the change. '*It was a lot like 'I have done with her, right now I am on a new person'. It is important to explore the phantasy about this*' (Y p.3, l.39). Feelings and thoughts about loss, disappointment, rejection and further emotional responses to change might surface. This period can be one during which it can be

difficult for the patient to sustain the link to the therapist and the therapy, and they may lack the internal strength to manage the transition.

N2 described the process of negotiating the waiting and the importance of the external network: the role of psychiatry and the MDT, as well as parent work (section II.3). N1 recommended that there should be time for six weeks' intensive treatment before the first break. P (p.7, l.20) stated that when there is '*the risk of disengagement, (it can be advisable) to start once weekly and then build up when there is a space rather than hand over at the end of the assessment*.'

Summary

This chapter presented the findings of Study 2. The research attempted to find answers to the questions: What processes and dynamics are involved in clinical decision-making about intensive psychotherapy at intake and assessment? On what basis is the decision to recommend intensive psychotherapy made?

The findings evidence the complex thinking process that took place in the multi-disciplinary intake group. The group thinking was evidently affected by the particular dynamics of each case. There was also evidence of the groups' own unconscious dynamics impacting on their clinical decision-making. The decision-making appeared to be influenced by tensions between professionals - possibly in part due to hierarchy - and differences in approach and thinking. At times the group did not function as well as at others, and thinking was impaired.

The group was observed having to negotiate between competing tasks, weighing up the patient's external and internal capacity as well as the service's capacity. Some of the indicators that were considered when deciding on intensive psychotherapy were found to be rather vague, contradictory and open to interpretation. The assessors' and the intake team member's subjectivity was found

to be of paramount importance when exploring clinical decision-making. The research raised many questions, and highlighted some external aspects – for example the parents' involvement – and some internal aspects, for example assessing ambivalence, as important considerations.

The following chapter is a discussion of the findings of Study 1 and Study 2 from a psychoanalytically informed perspective.

Chapter 6: Discussion

Introduction

This chapter provides a summary and discussion of the findings. The study aimed to explore the process of coming into intensive psychotherapy for adolescents. Study 1 aimed to find out which adolescents come into intensive treatment. Study 2 then explored how these adolescents are selected.

The discussion will focus on the following areas:

- Contradictions and paradoxes
- Movement: the patient's emerging capacity to 'bear strong feelings', 'think' and 'consider ambivalence'
- Parent work
- The institution as container
- Dynamics inherent in the clinical decision-making process

Finally the researcher will discuss limitations of the study and her learning from it.

1) Summary

a) Study 1

The first study consisted of an audit of intensive psychotherapy cases over a specified time period at an inner city clinic. The evidence highlights the fact that

intensive psychotherapy is a very limited resource - that is, it was only offered to one percent of the referrals in the specified time period. The study explored characteristics and features of the patient group as well as the process by which young people come into treatment. On the whole, the audit revealed a mixed picture, with the majority of patients (13) having a certain amount of external stability, being largely engaged in education and employment and outwardly stable living arrangements (14 patients or 84% living with one or both parents including one patient who had been adopted), with social services involvement in four cases. In contrast, three patients (20%) had very little outside stability (not in training, education or employment). In these cases the intensive treatment might have been undertaken instead of inpatient treatment.

None of the cases had been referred for intensive treatment; rather, the recommendation for intensive treatment was made during assessment or during weekly treatment. This highlights the fact that the consideration regarding whether to offer intensive treatment is an internal process inherently tied to the assessment and treatment process. 10 patients had a diagnosis at assessment stage[3;] however, based on the reports by the clinicians, the majority of patients had a range of long-standing mental health difficulties, with 10 of the patients having had numerous previous treatments.

Looking more closely at the patients' family backgrounds it became apparent that in 10 cases (60%) the psychotherapists reported parental mental ill health. At the same time parental involvement in treatment was only 42% (7 cases). Considering the complexity of the cases and the levels of reported parental mental

3 The reasons why there might a lower level of diagnoses are discussed in Chapter 3 Section 4a.

health problems, one might have expected more parents to be involved in treatment. The issue of parental involvement is also a focus in Study 2.

Every patient had between one and five professionals involved, either historically or currently. The audit highlighted the fact that a significant professional network was involved for the containment of the treatment in most cases. Considering the relative outward stability of the cases, this highlights a possible schism between outward stability and inward complexity. It may also indicate that intensive psychotherapy is offered to young people who do not necessarily have a lack of outward stability, but rather more complex mental health difficulties which are expressed as both internalising and externalising difficulties. This will be further explored in the discussion section.

The clinicians' answers in the audit about indicators for recommendation of intensive psychotherapy coincided with the themes that emerged in Study 2. In summary they are:

- case complexity including severity and longevity
- risk
- factors apparent in the relationship between patient and assessor

b) Study 2

Study 2 examined the intake and assessment process in more depth. A case study consisting of observations of intake meetings and interviews with assessors was set up to explore clinical decision-making when recommending intensive psychotherapy. The intake observations explored all referrals before decisions on intensive psychotherapy were taken; therefore, the following section will firstly look at indicators applying to weekly and then intensive psychotherapy.

The following indicators for psychotherapy were identified from the analysis of observation and interview data:

- **Developmental impasse or breakdown and trauma**

The cases discussed had all experienced some degree of difficulty with the developmental challenges of moving into adulthood. The data show that the participants explored whether the presenting difficulties might have been due to a developmental impasse or arrest, and/ or whether the patient might have experienced trauma. The clinicians explored how the patient's development, their historical experiences, and their current difficulties impact on their current life. The clinicians at intake considered and hypothesised about the young person's state of mind given their predicament. The assessors aimed to gain an understanding of the patient's state of mind and their internal world in the room.

- **Motivation**

Analysis of the data shows that the clinicians considered the motivation of the referrer, the young person and the family. It also reveals that one focus during assessment had been enhancing the young person's developing interest in their own predicament.

- **The quality of the young person's involvement with life**

Where on the spectrum from chaos to passivity and withdrawal from life was the young person positioning him/herself?

- **The place for psychotherapy in the young person's life**

How would treatment fit in with the young person's current life style?

- **The quality of the involvement and potential support from parents/ carers**

This will be further discussed in section 2.c).

Further, analysis of the observation and interview data suggests the following additional indicators for intensive treatment specifically:

- **Need for increased containment**

In Study 2, severity, complexity and longevity were present in nearly every case; however this was not always the case. Study 1 showed that some cases had some external stability while some had severely broken down. The intake team and the assessors explored risk, namely the young person's risk to themselves, or to others. Risk considerations also included the potential risk of having or not having treatment – for example, of the patient breaking down further. The impact on, and potential risk to, the treatment therapist was also considered, as was what support might be required from the institution to support the case.

- **Capacity to manage treatment demands**

Are the patient's circumstances and the support from their environment robust enough for a demanding treatment? For if the young person's manner of engaging with life and the support around them was either questionable or unstable then a more supportive and less intensive approach was thought potentially more suitable at least in the first instance. Previous experience of psychotherapy was considered a positive indicator. Sometimes intensive psychotherapy was considered in order to further development and/or the internalisation of gains already achieved in weekly work.

- **Increased intensity to provide greater challenge**

Would intensive treatment provide the appropriate frame to challenge 'rigid defences' and 'great resistance'? The relevance of this indicator might be apparent

from the referral but nevertheless needs to be considered as part of the assessment since only observation and consideration over time will provide answers to these questions. Interestingly, these are the very factors that were historically considered contra-indicators for psychoanalysis (see literature review, Chapter 2, Section 1).

The indicators derived from the referral provide only the background to the clinical decision-making process; they do not give sufficient indication for a recommendation of intensive treatment. The findings show that an assessment over a series of sessions is necessary to ascertain the quality of the patient's way of relating to the assessor and themselves, as well as how this can change over a given period of time. While the assessors' accounts were found to be largely determined by the respective cases, the findings highlight some factors that were considered in all cases. The analysis of the data from Studies 1 and 2 shows that the patient's internal capacity will be considered by exploring how they relate to the assessment and the assessor.

The data analysis shows that the assessors were looking for movement in terms of the patient's capacity to

- engage
- bear strong feelings
- think
- consider ambivalence

The assessors explored whether these capacities could emerge and develop during a series of four assessment sessions (see also Chapter 2 Section 6 b and Chapter 5 Section 2.b.ii). The findings show that the assessors were looking for emerging potential to develop a range of relational capacities in order to inform their decision about whether intensive therapy would be appropriate. The findings show

that assessing psychotherapists believe that the patient needs to have some - albeit emerging - interest in contemplating the meaning of their actions, some emerging capacity to bear strong feelings without acting on them (see below Section b on 'bearing feelings'). It was found that a case may sometimes need to be worked up in weekly psychotherapy to foster these capacities. The particular, idiosyncratic way of working with adolescents and young adults was highlighted and the assessors referred to their efforts at engaging the patient (see below 2.b.i). **The study referred to intensive psychotherapy as psychotherapy at increased frequency. The study did not explore the difference between twice, three or more times a week frequency but focused on intensive as more than once weekly psychotherapy. This study indicates that the choice of frequency is highly idiosyncratic and case dependent.**

Analysis of the observational data suggested that group dynamics affect the group's thinking. Decision-making appeared to be influenced by dynamics relating to the case as well as dynamics within the team - including group culture, different hierarchies and roles. The group seemed to struggle with constraints to their thinking at times; for example, there was some evidence of idealisation, omnipotence and conflict avoidance. The intake team dealt with potentially competing tasks and appeared to also be affected by external factors in their decision-making, namely by waiting list pressures and training needs. The assessors reported using their countertransference and exploring experiences of projective identification to come to some understanding of their experience of being with the patient. One of the ways in which they did this was by tracking the atmosphere and the changes taking place in the room.

The findings suggest that clinical decision-making about whether to refer for intensive psychotherapy involves weighing a number of sometimes competing and potentially contradictory factors. The clinicians used their understanding of the referral and their thinking about their observations of, and relationship to, the patient, to weigh up the above factors; they did this as part of a dynamic process which took into consideration the patient's state of mind, the patient's ability to develop during the assessment and their environmental set-up and support (friends, school, work, parents/carers). This weighing up process included consideration of the capacity of the service including waiting list and training capacity/needs. The clinicians used the thinking and containment provided by the group and its dynamics to develop their thoughts. At the same time group dynamics were found to potentially have a detrimental effect on group thinking (see below Section e).

This thinking seemed to take place when meeting as a multi-disciplinary staff team, and when having the team in mind. Throughout this process a formulation was developed about intensity, parent work, network involvement and transition. The analysis of the data from Study 1 and Study 2 shows that the intensive treatment was set up as a holding framework; the clinician holding the patient, the supervisor holding the clinician, the parent worker holding the parent, and the team holding the clinician.

2) Critical Reflection

This section aims to bring together the researcher's ideas about the findings and offer a critical response to them. In the first part the researcher offers her view on the findings and discusses them in relation to historical and contemporary literature.

Most of the indicators found had already been discussed in the literature in relation to individual case studies. Jackson (2012) describes some of the factors considered here. Some of the indicators from the findings might be implicit in clinical discussions (supervision communication with Emil Jackson, 2016) but are not directly described in the child psychotherapy literature. **This study brings together the different strands of thinking and in this way contributes to knowledge by making implicit thinking explicit and spelling out explicitly the child and adolescent psychotherapy thinking of the clinical decision making process.**

a) Contradictions and paradoxes

The following section will discuss some of the indicators for intensive treatment that have been identified in this study, namely risk, demands of intensive treatment, increased intensity to challenge defences and the difficulty in measuring 'emerging capacity'.

i) Risk

In some cases the increased intensity of intensive work was considered to possibly increase containment by providing a stronger framework, while in others, risk was found to be a contra-indicator particularly if there was not enough external support.

The findings show that the quality of the patient's engagement with life was considered. In some cases a 'chaotic' life style or extremely limited engagement with life were considered contra-indicators. While intensive work might provide containment for some patients, for others – perhaps those whose lives are particularly chaotic, or who are too withdrawn - this might not be the best suited approach.

The findings show that the assessors were looking for ‘some outside structure’, for the patient to be involved in ‘some life activities’. These external factors were perceived to provide potential balance to internal difficulties. It was deemed essential to analyse the patient’s specific circumstances. These findings confirm the literature on risk in adolescent mental health. Anderson (2000) recommends the internal and external factors relating to the young person to be considered, as they manifest in the transference. He also suggests that the patient's present and past circumstances be taken into account.

What are the circumstances under which the patient’s life may be considered too chaotic or the patient too withdrawn to be considered suitable? From the given data there is no clear answer to or certainty about this. An interpretation of the patient’s state of mind and their circumstances will always depend on the team’s and the assessor’s subjectivity (see below Section e).

ii) Demands of intensive treatment

Data analysis shows that both intake team and assessors considered intensive treatment to be demanding for the patient. Would the patient have enough support externally and internally to face the waves of regression and emotional turmoil they might encounter in intensive treatment? While a patient might lead a very restricted life, the participants paradoxically looked for a considerable level of emotional functioning. This can appear to be a possible contradiction and again it will depend on the idiosyncratic circumstances. The answer seems to lie in the combination of the patient’s emotional functioning and how this is evolving throughout the assessment and the patient’s environmental support.

iii) Increased intensity to challenge defences

The findings show that intensive treatment is demanding in that it aims to 'get to deeper layers', 'open things up' and challenge 'defences' (see Chapter 5 Section 2.a. iii). The findings highlight the importance of considering the patients' 'resistance' and their 'defences' and whether the patient has some capacity to explore these during assessment. At the same time these are the very defences that an adolescent patient might use against the potential of dependency in psychotherapy (see the section below on 'ambivalence')? If the patient's 'resistance' manifested itself in extreme passivity, would this then be a contra-indicator? Which defences will be considered as too rigid to be approached in this way? How is it decided whether the risk of breakdown by challenging the defences is too big so that intensive treatment may not be viable?

iv) How can these conditions be measured?

Data analysis shows that the assessment aims to tease out whether the patient has some capacity to bear strong feelings and engage, and whether their particular levels of chaos or lifelessness can be managed under the circumstances. Waddell (1999) describes this tension between the adolescent developing some capacity to feel and think and their simultaneous intolerance to suffering emotional pain (see Chapter 2, Section 2). The findings suggest that careful assessment is needed to ascertain whether the externalisation of the internal struggle may be containable in treatment and/or can be supported by the parents (see Section c below) to provide sufficient stability for the treatment process to take place. However these entities are difficult to measure. How much of these capacities might be enough? How confident does the clinician need to be that the patient can develop (see below Section 2.e.ii)? The findings raise more questions than they provide answers for.

b) Indicators for intensive psychotherapy during assessment

i) 'Movement' and 'engagement'

The findings show that part of the purpose of the four session assessment is to ascertain whether the patient has the capacity to engage in a therapeutic relationship and allow some 'movement' to take place. The assessors observed the patient's emerging engagement with the assessor, their thinking about themselves and the idea of treatment. 'Movement' encompassed change within the emerging relationship, the patient's understanding and thinking about themselves and the idea of treatment.

This concept of 'movement' is akin to Hobson's (2013) description of 'working over' when assessing adult patients. He suggests attempting some understanding and containment with a focus on development within the assessment. 'Working over' is developmentally orientated and concerns the promotion of change. Hobson (2013, p. 210) argues that the therapist has an 'opportunity to track movements in the relative emotional positions of him/herself and the patient'.

On the other hand, there is the particular effort the assessors described to support the development of this engagement. The assessors described their attempts to foster 'movement' within the 'engagement' during the assessment, supporting the patient to make some shifts in terms of how they related to themselves, the assessor and the idea of treatment. This assessor, for example, observed 'i*n the third session that there seemed to be a turning point when, the patient was almost becoming more connected to the idea of treatment'* (N1 p.4, l.51ff). Waddell (2002b) argues that the assessment process requires a combination of skills: analytic observation, impartiality, insight, judgment and interpretative restraint. The assessor needs to be able to meet the adolescent's changeability,

remaining versatile and flexible while keeping their preconceptions at bay. In this study reference was made to foster engagement and the particular skills involved. One assessor described wanting '*the patient to have an experience that a mind really is meeting another mind*' P (p.7, l.46). The findings display the idiosyncracies of the engagement process with adolescent patients. The following three sections discuss the main areas of 'movement' that were considered during the clinical decision-making process.

ii) Emerging capacity to 'bear strong feelings'

The findings show that the assessors looked for the patient's emerging capacity to 'bear strong feelings'. Can they bear anxiety? How do they manage when they feel upset? Can they use the assessor to contain their distress? How do they manage separations and gaps between sessions? Are they able to use their experience with the assessor to develop during the assessment? These findings agree with the discussion in the literature review (Chapter 2 Section 3). The literature describes how the clinician aims to get a sense of the patient's experience of containment, their level of integration and their capacity to internalise experience (Waddell, 2002a, Wittenberg, 1982, Horne and Lanyado, 2009). The findings show that observations of how the patient responds to the assessor when in need, and how this emerges throughout the assessment, are used to predict their emerging capacity to engage with treatment.

The following passage details how the development of this capacity is conceptualised in the literature and how the findings confirm the messages from the literature. Both the literature and the findings suggest that the structure of the personality should be considered in terms of containment. Waddell (2006, p. 150) links Bion's container/contained relationship to the relationship between mother and

baby, and the relationship between analyst and patient. She argues that the similarity lies in the 'availability of a mind capable of introjecting the baby's projective communications and evacuations'. Waddell (2002a) describes how the infant's external environment and their own unique predisposition combine to determine whether the baby, when in pain, expels that pain (projectively) or attempts to take something in which can ameliorate it (introjectively). The findings show that the assessment aims to ascertain where on this spectrum the patient may be. In one case the assessor described having to '*initially absorb anxiety for the patient to keep functioning*' (P p.5, l.22). This assessor highlighted the importance of the '*patient having the experience that the assessor was able to take in and bear'* (p.7, l.47). This also meant that the assessor needed to '*make use of the maternal function'* in addition to '*retain(ing) analytic capacity'* (p.2, l.14). The assessor observes what the patient does with the assessor's comments and interpretations: do they reject them or use them to grow? What is the quality of the patient's internal container? The assessors showed that they ascertain this by reflecting on their countertransference (see Section e.ii) below). The assessors explained that they make a prediction of potential development on the basis of how the patient relates to the assessor *'I think there probably was just enough, I felt there were moments, when I felt I could engage a bit more with her….* (N1, p.3, l.4) *and '…there was some hope around, even though she didn't express it* (N2, p.10, l.45ff).

iii) Emerging 'capacity to think'

The findings demonstrate that the assessors aimed to think with the patient about themselves and observe whether the patient can develop their capacity to think. Sometimes one of the first 'movements' that is encouraged in assessment is for the patient to develop an interest in their predicament, the assessor and the

treatment. Often the assessment aims to evoke a considerable amount of anxiety in order that the patient might begin to think about him/ or herself. Being 'able to think' is linked to introjective capacities (see above 2.b) ii). Waddell (1999, p. 220), as citied in the literature review (Chapter 2, Section 2), suggests that to 'think about and suffer emotional experiences feeds the mind and promotes growth'.

The following section will explore the idiosyncratic way in which the development of thinking during late adolescence is conceptualised. Waddell (2002b) distinguishes between three phases of adolescent development, namely early, mid and late adolescence, each with its respective tasks and struggles. The findings focus in particular on late adolescence (the average age in the audit being 18 and a half years). Waddell (2002a) suggests that 'the capacity to have emotional experiences which can be felt to be meaningful becomes the basis for further thoughts and learning'. She describes adolescents 'investigating their feelings in another personality'. She sees one of the tasks in late adolescence as 'furthering introjection; the projective mode begins to reduce and the introjective capacities develop' (Waddell, 2002a, p. 210). The findings show that the assessors looked for the patient's capacity to bear feelings and consider them without having to act. This process can evolve slowly, and it is clear from the data that a number of patients struggled with introjection. One assessor reported the patient needing to '*tip it out, they might not yet be able to stop and reflect'* (P p.3, l.24). However, in some cases slight shifts in the patient's way of relating to the assessor could be observed; for example, one patient was able to acknowledge that he wanted others to act rather than taking responsibility himself.

Is this concept of the 'ability to think' similar to 'psychological mindedness', an often cited prerequisite for psychoanalysis (Coltart, 1988)? The thinking about

‘psychological mindedness’ has developed over time. While, in former times, it was seen as a constitutional feature (Appelbaum, 1973), more recently psychological mindedness has come to be viewed as an area of development, a feature of the patient that might have potential to grow with the therapist’s help. Fonagy et al. (Tessier et al., 2016, Luyten and Fonagy, 2014) have written extensively on reflective functioning and the capacity to mentalise. Recent literature (Peterson, 2014) highlights the need to help the patient become an analytic patient. The findings show that some cases might need to be ‘worked up’, that the patient might not initially be available for the intensity and demands of intensive work. In this way the idea of developing the ‘ability to think’ might appear similar to Applebaum’s conceptualisation that in weekly sessions the therapist can provide some of the capacities that the patient lacks.

At the same time ‘psychological mindedness’ is conceptualised differently in child and adolescent psychotherapy. As described in the literature review (Chapter 2) child and adolescent psychotherapists work with patients who are not necessarily open to ordinary thinking in the consulting room (Catty, 2016). This can be particularly true with young people who drop into long silences or who act very chaotically and dangerously. Brady (2012, p. 302) links Bion’s thinking that the ‘purpose of analysis is the growth of the mind’ with the ‘child analyst’s goals of fostering development and understanding impediments to development’(Brady et al., 2012). This includes the development of thinking. As described above, Bion (1962) describes the baby projecting sense data and the mother translating this and returning them to the infant in a form that the infant can manage. It is one of the tasks of the child and adolescent psychotherapist to provide alpha function which the young person might use to make sense of their experiences in the first instance and

might internalise in the long-term (Lanyado and Horne, 2006). The findings show that whether, and to what extent, the patient was developing their capacity to think about themselves and their predicament was considered an indicator for intensive psychotherapy. '*She wasn't really prepared to change and to engage with it further. There was no clear sense of having a future, wanting a future …But she was able to discuss this'* (N1 p.4, l.14 – 17).

iv) Ambivalence – a particular focus when assessing adolescents

This section will explore the idea of 'movement' in the patient's thinking about the assessor and the idea of treatment. The findings suggest that the assessors aimed to ascertain the patient's ambivalence towards the idea of treatment and the assessor. The findings also show that considering the patient's ambivalent feelings forms part of an assessment of the patient's development and personality organisation. The following passage will discuss the findings in the view of the literature on ambivalence.

Thinking about ambivalence has evolved since Freud, who wrote in the Ratman and Little Hans about the chronic co-existence of love and hate towards the same person (Freud, 1909b, Freud, 1909a, Kris, 1984). Subsequently, ambivalence was viewed as interfering with the internalisation of the object. It was lack of integration that was seen to lead to excessive ambivalence and excessive super ego activity (Schwartz, 1989, Holder, 1975). The aim was then to modify ambivalence by resolving early conflicts. More recent thinking (Likierman, 1995, p. 155) associates ambivalence with mourning, arguing that ambivalence evolves from early splitting and implies 'the loss of the loved object'. Likiermann (1995, p. 154) states that coming to bear ambivalence engenders 'the capacity to entertain conflicting

emotions simultaneously'. Segal (1993, p. 59) describes the capacity to experience ambivalence as a 'fundamental achievement, a major step in development'.

Some of the literature on child and adolescent psychotherapy asserts that the child or adolescent's tolerance of frustration and ambivalence needs to be ascertained (Holder, 1975). The findings show that the assessment aims to ascertain the level of ambivalence within the patient, how ambivalence features in their 'internal landscape' (Williams, 2002) or their 'pictures of relationships with objects' (Hinshelwood, 1991).

The literature (Waddell, 1999) and the findings suggest that the force and intensity of the adolescent's changeability and fluidity is idiosyncratic to adolescent development. A series of session therefore offers the opportunity for a picture of their development in assessment to emerge and to be discussed. The findings highlight the importance of considering their pattern of attendance with the patient and challenging the patient's views about themselves. The concept of changeability when applied to adolescent development includes the patient changing within themselves as well as changing in their attitude towards the assessor and treatment.

The findings from this present study confirm the message from the literature that exploring ambivalence needs to be a particular technical focus when assessing adolescents. How does the patient's way of relating change throughout the assessment? Can an awareness of ambivalence emerge and be tolerated? The data analysis suggests that the development of the adolescent patient's capacity to tolerate ambivalence is a key characteristic of this developmental phase. One assessor recommended that '*one needs time to bring (out) different aspects and their ambivalence. The clinician needs to work with this in the assessment process, and not settle down too quickly for one thing or another*' (N1 p.10, l.23ff). This

assessor highlighted the focus on ambivalence, particularly about the idea of treatment and the assessor.

While this can be viewed as a particular aspect of changeability, this study also highlights a potentially underlying dynamic of adolescent development. As discussed in the literature review (Chapter 2, Section 6b) the adolescent patient might struggle with the idea of dependency and intimacy. Bronstein and Flanders (1998) link their patients' fear of being taken over by the treatment/ clinician to the adolescents' experience of having felt taken over by the physical changes they had gone through in puberty (Chapter 2 Section 6b). Zachrisson (2006, p. 110) suggests that 'emotional contact awakens hope and anxiety, as does the onset of treatment'. Zachrisson warns further that 'in this precarious state of mind, if anxiety outweighs hope, we lose the patient'(Zachrisson, 2006, p. ibid).

Lastly the findings show that ambivalence needs to be a particular focus because the treatment alliance is for the most part between the clinician and the patient only. 'O*ne starts with the young person, not with the family …, one starts with the young person and what they want, what they feel comfortable with, (this) is essential in the assessments with adolescents*' (N1, p.1, l.29). A focus on ambivalence is therefore an important part of the actual decision-making process with the patient. This is in contrast to working with younger children where ambivalent feelings will be explored with the child, but the treatment alliance is more regularly held and maintained by the parents and the parent worker (see Section 2 c below). The literature shows that a focus on ambivalence in assessment can help develop commitment to treatment (Hobson, 2013). Hobson argues that the patient needs a 'grip on a commitment to the kind of process that is going to be involved'.

From this small sample it appears that a focus on ambivalence within the assessment might enhance the potential commitment of the patient to the treatment. Further research could ascertain whether this can be generalised and whether considering the patient's ambivalence might facilitate engagement in the longer term.

c) Parent work

This study has highlighted some of the parameters of intensive treatment with adolescents and young adults. Do these patients benefit from having their parents involved and, if so, how might the treatment helpfully involve the parents? The findings of Study 1 show, that in a number of cases, parents had their own treatment and some undertook parent work while the patient was in intensive treatment; equally, a significant proportion undertook no parent work. The intake team and the assessors considered the parental involvement in the young person's life when deciding on what treatment might be most appropriate. When intensive treatment was considered some thought was given as to whether parents needed to support treatment and/or whether parents needed support in their own right.

Parent work is considered an essential part of child psychotherapy treatment (Sutton and Hughes, 2005, Rustin, 1998a). The IMPACT study (Catty, 2016, p. 130) included working with parents alongside their depressed adolescent children. Catty describes the purpose of parent work in this context: engaging the parents in the treatment process, thinking about the young person and his or her experience of the treatment, and considering issues connected to parenting. Catty highlights that this also includes thinking about 'relational issues within the family'; 'containment of parental anxieties aroused by the young person'; 'the parents' own issues where these impinge on the young person and, where appropriate, addressing historical and intergenerational factors within the family' (2016, p. 76). Catty (2016) describes

that parent work in short term psychoanalytic psychotherapy (STPP) is based on the principle that if ‘parents’ anxieties are sufficiently contained then they are better placed to think about their experiences as parents’ (ibid). Catty outlines how the parents can be supported to better understand and support their child's development and act more effectively as parents. According to Whitefield and Midgley (2015, p. 291) more ‘attention needs to be given to the neglected field of working with parents alongside individual child psychotherapy’.

The findings of Study 1 show that the parents were not as involved in treatment as one might expect, considering the high levels of complexity and parental mental health difficulties. This raises a number of issues.

Developmentally needing to separate and individuate (see literature review Chapter 2) adolescents may struggle with the idea of intimacy and dependency in a relationship with a psychotherapist (see the section above on ambivalence). Any proposal to have their parents involved might complicate this process further. The debate regarding whether or not, and how, to involve parents goes to the core of the adolescent condition, i.e. their journey towards independence and a revival of oedipal tensions (Waddell, 2003). Quagliata and Rustin (2004, p. 6) talk about a (potentially) more grown-up side of the adolescent’s personality which can take responsibility for sustaining treatment. It can however be a complex prediction to make whether the young person actually has this emerging capacity (see the section above on ambivalence). The findings of Study 1 show that in a large number of cases there was a considerable network involved in treatment. However, in some cases with limited parental involvement external agencies might provide the parental functions of supporting the treatment in conjunction with the intensive treatment team.

Where does the institution position itself in this regard, being mindful of the patient's needs and wishes and yet responsive to the presenting problem? How does the institution offer a third position, a place to think about the dilemmas involved? From this limited sample it seems that there is a risk that the institution might take on the role of facilitator of individuation and separation, and thereby inadvertently exclude the parent. Might there be a tendency for the institution to identify with the adolescent and collude with a potentially pathological wish to exclude the parents? The findings suggest that it is particularly important to assist the parents to support treatment at a time when the young person struggles with these developmental tasks.

The findings from Study 2 show, that while assessment of adolescents starts with the young person, careful consideration of the parents/ carers involvement is important when exploring their suitability and capacity to undertake treatment. The following questions need to be considered when deciding on interventions:

1. What is the quality of the parents' involvement in the young person's life? The parents' actual involvement in the patient's life might be different from the young person's experience of this. The balance between involving parents or not can be more delicate to strike with an adolescent having some or all of their ego functions performed by their parents. On the other hand some adolescents may appear externally separated from their parents. The findings also raise the issue of parental mental ill health. The young person may benefit from their parents accessing help even if they have separate lives.
2. Will the parents be able to support treatment and what assistance might they need in order to do so?

3. From the age of 16, the young person can decide for themselves whether they want their parents to be involved. There may be a risk that the idea of having their parents involved might make the young person less inclined to engage. On the other hand, having the parents involved may inadvertently help the patient develop a commitment to treatment (see the section above on ambivalence). The findings show that the assessor will carefully broach the idea of another clinician providing support to the parents. The aim may then be to provide containment for the young person by joining up the parents with the parent worker, with the parent worker and the patients' therapist being contained by the team (Briggs, 2012, Britton et al., 1989).
4. The patient's attitude towards, and perception of, their parents may change throughout the assessment.

d) The institution as container

The findings show that there is considerable network involvement in intensive cases and that considering how to facilitate the transition from assessment into treatment forms part of clinical decision-making. The decision-making, planning and containment are provided by the MDT and the institution. In this respect the findings support the literature which highlights the importance of the institution holding the work. According to Britton (1989, p. 87), the 'closure of the oedipal triangle by the recognition of the link joining the parents provides a limiting boundary for the internal world'. Bronstein and Flanders (1998, p. 30) emphasise the 'supporting environment of an institution which promotes understanding and shares the anxieties brought up' by the patients. They explain that the institution 'provides a third space for thinking, and does not function only at the meetings when the case is being discussed'. This containment also provides thinking space during the session as the therapist makes

'unconscious use of the institution' (ibid). The findings from Study 1 show that all cases were regularly reviewed in MDT meetings, and that in four cases specifically arranged review meetings and professionals meetings took place. All cases had ongoing supervision for one year and in 14 cases (84%) supervision lasted until the end of treatment. This would have been partly due to the fact that a large number of cases were seen by child and adolescent psychotherapy trainees. However the senior clinicians who reported on their intensive cases also referred to the containment provided by supervision.

e) Dynamics of the clinical decision-making process

i) Dynamics of the clinical decision-making process at intake

The following section will discuss what has been learnt about the dynamics of thinking and clinical decision-making in the intake team and how this matches existing literature. The findings confirm the messages from the literature on how thinking takes place in groups and how group dynamics affect group processes. There is however limited literature linking group dynamics and group thinking with clinical decision-making.

There is also scant research regarding the intake process in CAMHS. This study explored the kind of intake team decision-making which could be part of any of the models used in CAMHS as described in the literature review. However, there are some unique features about the set-up of this particular clinic, such as the fact that the observed team consists of senior clinicians representing the different teams in the service. In many CAMHS teams intake decisions may be taken not by a group but by a smaller number of people or even individuals. The intake clinicians may be more or less experienced in making these decisions as well as in providing the treatments they recommend. Waiting list pressures and training needs/ capacity are

particular issues in this clinic, but the associated concerns are transferrable to most clinics where decisions are made in the face of competing demands.

The following aims to link literature on group dynamics and group thinking with the findings. Some of Salomonsson's (2005) explorations of thinking in a supervision group can be applied to the intake group thinking process. Salomonsson (2012) describes what he calls 'weaving thoughts' in groups. He outlines the web of associations being contained by the group and the lead, and how they therefore become available to the individual members. The report is read out and there are moments of silence to ponder the material (Salomonsson, 2012). This process is evident in the intake team observations …'*There is silence as B reads this out. All the clinicians are sitting very still in their circle, there are some sighs…'* (Obs. 1, p.5, ll.40; see Chapter 5, Section 2 b.i). Salomonsson (2012) suggests that the case - in this case the referral - becomes the analysand to which the group associates. There is an atmosphere of evenly suspended attention and the group members use reverie in order to deepen their thinking. No association is regarded as decisive in the first instance; however, together, the thinking crystallises.

Armstrong (2004, p. 81) suggests that in group work, 'emotional experience is spread across the psychic field created by the meeting of one and another, within a defined or assumed setting.' This dynamic of the group as emotional container is also depicted by Waddell (2013) when detailing thinking in infant observation training groups and by Jackson (2008) when discussing work discussion groups. There is evidence in the intake team observations of the group thinking and the group functioning as an emotional container (see Chapter 5, Sections 1.a), 2.a.ii), 2. b.i). Armstrong (2004) describes the 'push and pull' within a group, a process akin to the developmental process of the individual. There is some evidence of 'push and pull' in

the intake team observations. '*This feels like a speeding up/ slowing down experience' (ibid). Again, there is a sense of moving back and forth between different concerns…*' (see Chapter 5, Section 2.d.ii). There will be a number of reasons for the push and pull within a group; here, for example, it may relate to waiting list concerns or training needs. However, the 'push and pull' process is particularly interesting in this context as it is often expressed in stark ways during adolescence. It would be interesting to learn more about how the push and pull within a case might have an impact on the push and pull within the team.

The intake group operates under certain parameters that support its functioning. Halton (Obholzer and Roberts, 1994) states that multi - disciplinary groups need to have a task, a time boundary and authority structures. He adds that it is the task that defines the organisation and activity of the group. Stokes (Obholzer and Roberts, 1994) explains how task focused teams have a common purpose and a membership determined by the requirements of the task, with each member having a specific contribution to make. The findings show that the intake group faces a number of competing tasks; to make clinical decisions, manage resources and supply trainees with appropriate cases. The findings illustrate how the group can struggle with these tasks (see Chapter 5, Sections 1.a), 2.a.ii), 2.b.i), 2.d.i) and ii).

The intake group makes decisions based on their operation as a group, and their decision-making is evidently affected by dynamics related to the referrals (for example see Chapter 5, Section 2.b.i) and team dynamics (see below). Bion's (1961) group theory introduced the idea of basic assumption mode when the group is defending against anxiety as a means of avoiding the task He cites three different

basic assumption modes: dependency, fight or flight, and pairing.[4] An example for basic assumption dependency might be when the group is looking to the leader to avoid thinking as a group. There is, for example, some evidence of idealising the idea of psychotherapy as a last resort: '*N reiterates her argument, 'she could not be sent anywhere else'* (Obs.1, p.5, l.20) (See Chapter 5, Section 2.d.i). In basic assumption fight and flight mode the group might mobilise against outside organisations which are perceived as not understanding, or not providing the appropriate treatment (see for example Chapter 5, Section 1.a), or the group might avoid conflict or tension by agreeing when really consensus has not been achieved (see Chapter 5, Sections 1.a and 2.d.i). In some discussions it was not clear whether the concern for the waiting list or the request for further information were used defensively. It is possible that the team tried to protect themselves from experiencing helplessness and uncertainty as well as from managing difference between team members by finding reasons not to engage with the material (see Chapter 5, Section 2.d.i). In the basic assumption pairing mode there may be pairing in the group; for example two members are expected to decide, while the group avoids operating and thinking as a group (see Chapter 5, Sections 1.a and 2.b.i) (Obholzer and Roberts, 1994).

4 There is also a fourth basic assumption of BA one-ness and BA me-ness, representing how group members might identify with the group completely and give up their individual thinking or, on the other hand, function as individuals only without reference to the group (Morgan-Jones, R. (2006) 'The Management of Risk of Recycling Trauma in the Context of Conflicting Primary Tasks: An Analysis of the Use of the Group Dynamic of Incohesion Basic Assumption Activity', *Organizational and Social Dynamics,* 6(1), pp. 22-41.). Hopper develops this further by distinguishing aggregation and massification as basic assumption modes, both leading to an attack on thinking. Incohesion, he suggests, contrasts the experience of oneness, fusion and massification on the one hand with that of fission, splitting, and aggregation on the other (Hopper, E. (2009) 'The Theory of the Basic Assumption of Incohesion: Aggregation/Massification or (BA) I:A/M', British Journal of Psychotherapy 25(2), pp. 214-229.).

Stokes (Obholzer and Roberts, 1994) adds that different professions have their own inclinations for certain types of basic assumptions (see Chapter 5, Section 1.a). Within the MDT the combination of professionals and their particular strategies can create a particular mix of avoidance and defence. While this research does not provide clear evidence of linking professions to types of avoidance, considering these dynamics could aid the continued learning of how to best make use of multi-disciplinary teams. As the data in this study is clearly limited, further research could helpfully illuminate how group dynamics affect team decision-making.

The findings show that the intake team hypothesises on the likelihood of the suggested treatment being viable. There are different ways of thinking about the meaning and implications of the team making such predictions. Hinshelwood (1991) describes how the unconscious transference and countertransference relationship expressed in the referral can provide clues about the patient. The findings show how the intake team members consider what the referral might say about the patient in terms of their understanding of the referrer's countertransference. Salomonsson (2012, p. 935), by contrast, suggests that 'private ideas might herald basic assumptions', that is, a 'member's comment might reflect an evacuation of his or her personal unconscious phantasy rather than an effort at understanding the presented material'. Hobson (2013) describes it as speculation to try to judge from a paper referral. This highlights the importance of not taking the clinician's thoughts about the referral as facts but as considerations. In addition the participants' responses to the referral may have given indications about the referrer's motivation and the underlying dynamics of the case, i.e. the state of mind of the referrer, the patient and their family (see Chapter 5, Section 1.a) and 2.b.i). This highlights the importance of observing

the process of decision- making while in situ, and for the group to pay attention to its own process.

This indicates that even given some generalisable indicators the decision is still subject to some uncertainty and unpredictability as there are unconscious factors at play. The researcher suggests that an awareness of team dynamics and how they affect decision making might help avoid the pitfalls of basic assumption group functioning affecting clinical decision-making.

ii) Dynamics of the clinical decision-making process in assessment

The findings indicate that there are some parallels between the intake team process and the psychotherapy assessment process in terms of 'taking in' the case. 'Taking in' seems to imply absorbing and considering the impact, as well as exploring the meaning of, the patient's presentation. There are also significant differences in these processes. The team uses their group thinking (see above), their individual clinical perspectives and their countertransference response to the referral on paper. The assessors evidently use observation and their countertransference, as well as their clinical understanding, experience and the team within them as their main tools when working with the patient. The findings show how the assessors attempt to make sense of how the patient uses the assessor and what this might mean. Spillius (2011) describes how the assessor's countertransference is in part a response to the patient's projective identification. The findings show that the assessor attempts to make a formulation containing hypotheses about the patient's internal object relations, their relationship with the assessor and a prediction about the patient's potential capacity to use psychotherapy. The results concurred with the thoughts of Crick and Hobson on decision-making in assessment (Crick, 2014, Hobson, 2013).

There is a consensus in the literature on the importance of the clinician's external and internal setting (Crick, 2014). Crick (Pérez et al., 2015, Crick, 2014, Crick, 2013) highlights the fact that the clinical decision-making process always depends on the particular mix of patient and clinician, and emphasises the analyst's use of their subjectivity as a fundamental element[5]. While the subjectivity of the participants was never overtly discussed or referred to, the way in which the indicators were considered (see Section a) Contradictions and paradoxes) suggests that each clinician had their own, subjective approach to the work. Evidently, clinical decision-making is a highly idiosyncratic and case-dependent process. The findings also demonstrate that the participants had their particular takes on the situations they were confronted with; indeed, the researcher occasionally wondered whether the participants had the same understanding of the processes they described (see Chapter 5, Section 2.b.ii and iii), and the section above on 'bearing strong feelings' and 'ambivalence'). The data analysis showed that the clinicians' experience and analysis of the parameters and circumstances evaluated in each individual case depend on the clinician's take on internal factors apparent from their contact with the patient. The assessors did not all name the same capacities as relevant. One focused in particular on 'bearing strong feelings' and another on considering 'ambivalence'. The assessors' apparent disparity over the capacities in focus raises a number of questions. Are the differences explained by the idiosyncrasies of each case? Do the assessors have the same processes in mind? If there is a difference in thinking, is one focus more important than the other? Does this mean that assessors do not necessarily agree on what they are looking for in an assessment? It may be

5 Kleinian literature tends to focus less than other psychoanalytic models on the analyst's subjectivity and the researcher will not debate the differences within psychoanalytic theory in this regard.

that the psychotherapist's subjectivity needs to be explicitly considered when working with adolescents.

The team was found to provide a space for reflection - perhaps to consider aspects that had been out of the assessor's awareness or dynamics between patient and assessor that could be better understood within the thinking space provided by the team (for example Chapter 5, Section 2.a.ii and iii). The team itself is of course subject to its own group dynamics which will affect the decision-making. Therefore clinical decision-making is influenced by both the assessor's subjectivity and group dynamics of the team.

3) Limitations and ideas for further research

The researcher began the audit five years ago with a particular interest in formulation; however, when designing Study 2, the focus shifted to clinical decision-making. The following passage will highlight some of the methodological limitations inherent in this study, and will put forward some ideas for further research. The amount of data used in this professional doctorate is clearly limited, the audit focusing on only 17 cases and the interviews on 4. The researcher does not claim that her findings can be generalised, and this therefore remains a task for future research.

In terms of research design and methodology the following limitations were observed. Firstly the audit focused on intensive cases only. In retrospect it would have been interesting to audit all referrals. From the current data it is therefore not clear whether the features the audit describes are applicable only to intensive or to all psychotherapy referrals. Further research could helpfully explore why intensive treatment was chosen over weekly treatment by comparing weekly and intensive cases.

With hindsight it would have been useful to make intake part of the audit process. It would have been interesting to find out how cases referred for psychotherapy fare during intake and assessment. For example, how many cases were taken on as psychotherapy cases that had not been referred for psychotherapy? It would be interesting to see how many of those patients referred for psychotherapy and allocated to psychotherapy at intake did start intensive treatment. From the current data it seems that intensive treatment is more likely to be recommended as a treatment modality after assessment or even after a period of treatment. It could also be argued that there is also a potential for misinterpretation of the data as the intake observations included all referrals and the interviews focused on intensive cases only. There is also potential for misinterpretation due to the fact that Study 1 collected data retrospectively, and therefore the data is based on the therapists' recollection and includes details that would not have been available at the beginning of treatment. An audit that studies cases from the beginning of treatment might capture different data.

The following ideas for further research arose from the study. The audit highlighted the number of patients who had undertaken intensive psychotherapy instead of inpatient treatment. It warrants further exploration, including a comparison of outcomes, to understand whether intensive psychotherapy may be a cost-effective alternative to inpatient treatment.[6]

[6] There is limited research into the cost effectiveness of intensive psychodynamic psychotherapy (Lazar, S. G. (2014) 'The Cost-Effectiveness of Psychotherapy for the Major Psychiatric Diagnoses', *Psychodynamic Psychiatry,* 42(3), pp. 423., Lazar, S. (2010) *Psychotherapy is worth it.* US: American Psychiatric Publishing, Inc.; 1 edition.) The IMPACT study explored cost-effectiveness of time limited psychotherapy with adolescents. Berghout's study (Berghout, C. C., Zevalkink, J. and Hakkaart-van Roijen, L. (2010) 'A cost-utility analysis of psychoanalysis versus psychoanalytic psychotherapy', *International Journal of Technology Assessment in Health Care,* 26(1), pp. 3-10.) shows that the cost-utility ratio of psychoanalysis relative to psychoanalytic psychotherapy, is within an acceptable range. While psychoanalysis cannot be equated with psychoanalytic psychotherapy, it is used here for

From the intake team observations it seems that only young people who were referred specifically for psychotherapy were considered for intensive psychotherapy. Generic referrals were referred for assessment, possibly having a range of treatment options in mind. It would be instructive to follow different types of referrals over time and observe the clinical decision-making processes involved.

There are significant gaps in this research about how pressure from the waiting list and training needs/ capacity are weighed against the need ascertained from reflecting on the referral in the intake group. Certain dynamics were observed, but it would warrant further observation and more detailed focus in order to provide more succinct results about the negotiating and thinking process during intake.

The variety of ways of thinking about 'making use of psychotherapy' also highlights several limitations in the research; it might have been helpful for the meaning of 'making use of psychotherapy' to have been the sole focus. The focus on thinking, bearing feelings and ambivalence opens up more questions than it answers, and further research into 'evolving thinking' in the assessment relationship might pinpoint which factors predict future engagement. As regards studying engagement, it would be instructive in future to focus solely on the patient's ability to engage by gathering data from a wider range of assessors. The assessors did not all focus on the same parameters – for example, some focusing on the emerging thinking process, some focusing on emerging awareness of ambivalence - which meant that this research has not been able to identify those parameters all

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comparison as more intensive treatment. The writers encourage research into a variety of cost-utility ratios with different types of patients. They also encourage cost-utility analyses comparing psychoanalytic treatment to other forms of (long-term) treatment. Emil Jackson (presentation 'Assessing adolescents for intensive psychotherapy' at the Tavistock) found that the cost of intensive treatment for one year, including psychiatry appointments equated to about three weeks inpatient treatment for an under 18 and four weeks in patient treatment for someone aged over 18.

assessors agreed on. It would be interesting to ascertain whether this was solely a result of their subjectivity, or the respective case, or whether it may be possible to single out definite parameters of assessment. With a larger sample, it may also be possible to see whether the results can be generalised.

It would also be interesting to learn more about how the MDT contributes to the decision-making process. How do the hypotheses evolve and change throughout the assessment for the assessor and the MDT? This could be usefully explored in observations of weekly team meetings. Further research could help to shed light on how case and group dynamics affect clinical decision-making: perhaps, for example, it could be further demonstrated how group dynamics can impede group thinking, and whether considering these dynamics would aid the containment of complexity and help make decisions with better outcomes.

Finally, there was no outcome data in this research, and it is therefore not known whether these indicators actually lead to improved practice. In further research it could be explored whether these ways of making decisions about who should be offered intensive therapy are actually appropriate and associated with better outcomes.

4) Conclusion and implications for practice and training

The following conclusion outlines the learning for referrers, students and institutions working with adolescents and young adults.

The referrer might want to know which adolescents/ young adults are likely to benefit from intensive psychotherapy. From this study it has not been possible to state with any accuracy what is being looked for in an adolescent/ young adult who might be offered intensive treatment. However, the study has found evidence of an implicit conceptual framework for clinical decision-making when making a

recommendation of intensive psychotherapy for adolescents and young adults. Some identifiable and transferrable criteria have been defined and further research could further their generalisability, and develop them. **The question arises to what extent this framework could function as a manual or diagnostic tool. This study highlighted how the idiosyncracy of each case affects decision making, and how the decision making process is highly subjective and affected by group dynamics. It is therefore not possible to assume that the same criteria apply to every case, and that the same mix of criteria leads to the same decision outcomes. The study shows that the clinicians, while using a shared language, might not all refer to the same process, and that the language might be applied differently depending on the case. Given the complexity of the field it is not possible to design a manual that will fit all. However this framework can provide a tool to guide the clinician before and during an assessment. The framework can provide a map for the field of clinical decision making with patients of this age group.**

The following indicators for intensive psychotherapy were identified:

- A developmental component in the presenting problem
- Experience of trauma
- Reduced engagement with life
- Motivation for treatment
- Increased need for containment
- Increased intensity required to challenge resistance and rigidity
- Capacity to manage treatment demands
- Sufficient support from the environment, including parents

Adolescents who present with more or less complex and severe symptoms and circumstances need to take part in an assessment which will clarify whether they could benefit from intensive treatment. It was found that this process can only be explored in the consulting room over a period of time (four sessions in this study) where the patient's responses to the invitation to engage can be observed and considered. The assessors also considered the role of the parents in the patient's life and what support they themselves might need in order to support treatment. **The study highlighted the importance of the focus on parents, in particular with this age group who might struggle with their developmental tasks.** Lastly, the study emphasised the role played by the team and also the network in thinking together with the assessor.

The child and adolescent psychotherapist in training might want to consider the technical idiosyncrasies involved when working with this age group, such as: how to engage adolescents and young adults, and how to support and discern 'movement' in terms of the patient's use of the assessor to contain feeling states and to think. The particular focus on ambivalence forms not only part of an assessment of the patient's state of mind but also a discrete element of the assessor's technique when exploring with the patient whether they will realistically commit to treatment.

The institution was found to provide considerable containment for the case during clinical decision-making, assessment and transition into treatment. While the intake team benefits from the multi-disciplinary thinking and containment provided by the group, it also contends with group dynamics which have the potential to influence clinical decision-making. The study has shown both case and group dynamics impacting on clinical decision-making.

The researcher suggests that an awareness of these dynamics and how they affect clinical decision-making might help avoid the pitfalls of basic assumption group functioning affecting clinical decision-making. **In this way the study might have dispelled the myth of the clarity of the multi-disciplinary decision making process and showed that this process is of course affected by group dynamics. The case study focusing on a training organisation threw light on the particular projections towards the organisation, for example in this case a possible culture of one should know and must know. The study therefore highlights the importance of the organisation questioning its own decisions and decision making process.** Further understanding of these dynamics could aid the continued learning of how to make best use of multi-disciplinary teams.

This study has highlighted the prerequisites implicit when intensive psychotherapy is considered, and at the same time has evidenced that the decision whether to refer a young person for intensive psychotherapy is a complex one. The main challenge involves gauging whether the patient has the emerging capacity to engage with the therapist and the therapy, and also consider their own predicament. Analysis of the data shows that intensive work is perceived to require either considerable internal capacities or the potential to develop these capacities, perhaps with the help of network support (i.e. from parents, a wider network, the institution) to provide some of these functions in the interim. When making decisions about intensive treatment, the team took the length of the waiting list and the institution's training capacity into consideration as intensive treatment is both resource intensive and a training issue (in the sense that trainees are required to deliver it). This decision will involve, in part, a prognosis regarding whether the case has the potential to last, for the benefit of the patient and the trainee. Lastly, this decision-

making process is affected by the MDT's dynamics and the assessor's subjectivity, factors which of course apply to all clinical decision-making, intensive or otherwise.

The study confirmed Harari's (2011, p. 180) statement that 'every man-made order' is 'packed with internal contradictions'. At the same time, he says, there is forever a striving towards reconciliation and overcoming contradictions. This tension is not only at the heart of a framework for clinical decision-making about intensive psychotherapy. Maybe it is particularly accentuated when focusing on adolescents, a life stage which is characterised by inherent contradictions and one in which Eros and Thanatos co-exist in close proximity. This study has made an effort to explore these complexities and thereby learn from experience.

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Appendices

Appendix 1: UREC

EXTERNAL AND STRATEGIC DEVELOPMENT SERVICES
uel.ac.uk/qa

Quality Assurance and Enhancement

UEL University of East London

4 September 2015

Dear Valerie,

Project Title:	**Coming into intensive psychotherapy for adolescents: perspectives from the patient, the clinician and the institution**
Researcher(s):	**Valerie Curen**
Principal Investigator:	**Valerie Curen**

I am writing to confirm that the application for the aforementioned NHS research study reference **14/EE/1294** and R&D reference **148664**, has received UREC ethical approval and is sponsored by the University of East London.

The lapse date for ethical approval for this study is **4 September 2019**. If you require UREC approval beyond this date you must submit satisfactory evidence from the NHS confirming that your study has current NRES ethical approval and provide a reason why UREC approval should be extended.

Please note as a condition of your sponsorship by the University of East London your research must be conducted in accordance with NHS regulations and any requirements specified as part of your NHS ethical approval.

Please confirm that you have conducted your study in accordance with the consent given by the NHS Ethics Committee by emailing researchethics@uel.ac.uk.

Please ensure you retain this approval letter, as in the future you may be asked to provide proof of ethical approval.

With the Committee's best wishes for the success of this project.

Yours sincerely,

Catherine Fieulleteau
Research Integrity and Ethics Manager
For and on behalf of
Professor Neville Punchard
University Research Ethics Committee (UREC)
Research Ethics
Email: researchethics@uel.ac.uk

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Appendix 2: Audit Questionnaire

CONFIDENTIAL AUDIT DATA SHEET UNDER DIRECTION OF EMIL JACKSON
Not to be stored in the patient's record.

Adolescent Department Nov 2012

Audit of Intensive Cases (seen 2 and 3x weekly)
1 Jan 2009 and 31 Dec 2011
(including cases that ended in Jan 2009 or started in Dec 2011)

Please refer to your case notes when completing, do not rely on memory alone

Name of Therapist

Patient file number and initials (needs to be coded)

1. About the adolescent (13 to 25 years old)

Date of referral for assessment/treatment

Age at the start of assessment/treatment

Gender Ethnicity (add ethnic group)

2. Living arrangements (who they lived with at the time of referral)

Birth parents(both)	Birth parent (single)	Reconstituted family
Adoptive family	Foster family	Independently
Hostel accommodation	Other	

3. Education as recorded at the time of referral

Mainstream	Special school	Pupil referral unit
Further or higher education	Not in education	other (please specify)

Have they ever been excluded from school? If yes please give details

4. Employment at time of referral (please tick)

Full-time employment	Part-time employment	In education or training	Not in employment, education or training
Other (please describe)			

Has the young person been involved in the criminal justice system and/or youth offending team? If yes please provide details

5. The Adolescent's Family

From the referral what are the difficulties in the family (please tick all that apply)

Mental health problems parents	Mental health problems siblings	Drug abuse parents
Alcohol abuse parents	Domestic violence	Physical health problems parents
Physical health problems siblings	Bereavement	Separation/Divorce of parents
Upheaval of family to this country	Poverty	
Other difficulties - please give details…		

6. Referral, Assessment and History of Previous Treatment

What service/treatment was the adolescent referred to the Tavistock for?

What were the presenting problems at the time of referral?

CONFIDENTIAL AUDIT DATA SHEET UNDER DIRECTION OF EMIL JACKSON
Not to be stored in the patient's record.

Who originally assessed the adolescent following referral?
(Please give profession)

Who referred for adolescent for intensive therapy? (Please give profession)

When was the adolescent first in contact with mental health services?

How long has adolescent or family been known to the Tavistock/ other clinical setting

Years…….. months……..

What treatment had been tried previously? Please tick all that apply and include number of different episodes of treatment

Family therapy	Medication
Individual therapy (state frequency)	CBT
Brief Therapy or IPT	Other (eg psychiatric review) please specify
Inpatient unit	

Other professionals involved with the adolescent, now or previously (please tick all that apply):

Social Services	Psychiatrist	Paediatrician
Psychotherapist	Occupational Therapist	Educational Psychologist
Clinical Psychologist	Support staff at hostel accommodation	Other - please specify (eg school counsellor)

7. The Adolescent at the Tavistock

Has the adolescent been given a diagnosis? If yes please detail

Cluster Number (of those assessed since 2011, aged over 18)

What were the adolescents' central anxieties, difficulties and dominant object relations as you understand them at the assessment stage (may include transference relationship)?

Was there a change in therapist between assessment and treatment?

What were the determining factors from the assessment that resulted in the recommendation for intensive treatment?

Were the sessions increased from being seen once a week first?

What were the determining factors from less frequent treatment that resulted in the recommendation for intensive treatment?

8. About the Intensive Treatment

Start date for intensive treatment	
Number of sessions offered	
Number of sessions attended	
Is treatment on-going?	
End of treatment	

9. Parent work

Are the parents/carers seen by another health professional? If yes, please state discipline

Why are the parents seen (or not seen) and how often?

10. Network

Which of the following meetings have you (or someone else involved in the case) attended in last year? (please include number of meetings)

Professionals meeting	Review meeting
Review/discussion about adolescent in team meeting	Other (please state)

11. Ending

How long did you see the adolescent for intensive treatment?

Years	months

How/why did the treatment end?

Mutual agreement	☐	Referral to other agency	☐
Further treatment declined by patient	☐	Referral to private therapy	☐
Patient dropped out (eg DNA's repeated cancellations)	☐	Moved out of area	☐
Treatment ended by therapist	☐		

Other (please specify) ☐

12. Supervision

Did you have supervision for this case and how long for? ☐

Please name particular ways in which supervision aided your practice

☐

Please give the name of your supervisor ☐

13. Measurement of change since intensive treatment began

Which evaluation tools were used for assessing difficulties, experience of treatment and progress?
Please provide details of score changes if known

YPSR	Goal-based outcome
CORE	Chi-Esq

CONFIDENTIAL AUDIT DATA SHEET UNDER DIRECTION OF EMIL JACKSON

Not to be stored in the patient's record.

What were the adolescents' central anxieties and dominant object relations as you understand them at the end of treatment (may include transference relationship)

On the scale below please rate change in relation to the adolescent's behaviour and symptoms (as compared with when they started intensive treatment)

Much worse	Slightly worse	The same	A little better	Considerably better	Completely better

What factors do you think have helped your work with this adolescent?

What factors have hindered your work with this adolescent?

Has this case been re-referred since treatment ended? | |

Is there any long-term monitoring (post discharge)? If so please state which measures

7

CONFIDENTIAL AUDIT DATA SHEET UNDER DIRECTION OF EMIL JACKSON

Not to be stored in the patient's record.

In your opinion what would have happened had this adolescent not been offered treatment?

Could the adolescent have managed on less intensive treatment? If not, why not?

We are considering creating a follow up questionnaire which would be sent to all ex-patients who were offered intensive therapy (2x or 3x weekly). This would enable us to gather important data about their (retrospective) experience of therapy as well as their current circumstances and progress since ending. Ex-patients would, of course, be under no obligation to return the form.

In principle would you have any objection to an optional follow up questionnaire of this kind being sent to your patient?

Yes	No

If you think it is contra-indicated can you please clarify why?

Thank you very much for the time and effort you have put in to complete this form. The information will be used to help shape future services.

When complete please send to Emil Jackson via tray in department or by email

Valerie Curen
Child & Adolescent Psychotherapist in Specialist Training

Emil Jackson
Head of Child & Adolescent Psychotherapy, Adolescent Department

Appendix 3: Information Sheet observations

Version 3 5.5.2015

The Tavistock and Portman NHS
NHS Foundation Trust

Directorate of Training and
Postgraduate Education
Tavistock Centre
120 Belsize Lane
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Valerie Curen
Chief Investigator
Professional Doctorate in Child Psychotherapy
Tavistock Centre/University of East London
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University of East London
Tavistock and Portman NHS Trust

My name is Valerie Curen, I am a child and adolescent psychotherapist and studying for a doctorate at UEL. As part of my research I am doing a piece of research that will be submitted as part of my dissertation. My supervisors are Emil Jackson and Nick Midgley. The purpose of this letter is to provide you with information to help you decide whether you want to take part in this study.

Project Title
Process of coming into intensive psychotherapy for adolescents

Project Description
I would like to invite you to take part in this study, which is trying to understand more about the assessment of adolescents for intensive psychotherapy.

As part of the study, I would like to observe intake team meetings and interview a number of clinicians about their experience of psychotherapy assessments.

What am I asking you to do?
With your permission I will observe two intake team meetings.

Confidentiality
The observations will be written up and I will use what I have learnt from the observations in my study. All personal details will be removed so the material is anonymous.

The findings will be shared with the staff in a way which does not identify any of the people who gave their views. If you are willing to participate, you will be asked to sign consent for information to be gathered and used. All responses will be gathered anonymously. After the research is finished the original data will be kept for a required time period and then destroyed. Should the research results be published, any personal information will be de-identified.

Where?
The interviews and observations will take place at the Tavistock clinic.

What if you change your mind?
You are not obliged to take part in this study, and are free to withdraw at any time. Should you choose to withdraw from taking part in the study you may do so without disadvantage to yourself and without any obligation to give a reason.

Further Information
All research in the NHS is examined by an independent group of people called a Research Ethics Committee. This is to protect your interests. This study has been reviewed and given a favourable opinion by the Proportionate Review Sub-Committee of the NRES Committee East of England – Norfolk

University Research Ethics Committee
If you have any queries regarding the conduct of the study in which you are being asked to participate, please contact:

Catherine Fieulleteau, Ethics Integrity Manager, Graduate School, EB 1.43
University of East London, Docklands Campus, London E16 2RD
(Telephone: 020 8223 6683, Email: researchethics@uel.ac.uk).

Thank you for taking the time to read this information sheet and consider taking part.

Appendix 4: Information Sheet Interviews

Version 3 5.5.2015

The Tavistock and Portman NHS
NHS Foundation Trust

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University of East London
Tavistock and Portman NHS Trust

My name is Valerie Curen, I am a child and adolescent psychotherapist and studying for a doctorate at UEL. As part of my research I am doing a piece of research that will be submitted as part of my dissertation. My supervisors are Emil Jackson and Nick Midgley. The purpose of this letter is to provide you with information to help you decide whether you want to take part in this study.

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As part of the study, I would like to observe intake team meetings and interview a number of clinicians about their experience of psychotherapy assessments.

What am I asking you to do?
With your permission I will arrange to meet with you for an interview. I will then ask you a few questions and audio record your responses.

Confidentiality
Your responses will be audio-taped solely for the purpose of this study. The audiotapes will be transcribed and I will use what I have learnt from your interview in writing up my study. All

personal details will be removed so the material is anonymous. The tapes will be stored in locked cupboards and be destroyed once the project is completed.

The findings will be shared with the staff in a way which does not identify any of the people who gave their views. If you are willing to participate, you will be asked to sign consent for information to be gathered and used. All responses will be gathered anonymously. After the research is finished the original data will be kept for a required time period and then destroyed. Should the research results be published, any personal information will be de-identified.

Where?
The interviews and observations will take place at the Tavistock clinic.

What if you change your mind?
You are not obliged to take part in this study, and are free to withdraw at any time. Should you choose to withdraw from taking part in the study you may do so without disadvantage to yourself and without any obligation to give a reason.

Further Information
All research in the NHS is examined by an independent group of people called a Research Ethics Committee. This is to protect your interests. This study has been reviewed and given a favourable opinion by the Proportionate Review Sub-Committee of the NRES Committee East of England – Norfolk

University Research Ethics Committee
If you have any queries regarding the conduct of the study in which you are being asked to participate, please contact:

Catherine Fieulleteau, Ethics Integrity Manager, Graduate School, EB 1.43
University of East London, Docklands Campus, London E16 2RD
(Telephone: 020 8223 6683, Email: researchethics@uel.ac.uk).

Thank you for taking the time to read this information sheet and consider taking part.

Appendix 5: Consent Form Version 2 5.5.2016

Version 2 5.5.2016

UNIVERSITY OF EAST LONDON

Consent Form

Consent to Participate in an Experimental Programme Involving the Use of Human Participants

Process of coming into intensive psychotherapy for adolescents

I have the read the information leaflet relating to the above programme of research in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what it being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to the data. It has been explained to me what will happen once the study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Investigator's Name (BLOCK CAPITALS)

.....

Investigator's Signature

.....

Date: .....

Appendix 6: Interview Questions

The researcher designed interview questions following advice from her supervisor and having Smith, Flower and Larkin (Smith et al., 2009) in mind. The researcher aimed to keep the research question in mind when formulating the schedule. Please see the interview schedule below. The interview questions were discussed in supervision before the first interview, in order to validate that the question were appropriate and that they were not leading into a particular direction. Each participant was asked the same questions to minimise bias. Open formulations were chosen for example, 'Can you tell me about your experience of assessing this patient?' 'What was it like being in a room with the patient?'

The researcher used starter questions to open up the topic. The researcher followed up initial questions with supplementary questions reflecting the interests of the interviewees. Specific prompt questions were asked to elicit further detail. Interview questions were worded carefully not to lead participants but to allow themes to arise from the preoccupations of the interviewees rather than the interviewer. Prior to the interviews the researcher answered any questions and notes were not taken during the interview in order for the researcher to be fully available to the experience. There was time and space to discuss any questions or concerns about the recording of the interview.

The first question 'What are the particularities of assessing an adolescent?' was designed to open up the field of inquiry, this was not specifically focused on intensive work but a general opening about the assessment process and experience. The next question was 'What were your thoughts about the patient before you met them?' This was meant to invite the interviewee to describe possible preconceptions about the patient as well as the pathway the patient might have had so far. With the next question' 'Can you tell me about your experience of assessing this patient?' the researcher invited the interviewee to reflect on their experience of the process. The next two questions were aimed to deepen this exploration: 'What was it like being in the room with the patient?' and 'What was your countertransference experience?'

The following question was narrowing down the focus into the consideration of intensive psychotherapy 'What were you thinking about within yourself when

considering intensive psychotherapy as an option?' and 'At what point did you decide that s/he might be a candidate for it?'

The next series of questions focused on the decision making process within the assessment, for the assessor themselves and for the assessor within the team: 'How would you say this decision was made?' and 'For the case in question what factors were you considering when deciding on intensive psychotherapy?' also 'What were your thoughts on these factors?'

A number of questions aimed to illuminate risk concerns; 'Did you have any concerns about the patient if offering once weekly?' 'Did you have any risk concerns about offering intensive work?' 'What were your thoughts on risk to the patient of having no treatment?'

One question pertained to whether the case would be a training case and how this would be set up. 'What were your thoughts on risk of treatment to the trainee?' This question related to the next question: 'What were the forces affecting the decision?' This question was meant to throw light on external factors influencing the decision, external factors pertaining to the particular young person as well as those pertaining to the clinic.

'Was there a consideration of the case needing to be worked up?' This question aimed to explore the process of how the intensive work was set up, did this patient need to be seen weekly in the first instance, might there have been a thought that they would not be able to manage the intensity in the first instance. The last question was 'Is there anything that wasn't covered in the assessment that you would have liked to have been?' This question was intended to open up questions around the specific assessment that might challenge the given frame. The focus was about the learning from the assessment with hindsight and/or that might have led to the assessment being extended at the time.

The researcher developed her interviewing technique by staying with the questions when new openings arose rather than keeping with the schedule. However was the researcher to do this again, she would refine her questions to ask further about atmosphere and relating.

Actual interview questions

What are the particularities of assessing an adolescent?

What were your thoughts about the patient before you met with them?

Can you tell me about your experience of assessing this patient?

What was it like being in the room with the patient?

What was your countertransference experience? What were you thinking about within yourself when considering intensive psychotherapy as an option?

At what point did you decide that s/he might be a candidate for it?

How would you say this decision was made?

For the case in question what factors were you considering when deciding on intensive psychotherapy?

What were your thoughts on these factors?

Did you have any concerns about the patients if offering once weekly?

Did you have any risk concerns about offering intensive work?

What were your thoughts on risk to the patient of having no treatment?

What were your thoughts on risk of treatment to the trainee?

What were the forces affecting the decision?

Was there a consideration of the case needing to be worked up?

Is there anything that wasn't covered in the assessment that you would have liked to have been?