How do Psychoanalytic Child and Adolescent Psychotherapists think about State of Mind Assessments and what are their experiences of carrying them out?

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Love and gratitude of a different nature go to my sons, partner, and close friends and family. They have kept me afloat and anchored, when the seas have been bumpy and rough.

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ABSTRACT

Objectives

Aims of this research study were:

1. To understand how Child and Adolescent Psychoanalytic Psychotherapists (CAPPTs) think about the psychoanalytic SoM Assessment.
2. To explore CAPPTs experiences of offering SoM Assessments in CAMHS.
3. To understand if there are identifiable aspects of case presentations that make them particularly suited to a SoM Assessment.
4. To add to the literature available on the SoM Assessment.

Method

Nine CAPPTs were interviewed using a semi-structured interview schedule. Interviews were transcribed then analysed using Reflexive Thematic Analysis.

Findings

CAPPTs develop personal conceptualisations of the SoM Assessment. Learning what a SoM Assessment is occurs through relational strands of learning. Participants agreed the most valuable element of their learning are their experiences of doing the assessment. Participants shared clinical examples which demonstrated creative differences in approach to offering SoM Assessments. SoM Assessments are underpinned by identifiable 'Core Components'. The SoM Assessment is considered an important means by which the CAPPT shares the psychoanalytic voice of Child Psychotherapy within the MDT. The CAPPTs use of language is scrutinised

considering how accessible this voice is, and the extent to which the SoM Assessment can be held in mind by MDT's.

Conclusion

The SoM Assessment develops through five strands of learning. Variation and flexibility are inherent to the SoM Assessment and considered strengths. CAPPT's demonstrate how they make use of their own internal world through the Core Components of the SoM Assessment. The SoM Assessment is an attentive response created anew each time with the unique patient at its centre. Participants agreed further use could be made of this assessment. The importance of the SoM Assessment in bringing the psychoanalytic voice to MDT's is confirmed.

Key words: child psychotherapy, State of Mind Assessment, formulation, internal world, psychoanalytic assessment, consultation, supervision, psychoanalytic voice, Multidisciplinary team

1.0 INTRODUCTION

1.1 Research Aims

This project seeks to find out how Child and Adolescent Psychoanalytic Psychotherapists (CAPPTs[1]) think about psychoanalytic State of Mind (SoM) Assessments, and what their experiences of carrying out this specialist assessment are, in order to add to the current literature available. The project proposes a definition of the SoM Assessment, a term understood through personal communication to be coined by Ricky Emanuel, to originally indicate a specific assessment offer that child psychotherapists could make to social workers in order to integrate CAMHS thinking into social services. Ricky explained that he and his team:

> *… thought it would be helpful if social services could have some idea about the state of mind of the children they were wanting to place, as therapy itself could not be offered in such uncertain circumstances. A kind of protocol was established whereby the child psychotherapist would meet with the people asking for the assessment, and then see the child on their own 3 times, and then meet with the referring people to feedback at the end. In all a 5-session package… this model was also used at the Royal Free hospital in liaison work on the ward where children were undergoing bone marrow transplants and other invasive procedures and who were sometimes too ill to use standard therapy. It was felt to be helpful to have some insight into how they were experiencing their world and the treatment, and the meaning they were making out of being so sick and sometimes going to die. (Emanuel, 2023, Appendix B)*

The study is explorative and aims to better understand the perspective, experiences, and personal thinking of CAPPTs in relation to this specific assessment. The study

[1] Henceforth I will use the acronym CAPPT(s) to refer to Child and Adolescent Psychoanalytic Psychotherapist(s). See Appendix A for full list of acronyms.

aims to explore if there are identifiable aspects of Child and Adolescent Mental Health Service (CAMHS) case presentations which make them particularly suitable for this type of assessment, considering when, how, and why this assessment might be carried out in contemporary CAMHS.

Thus, the central research question is:

How do Psychoanalytic Child and Adolescent Psychotherapists think about State of Mind Assessments and what are their experiences of carrying them out?

1.2 Rationale

During my professional training I became interested in the potential and scope of the psychoanalytic SoM Assessment in CAMHS. This was for several reasons which emerged during my own experiences of offering the assessment:

1. I felt I learned much about my own identity and development as a CAPPT through conducting SoM Assessments.
2. My MDT colleagues were fascinated by the contribution of a SoM Assessment and increasingly requested them during the time I trained.
3. SoM Assessments feel meaningful as a timely brief intervention in CAMHS. They offer a variety of functions including intervention-treatment; consultation; offering understanding of a child's presenting developmental difficulties. SoM Assessments can inform a network's decision-making; make recommendations; and share a psychoanalytic perspective.
4. As a trainee, very little existing literature was recommended or discovered through personal searches, on this particular assessment.

There is a marked gap in the literature available on SoM Assessments. This is curious, given the SoM Assessment is a core competency for ACP CAPPTs. Petit and Midgley's study (2008) illustrated that of the assessment work undertaken by Child Psychotherapists in a single CAMHS team audited, 59% of these assessments were SoM Assessments. Peta Mees instructive paper confirms the literature '*is sparse; there is very little that specifically addresses this type of assessment…*' (Mees, 2017). During my training, fellow trainee CAPPTs either seemed to express a sense of the assessment being well-understood and held in mind within their MDT's, **or** a sense of the assessment being hard to understand, infrequently requested, and not having very much of a profile within their teams.

Additional hopes for the project are that participants will have benefitted from an opportunity to reflect on their experiences, which may in turn contribute to development in their own clinical practice with service users, as well as potentially offering insights into the teaching and learning about SoM Assessments within the training experience of CAPPTs. Finally, I hope that the findings of my research might contribute to our professional thinking and discussion about how we share the voice of child psychotherapy within our Multidisciplinary Teams (MDT) in CAMHS, acknowledging the value and relevance of the SoM Assessment in this endeavour.

This research is relevant to all CAPPTs offering SoM Assessments in CAMHS - it is a Core Competency for the ACP accredited child psychotherapist. There is also a

relevance to service leads, who are responding to pressures upon services to assess and assign care pathways and treatments as quickly as possible.

Due to the on-going impact of the Covid-19 Pandemic, my original project design had to be altered. I decided to set the project presented within my own NHS Trust, feeling it would be more manageable to recruit participants working within a context that although rapidly changing, I was part of and therefore more aware of any changes impacting clinical work. This Trust comprised of 5 CAMHS clinics, and as such all were invited to take part in order to offer complete representation of the views and experiences of CAPPTs in CAMHS within this Trust.

2.0 LITERATURE REVIEW

2.1 Introduction

There is abundant literature on psychoanalytic psychotherapy assessment, including Rustin and Quagliata's book *Assessment in Child Psychotherapy* (2004), Miller's paper on an Under Five's Counselling Service (2004), and contributions by Rhode (2004), Lanyado (2009) and Green (2009). All refer to State of Mind Assessments, but none offer detailed exploration. Assessment principles or frameworks are illuminated in these texts, developed in part from Anna Freud's 'Provisional Diagnostic Profile' (1965) which Green highlights, and Winnicott's *Therapeutic Consultations in Child Psychiatry* (1971) which provide approaches utilised within psychoanalytic assessments today. Waddell (2002) offers explanation of the concept of 'states of mind' as developments on from the work of Melanie Klein and Wilfred Bion. A concept referred to as the assessment 'package' by Hinshelwood (cited in Mees, 2017), supports the idea that through assessment the Child Psychotherapist offers containment and understanding of the patient's internal and external worlds, together with a formulation which must be shared appropriately, suggesting that an assessment can be an intervention in its own right (Green, 2009; Mees, 2017; Rustin, 2004a; Miller, 2004). Despite the wealth of literature available on psychoanalytic assessment broadly, the literature dedicated to the SoM Assessment is sparce.

2.2 Aims

This study aims to add to the current literature available on SoM Assessments. My intention was to explore how this specialist assessment is thought about, approached,

and experienced by CAPPTs, and through the literature search to identify key texts that might contribute to this.

My initial literature searches identified only one paper focusing on the SoM Assessment exclusively (Mees, 2017). I became curious to understand what terms of reference would be used by participants. I considered engaging in a secondary literature search post interviewing. McLeod suggests qualitative research in counselling and psychotherapy aims to '*push the horizon of understanding a little further by… following the data wherever they lead*' (2011); Creswell and Poth advocate exploring '*unusual angles*' or greyer aspects (2018) to develop in-depth understanding. The aim of my additional search was to explore and expand upon the understandings offered by participants by searching selectively for literature references made by them or key words or phrases used in interviews.

2.3 Method

My initial literature searches drew sparse results. A total of 12 book chapters or journal papers made some reference to 'State of Mind', including Mees' paper (2017). I decided to write up my literature review after undertaking the study interviews. This decision was determined in part by a wish to avoid the risk that my in-depth knowledge of any existing literature might influence participants' responses in interview; and my curiosity to learn about the participants' own knowledge of the assessment, how they had acquired it, whether through teaching, individual inquiry, or specific experiences, and for this to inform a secondary search. With interviews completed, the secondary search undertaken identified a further four papers. I began with a precis of all papers.

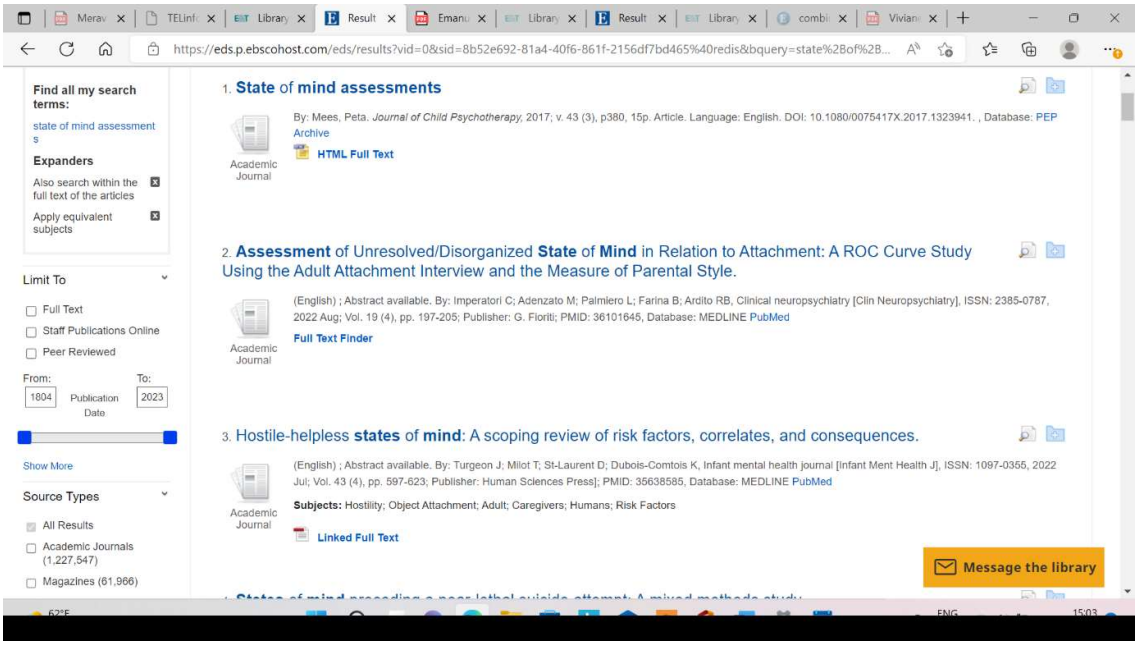
From this I organised what I understood to be the main points of significance made by the authors, into the search results presented.

2.3.1 Search Strategy used to identify relevant literature and research

- The databases PEP Archive, PSYCHinfo, Psych Articles and Psych Books were chosen for the literature searches to optimise relevant results.
- An initial search for 'State of Mind Assessments' ascertained that only one paper existed with the words State of Mind Assessment in the title which was relevant (Figure 1). On peripheral glancing none of the other papers seemed relevant, most concerned with adult populations.
- The phrases 'psychoanalytic/psychodynamic assessment', 'psychoanalytic/psychodynamic examination', 'CAMHS' or 'child psychotherapy', and 'state of mind' and 'emotional state' and 'internal world' were considered separately.
- Key words and their synonyms were entered individually into the electronic database. The Boolean operator term OR was then used to combine key words conceptually. Searches were run for each concept. The Boolean operator AND was used to combine concepts (Table 1).
- Database search expanders were turned off.
- Limiters were applied to results generated: English language only; link to full text.
- All titles were scanned for relevance, with attention paid to age ranges referenced as significant to the body of research evidence.
- The abstracts of selected papers were then read and from these, papers were chosen for more detailed review.

- Finally, an iterative process was employed to identify papers/ chapters which had not been captured in the database search. This involved reviewing the reference lists of papers read and searching key terms from interview.

Figure 1



Screen shot of initial literature search for 'State of Mind Assessments'

Table 1

Search Number	Search Terms	Number of papers returned.
S1	Psychothera* OR psycho* AND assess* OR exam*	3,893,864
S2	Child and adolescent mental health OR CAMHS	8,347
S3	State of mind OR emotional state OR internal world	54,841
S4	S1 AND S2 AND S3	82

Electronic database literature search terms

Following the final combined search, I sorted for relevance and applied Limiters: English and Linked to full text. The Mees paper was the second paper, and the next ten or so results had some relevance on initial inspection.

2.3.2 Secondary Literature Search

Figure 1 demonstrates the scarcity of published literature/research available specifically related to the SoM Assessment. Although Table 1 might appear to contradict this, on reading the abstracts of many, there was merely a cursory reference to a patient's state of mind made. The second search post-interviews drew upon two terms used frequently by participants:

Table 2

Secondary Search Terms
Psychoanalytic concept of 'mind'
Psychoanalytic 'formulation'

Secondary search terms from interviews

Papers were selected purposefully based on an initial scan for relevance. Those considered pertinent are presented in Results.

Participants repeatedly raised a question about where the name of the SoM Assessment had come from during interviews. Whilst literature searches did not yield an origin story, I contacted the then Course Lead at my training institution, who put me in touch with Child and Adolescent Psychotherapist, Ricky Emanuel. Ricky shared a

pragmatic narrative of the assessment's origin through personal communication with me, and as such this is also considered within the literature search results, being fundamental to how the SoM Assessment became established (Appendix B).

2.4 Results

The initial literature search resulted in 12 papers or chapters deemed relevant to the research question. The secondary search resulted in an additional four. Presented first, setting the current scene, are the five papers of most direct significance to understanding the SoM Assessment, and Ricky Emanuel's personal account of the origin story of this assessment. Following this, the remaining papers are organised into two areas in terms of their contribution to the research question:

a) Assessment in Child Psychotherapy
b) Conceptions of Emotional Development

There were no results that shared collective experiences of carrying out SoM Assessments.

2.5 The State of Mind Assessment: Setting the Scene

In Ricky Emanuel's explanation of how this particular assessment by a child psychotherapist came to be, and the pragmatic nature of how he named the assessment, several important things become established providing something of an origin story. The first is that the SoM Assessment was an offer formally established in the early 1980's, as part of a project established between child psychotherapists in

Ricky's team and social services. The aim of the assessment was to provide a way of integrating the thinking of CAMHS into social services, in particular to offer '*some idea about the state of mind of the children they were wanting to place, as therapy itself could often not be offered in such uncertain environmental circumstances*' (Appendix B). My understanding is that it was felt important to be able to offer some explanation as to why therapy might not be possible to offer at that time, but also to offer some suggestions as to what might be helpful or needed for this young people instead, recommendations which would be informed by an in-depth understanding of the child's internal world, in relation to their external environment. A '*5-session package*' was established, structured to enable the child psychotherapist to meet initially with the referrer(s), then to have three individual sessions with the child at the heart of the assessment, and then to feedback to the referrer(s) at the end. Ricky explained that the SoM Assessment was not only used in this way but was flexibly used with another cohort of patients too, those who were hospitalised and undergoing bone marrow transplants, and who were therefore '*sometimes too ill to use standard therapy*' (Appendix B). This creative aspect of the origin story from Ricky Emanuel is pivotal to the ways in which this assessment has evolved since then, and the varying ways in which it is depicted to be used today, by participants involved in the project. A final important aspect of the origin story from Ricky, is that he named the assessment a 'State of Mind Assessment', specifically to distinguish it from psychiatry, '*who did mental state examinations or assessments following a standard protocol*' (Appendix B). From this it is possible to see that there is a link between the two modalities of assessment, but that this link relates to a fundamental difference in method, the psychiatric assessment being protocol-driven, and the child psychotherapy

assessment being a creative response to the referrer and the child they are concerned about, contained within a 5-session structure.

The primary paper with a dedicated focus on the SoM Assessment, written by Mees in 2017, is a heavily circulated paper amongst training CAPPTs. It is an explanatory paper written for the *Journal of Child Psychotherapy* in which Mees also identifies a lack of literature on the SoM Assessment. It is not established why this might be, but Mees acknowledges most of the relevant literature relates to psychoanalytic assessment more broadly. Mees identifies similarities between the SoM and assessments for psychotherapy, but notes a difference being how useful the assessment might be to the referring clinician, family, and network, in terms of the consultative aspects of the SoM Assessment. This is in addition to the CAPPT offering to assess and provide a formulation of the child's presenting difficulties.

Mees delineates the structure and method of the SoM Assessment, and the core techniques of the CAPPT in the assessment, identifying working with the transference and countertransference, formulating, and offering containment through the assessment being an intervention in itself. The scope of the SoM Assessment to offer recommendations is also highlighted as different to an assessment for psychotherapy. Mees concludes the SoM Assessment is '*a package*' (Hinshelwood 1995 as cited by Mees 2017) offered by a CAPPT within a multidisciplinary team in response to a colleague or family's request, which might be for a wide range of reasons, relating to a '*complex or puzzling child*' (2017, p.393). Fundamentally and explicitly, the therapist in the SoM Assessment is responding both to the child at the centre of it, as well as the family and professionals around them.

Petit and Midgley (2008) present the results of a small qualitative study in a research paper which helps set the scene for my research question. Their study audited a CAMHS service in a similar locality to the one in which my study was based and discovered that 45% of the work undertaken by CAPPTs in this service was assessment work, and of this 59% were State of Mind Assessments. This is highly relevant when considering the assessment must at that time have been one of the most demanded types of assessment work offered by CAPPTs in CAMHS, and begs the question therefore, why there is such little focus on it in the literature available? This fact seems incongruent with my anecdotal experience of the percentage of SoM Assessment work that CAPPTs carryout within contemporary CAMHS.

Petit and Midgley (2008) focus on literature related to the process and purpose of assessments in CAMHS, referring to Anna Freud's 'Diagnostic Profile' (1965), which they explain was amended by clinicians from the Anna Freud Centre to create a 'Revised Provisional Diagnostic Profile' in 2016. This revision was in response to developments in psychoanalytic thinking, namely the importance of '*object relations*', the work of Winnicott and attachment theory (2008, p.154).

On reading Anna Freud's work *Normality and pathology in childhood: Assessments of development* (1965), it emerged for me that Anna Freud's 'Diagnostic Profile', and subsequent formal and informal revisions and adaptations, form the basis of the current SoM Assessment as is used in CAMHS. Anna Freud considered the '*mental*

equilibrium of human beings' as based upon intrapersonal, and interpersonal conditions, in combination with the environment, stating, '*In this constantly shifting internal scene of the developing individual, the current diagnostic categories are of little help and increase rather than decrease the confusing aspects of the clinical picture*' (p.109). She posited diagnostic categories for child patients were subsumed from the field of adult analysis, adult psychiatry, and criminology, at that time: '*The whole psychopathology of childhood has been fitted, more or less forcibly, into these existing patterns*' (p.110). Anna Freud argued these ways of diagnosing childhood pathology were '*unsatisfactory as a basis for assessment, prognosis, and selection of therapeutic measures*' (p.110). She felt that difficulties encountered by children were most often a result of '*strains and stresses which are inherent in development itself*' (p.119), a dynamic and ongoing process. She conceptualised '*phases of growth*', contributing to her concept of 'Developmental Lines', through which she attempted to provide a sense of '*developmental sequences*' which might provide a framework for thinking about pathological and normal difficulties in emotional and psychic development. She stipulated, '*There is in childhood no stable level of functioning in any area or at any time; that is, there are no fixed points from which to take our departure in assessment*'… There is always '*alternation between progression and regression*' (p.122). This cyclical but ongoing movement is seen as inherently normal in human psychological development. The exception is impairment of '*the child's capacity to move forward in progressive steps until maturation, development in all areas of the personality, and adaptation to the social community…*' (p.123). Deficit or impingement in these developmental tasks are to be taken seriously and acted upon swiftly.

In the assessment of children, Anna Freud urges child analysts to '*look at the clinical pictures before them with new eyes and assess them according to their significance for the process of development*' (p.124). She suggests assessing childhood pathology '*by development and its implications*', '*by type of anxiety and conflict*', and by attempting to create '*a metapsychological profile of the child*' (p.123-138), which leads to her 'Draft of Diagnostic Profile'. This lengthy prompt-sheet for assessment of the child's personality and ways of functioning requires the assessing therapist *'… to reassemble the items mentioned above and to combine them in a clinically meaningful assessment*' (p.147). This multi-faceted conceptualisation of assessment of childhood difficulty speaks to the notion of the SoM Assessment as '*a package*' in which the clinical understanding is shaped by experience with the child, understanding of childhood development and internal worlds, forming a holistic profile of the child from which a formulation and recommendations can be made (Hinshelwood 1995, Mees 2017).

Critiques and developments of Anna Freud's 'Diagnostic Profile' include Green's 1995 paper which unpacks the '*diagnostic assessment*', stemming from Anna Freud's work on '*observing developmental processes as they unfold*', which developed through observations of children in clinical and natural settings (p.174). Green explains '*ultimately we hope to offer a psychodynamically formulated understanding of the child and his particular difficulties*', suggesting there are different levels at which the therapist tries to understand the child, one of these being '*from the 'inside' by asking ourselves what the subjective world feels like for him*'. The therapist is to consider, '*what sort of*

internal figures inhabit his internal world and what feelings have clustered around these figures?' (p.173).

Without naming the SoM Assessment, Green summarises,

> *'The diagnostic sessions provide an opportunity to gain a sense of the actual child, how he relates and plays out or narrates his internal preoccupations. We then try to integrate this with what we know from external sources, i.e. the social history, psychological assessment and any additional reports such as that from school. In the final assessment there is an attempt to offer a psychodynamic formulation of the child' (p.173).*

This appears to be close to my own experience of the current SoM Assessment. Green acknowledges '*Sometimes a particular child can present a very mixed picture*' (p.179). Flexibility on the part of the therapist is viewed as essential if they are to make use of the relevant frameworks of potential in understanding any one child's difficulties; there is to be a developmental perspective within the psychoanalytic formulation. It is notable that there is little reference to parents/carers alongside developmental processes here - despite there being overt reference to the therapist as object. The significance and assessment of parental/carers role in development and childhood pathology has perhaps been addressed in literature beyond the scope of this study. It would be interesting to explore in relation to further research on the SoM Assessment.

The final paper with most direct relevance is by Davids, Green, Joyce, and McLean (2017). In their 'Revised Provisional Diagnostic Profile: 2016', the authors explain this assessment approach is '*provisional since information at this stage will always be incomplete*'. Stating this as a limitation, and that an understanding of unconscious

processes '*can often only be elucidated through therapy/ analysis*', the authors continue to say that the Revised Provisional Diagnostic Profile (RPDP) can still '*capture both the child's psychopathology, the developmental level he/she has reached, and his/her healthy functioning*' (p.149). The RPDP makes use of a developmental framework and '*normative stages of development are implicit, and knowledge of this is essential… Psychopathology is conceptualised as arising either through the operation of a deficit or because of conflict*' (p.149). The authors assert '*all inferences should be backed up by evidence*', '*speculation or giving alternative hypotheses is often helpful*' and urge '*It is important to be succinct*' (p.150).

Component parts to be considered within the RDPD include:

1. The referral
2. Family considerations
3. Description of child
4. Environmental factors
5. Psychic development
6. Structural aspects of and capacity for object-relationships
7. Self-development
8. Relationship to bodily self
9. Aggression
10. Ego function and development

11. Quality of the supergo and ego ideal

(Davids, Green, Joyce, and McLean, 2017)

Components 1 - 4 were all named by participants interviewed. The RPDP recommends two tasks are undertaken:

1. A diagnostic statement is made by the therapist as part of their understanding; '*the most important section since it should bring together the different sections of the profile to give a formulation of the child's development and psychopathology*' (p.155). A formulation is explained as '*a narrative account which links different factors and attempts to assess their relative importance as well as the ways in which they interact*' (p.156).

2. Recommendations are made. The RPDP was originally used to assess suitability for psychotherapeutic treatment. The authors assert it is important when making recommendations to consider more broadly the suitability of this and alternative treatments available, including no further treatment at all.

2.6 Assessment in Child Psychotherapy

There is abundant literature on the broad area of assessment in child psychotherapy. The focus of this review is on literature within this area pertinent to the SoM Assessment.

My own understanding of the assessment began prior to my literature searches, from Mees' paper, the help of my supervisors and clinical work, and in doing SoM Assessments and in thinking about referrals for them within the MDT. Relevance when

reviewing the literature on assessment in child psychotherapy was subjectively judged by me from this contextual position.

2.6.1 Structure and Process of Assessments

Without naming the SoM Assessment, Miller describes a necessary intervention for a patient in which therapy had failed to make the improvement hoped for: '*… a thorough individual assessment of his state of mind: three sessions with a child psychotherapist…*' (2004, p.119). Mees' 2017 paper refers to the similarities and nuanced differences between the SoM Assessment and an assessment for psychotherapy. Both are offered within a psychoanalytic '*frame*' in which concrete '*ground rules*' are established (Beveridge, 2004). Mees suggests the SoM Assessment comprises of three individual sessions for the child with the therapist, encapsulated by an initial meeting and a feedback session at the end in which the parents or carers are involved. Walker (2009) suggests in the SoM Assessment,

> *…we offer to see the child individually for a number of sessions in order to explore his emotional difficulties and arrive at a formulation of the internal dynamics.* (p.14).

Green (2009) outlines the key features of an assessment for individual psychotherapy, identifying seven core considerations which I consider are potentially relevant to and part of a SoM Assessment:

a) A developmental framework (Green references Anna Freud's 1965 work)
b) How 'stuck' the child is
c) The nature of the child's relationships and sense of self
d) Regulation and mastery of the self
e) The nature of defences and anxieties

f) Ego development

g) Resilience

Green concludes the therapist must take all these aspects into account through the assessment process, as well as their overall sense of how well the child has, and is, managing the developmental tasks of maturation. Miller (2004) recommends establishing a *'…friendly, interested, receptive, non-judgemental stance…*' (p.116), in which brief interventions, which some CAPPTs consider the SoM Assessment to be, can take place. She describes the Under Fives' Counselling Service at The Tavistock, linking this model to Winnicott's *Therapeutic Consultations in Psychiatry* (1971). Miller outlines the intervention structure as up to five sessions, implicitly referring to the role of supervision, explaining, '*support and discussion times are not just desirable but essential*' (2004, p.108). Speaking to the '*snapshot*' element of assessment, Miller posits, '*The child is always the child in context… any child's difficulties need exploring in the setting of relationships*' (p.109). The CAPPT's task is to assess a contextualised picture of the child, at a particular point in time. Rhode (2004) suggests '*transgenerational factors are more readily observed in family sessions*' which comprise part of an assessment (p.19). She also references doing assessment with a partner-clinician, demonstrating through case example how the therapists' '*combined response to him gave the most useful indication of how things were to go*' (p.15).

2.6.2 Framework and Techniques of the Child Psychotherapist in Assessment

In *Assessment in Child Psychotherapy* (2004a), Rustin acknowledges the links between models of assessment for psychotherapy practised at The Tavistock and

good practise in many CAMHS services, referring to a '*shared underlying psychoanalytic frame of reference*' (p.1). Essential to technique are '*close and detailed observation*', followed by '*ongoing discussion of work in progress with experienced colleagues*' (Rustin, 2004a; Miller, 2004). A simple and consistent clinical setting creates a '*constant frame*' within which to assess the child's response to the therapist; '*flexibility of approach*' and '*imaginative responsiveness to the needs of patients in the course of initial exploration*', are supported by a '*firm external structure*', she argues (Rustin, 2004a, p.3; 2004b). From this we get a sense of the triangular relationship between a psychoanalytic theoretical framework, psychoanalytic techniques of the CAPPT, and an external structure or frame. Crockatt (2009) refers to '*basic psychoanalytic principles*' then '*more recent theoretical developments*' which include attachment theory, contributions from neuroscience, and an overview of normal development in explaining the theoretical foundations that Child Psychotherapists utilise when thinking about the emotional development of children. In another chapter, Green (2009) states the '*core of psychoanalytic psychotherapy centres on the transference and countertransference relationship*', asking '*What sort of experience does the therapeutic contact offer a particular child and how, too, does a therapist reflect on his or her part in the therapeutic engagement in order to understand the child?*' (p.175). Green refers to a developmental framework, with theoretical underpinning, that is used by the Child Psychotherapist '*as a systemic way of approaching assessments and making treatment recommendations*' (p.175) The SoM Assessment is not named during this chapter. The literature review indicates it is hard to ascertain a published narrative for the development of the SoM Assessment.

Rustin and Green state that the techniques used by the CAPPT in assessment stem from an '*understanding of the central role of transference in human relationships*' (Rustin, 2004a, p.4). Green explores how the CAPPT utilises their own countertransference in response to the transference to aid understanding of the child's conscious and unconscious communications. She notes that these communications often occur at a '*visceral level where a feeling is unspoken but palpable*' (2009, p.177). Rhode (2004) explains the therapists utilisation of the countertransference as part of the assessment process as invaluable as '*powerful emotions*' are often felt when assessing, particularly those with communication difficulties, and '*often these may turn out to be our best guide*' (p.11). Rustin (2004a) references Bion's concept of projective identification (1962) to suggest '*unexpected feelings*' felt by the therapist '*can be an important clue to the patient's state of mind*' (p.5).

Winnicott suggested interpretation might not be a part of the techniques applied in contexts such as consultation and assessment. He felt interpretation could stir up '*problems of the transference and of resistance*' (1971, p.10), with patients forced to accept or reject interpretations in a time-pressurised situation as compared to on-going treatment. Whilst the Child Psychotherapist is unlikely to interpret the transference in assessment, the therapist benefits from being receptive to the experience and impact of having the child and family together in a session (Rhode, 2004; Miller, 2004). Rustin suggests offering '*a taste of what this approach would entail*' (2004a, p.5) can be useful if the therapist considers psychotherapeutic treatment might be suitable, to explore how the child receives links and suggestions from the therapist, if they are interested

in their own mind, or interested in the possibility of the therapist thinking about them (Rustin, 1982).

Winnicott's *Therapeutic Consultations in Child Psychiatry* (the book indicative of an important relationship between child psychoanalysis and psychiatry), describes '*making sense of psycho-analysis in economic terms*', Winnicott suggesting in applied brief models '*there is much more free interchange between therapist and the patient than there is in a straight psycho-analytic treatment*' (1971, p.1). Winnicott describes his technique of applying psycho-analysis to child psychiatry as '*extremely flexible*' (1971, p.2), arguing it is impossible to know how to do this through a single experience, implying learning comes through experiences of doing, and this develops over time, and with cumulative experience. He stated, '*there is no way of teaching by talking about the cases*', instead urging students to engage in '*detailed reading, and study and enjoyment of total cases*' (p.2-3). Winnicott found pleasure in immersive learning through the experience with the patient, supported by theoretical underpinnings of psychoanalysis. Lanyado (2009) suggests Winnicott thought flexibly and creatively in response to his patients, adding this is essential and valued within a psychoanalytic perspective. It is implied that to respond creatively or with flexibility, the CAPPT must have a secure sense of the framework within which they can manoeuvre: '*where child and adolescent psychotherapists are "practicing something else appropriate for the occasion"*' (Lanyado 2009, p.197, cites Winnicott 1971).

Winnicott (1971) identified essential capacities of the therapist in applied work. This included the ability to identify with the patient without losing personal integrity, the

ability to contain the patient, not to rush to attempt a cure, and the capacity not to retaliate when provoked by the patient. He also mentions the importance of '*professional reliability*' and '*the personal growth process which, we hope, never stops*' (p.2). Here we might see personal analysis as part of the psychotherapist's internal framework, in Winnicott's mind. It is the individual therapist's response to each unique patient that also means it is impossible to copy or reproduce an approach or have a uniform way of assessing or consulting a patient, '*because the therapist is involved in every case as a person, and therefore no two interviews could be alike…*' (p.9).

Miller (2004) adds to the repertoire of psychoanalytic techniques used within an assessment framework, '*bearing powerful infantile projections of disturbance*' (p.112). She suggests it is the combination of the experience of carrying out brief work, combined with a foundation of '*thorough psychoanalytically-based training and a background of work in depth*' that can '*greatly add to our capacities to assess a child*' (p.117).

2.6.3 Aims and Outcomes

Miller suggests both Under Fives' and assessment work leads to action, that establishing what action is needed comes through '*finding out by direct experience what that family is like*' (2004, p.115). She suggests the observing therapist needs to approach the task and identify aims with an open mind, clear from expectations or bias, despite the effort this can take. Crockatt (2009) suggests the common aim of assessment in CAMHS is,

> *… to contribute to the overall understanding of a case – to assist the multi-disciplinary team; as an aspect of an assessment for social*

> *services; or as an element of a court process. The aim is to shed light on particular behaviours, or on the extent of emotional damage that a child has sustained, through understanding and working with the internal world of the child' (p.110).*

Walker (2009) suggests the CAPPT's assessment aims to '*include an evaluation of the internal resources of the child and the external environment around him*' (p.9). Lanyado (2009) asserts it is possible to identify themes in presenting difficulties in just a few consultation sessions, which can inform future work or potential recommendations. She relates to the work of Balint *et al*. (1972) agreeing '*This idea of applied psychoanalysis remains central to psychoanalytically trained psychotherapists' approach to consultations and brief work*' (p.195). Green (2009), describes the therapists aims through longer-term work, which seem simultaneously relevant to the aims of the SoM Assessment:

> *… her sentient and reflective psychoanalytic self to attempt to understand and make sense of the child's emotional world…* [trying to] *understand the child's central identifications, the internal figures who inhabit a child's emotional and mental life and, in conjunction with this, the ways in which the child feels and thinks about himself… the therapist also tries to grasp and comprehend the ways in which the child seeks to protect himself against the pain, hurts, anxieties and confusions engendered by his inner life. Attention is also given to aspects of the child's experiences that are sources of pleasure, self-esteem and satisfaction, which promote resilience* (p.176).

Rustin (2004a) feels the aims of an assessment are to offer an experience of containment, of hope, and one that does not '*re-traumatise unwittingly*' through a repeated experience of external failure -perhaps urging therapists to be mindful of the initial offer and managing the patient's expectations around therapeutic contact (p.6).

Rhode (2004) asserts it is important to '*distinguish between two different aspects of the assessment process*' (p.13), one being to tentatively offer some formulation about the problem, the other being to make a judgement on whether child psychotherapy is a suitable approach, or if some other treatment might be better suited. Rhode suggests the opportunity for reflection with parents can be helpful in terms of thinking about recommendations and potential future work. She suggests the CAPPT in their formulation should attempt to consider and give some explanation of verbal and non-verbal communications. She moots having a '*provisional hypothesis*' (2004, p.28) encouraging a stance in which the therapist is not being rigid in predictions about outcomes, allowing for adaptation within extended assessment (Rustin, 2004a; 2004b; Horne and Lanyado, 2009). Hinshelwood (1991) asserts '*assessments should be no less psychodynamic than psychotherapy itself*' (p.174), suggesting psychodynamic formulation requires developing '*a special clarity of thought*', and *'the intuitive production of hypotheses*' which he argues is possible through assessing '*three-areas of object relationships… the current life situation, infantile object-relations, and the relationship with the assessor*' (p.167). Hinshelwood suggests this makes it possible to order *'the various objects and the various relationships into a coherent narrative'* (p.172).

2.6.4 Assessments and Consultation by CAPPTs in the MDT

Crockatt (2009) details the roots of the multidisciplinary team (MDT) in CAMHS from the establishment of NHS child-psychiatry departments in the 1920's following the development of the Child Guidance movement. She explains in 1995 the NHS Advisory Service published a review of CAMHS (*Together We Stand)*, which concluded that the

most successful outcomes for children and families occurred when professionals worked together to consider the needs of the child:

> *This required teams of professionals who could offer different yet complimentary perspectives in terms of assessment of need and psychopathology, and who could provide a variety of treatment options* (p.102).

Petit and Midgley's 2008 study paid attention to the '*purpose of assessment*', considering the tension between '*expert*' and '*therapist*' positions, suggesting the CAPPTs assessment will provide '*the translation into thoughts and into common language of feelings and emotions… if they are to be able to share their understanding with fellow professionals*' (p.151), concluding,

> *… further study of the way in which assessment is actually carried out and made use of in an NHS setting is clearly needed… understanding is essential in a multidisciplinary CAMHS context in which communication and cooperation between different professionals is essential and the particular skills of various disciplines need to be utilized fully in order to provide the best possible service for children and their families* (p.153).

Of the particular role of the CAPPT within the MDT, Crockatt observes, '*The primary focus is the internal world of the child*', '*Child psychotherapists embrace complexity*', both of which are potentially vital '*in situations where children are not able to articulate what they are feeling, but are perhaps behaving in a particular way as an expression of distress, anxiety or confusion*' (2009, p.105). This is pertinent to the task of the SoM Assessment, in my view.

In referring to Winnicott (1971) Lanyado (2009) outlines a shift from longer-term treatments to 'consultation' models in many services as attempts to reduce rising waiting lists. Lanyado argues,

> *…when thinking about consultation work, economic and pragmatic arguments can obscure the fact that for some children a fixed number of consultations, a clear focus for the work, or a clear date for ending the therapy, may be the best form of treatment plan for their problems at the time of referral (Lanyado, 1996, 2006)* (p.192).

Lanyado suggests the consultation model can be useful in engaging young people who do not wish to be patients, or where there might be a sense that the young person is not the sole person in the family constellation in need of support -as Winnicott suggested, the child's symptoms can be indicative of ill-health in one or both parents (1971). Miller suggests, '*It is always worthwhile asking the question, "Why is this family member the referred patient?" and wondering what it is that the family cannot manage to integrate that is seen in the child*' (2000, p.111).

Winnicott described '*getting into contact with a child'* (1971, p.3) as a skill that the therapist needs to be able to do relatively quickly in brief work. He suggested when the psychotherapist successfully connects with the child in the first or early sessions, it is felt positively by the child:

> *…so that whereas a child was caught up in a knot in regard to the emotional development, the interview has resulted in a loosening of the knot and a forward movement in the developmental process (p.5).*

This can in turn can be felt and made use of by the parents. Rustin suggests, the sense of a '*shared task*' at a timely moment for a family can '*facilitate a big shift*' (2004a, p.2-3), Lanyado adding that a timely response can be '*good-enough and sufficiently helpful*', adding '*the therapists' task is to be a catalyst for change in the family's emotional life*,' (2009, p.198). This is arguably more possible before difficulties become internalised or entrenched. If the psychotherapist can engage and activate some change or movement within the parents, or potentially the professional network around a child, it might be that the CAMHS therapeutic offer can be reduced or minimised for some cases. Rustin adds, *'… an assessment is a significant process in its own right – not just an assessment for something else – it should be viewed as a brief intervention with therapeutic potential*' (2004a, p.2; Mees, 2015). Lanyado summarises, '*The dilemma of how to meet the psychotherapeutic needs of as wide a population of children and families as possible is acute and concerning for the profession as a whole*' (2009, p.197).

Difficulties in brief work are identified by Laynado (2009) who suggests (like Winnicott) the therapist must be highly and rapidly able to attune to the child, due to the short amount of time available to do so. This can be emotionally demanding work for the therapist, and their capacity to make use of their countertransference and respond intuitively is crucial. They may have to be slightly more directive than in on-going therapy, but this she argues, can also be what makes the work exciting and rewarding.

2.7 Conceptions of Emotional Development

In an early chapter in her book *Inside Lives*, Waddell (2002) references ideas of growth and development that '*imply a linear progression*' which is now somewhat out of date, suggesting subsequent ideas around the development of human nature do not easily fit into a chronological framework. She proposes such alternative conceptualisation '*is what some psychoanalysts call "states of mind"*' (p.5). Winnicott, in his applied psychoanalytic work shared that, '*the backbone of all the work described here is the theory that has grown up with me of the emotional development of the individual*' (1971, p.10). He acknowledged the literature was vast on the area. Horne states '*Anna Freud gave probably the clearest early model of normal development from which pathological diversion could be assessed, with the emphasis on normality*' (Horne, 2009, p.27).

Green (2009) states, '*How we experience, regulate, 'organise', represent, live out and communicate our emotional lives is of primary interest to the child and adolescent psychoanalytic psychotherapist*' (p.176), adding '*at the heart of a child's emotional development lies the relationship between the child and his primary caregivers*' (p.178). To my mind these ideas are central to the aims or efforts of the SoM Assessment. Waddell (2002) asserts, '*Any one state of mind in the present, however fleeting, is founded in the past, and at the same time it encompasses a possible future*' (p.5). She suggests an inquisitive engagement with a patient's state of mind, asking if it nurtures developmental possibility, or if it '*further confines potential growth within a static or frozen "mindset"*' (p.6). She suggests mental states might be '*ephemeral or entrenched*', offering encouragement to move on or temptation to look back. Each state of mind has an impact upon the personality as a whole, she explains, the '*degree*

of impact varies according to the interplay between developmental stage, and within that stage, the attitude of mind which is dominant at any one time' (Waddell, 2002, p.6; Horne, 2009).

Green (1995) explains the '*diagnostician*', or to my mind the assessing clinician, '*will have to draw on a 'general' developmental story and to accommodate to the individual experiential 'story' in order to arrive at an understanding of the child*' (p.173). She suggests different theoretical underpinnings utilised by the therapist influence this and references Freudian theory which emphasises '*distinct phases*' of development alongside '*drive theory*', suggesting '*stages are considered to be a universal path although the overall shape and direction will differ between individuals*' (p.173). The developmental perspective was added to by a genetic approach, with debate about the focal point being '*instinctual life*' or the '*internal object world*' (p.174). Mary Main and colleagues brought to this debate '*attachment research*' (1984), considering internal working models of attachment could also be considered as '*one's "state of mind" with respect to attachment*' (Main, Kaplan and Cassidy 1985 as cited in Eagle, 2013), broadening again the more traditional psychoanalytic framework. Stern's conceptualisations of '*affective attunement*' and '*intersubjectivity between infant and mother*' added further facets to potential frameworks for understanding emotional development (Stern, 2002). Different theoretical underpinnings, and interplay between them, '*suggest that the 'framing' of an account of a child's very early development can be open to different shifts of emphasis*' (Green, 1995, p.174).

Waddell (2002, p.6) references the theories of Klein and Bion which have enabled thinking about the,

> *… nature and meaning of human behaviour as it is affected by the changing predominance of different mental states and by the impact of those states on the developmental shifts appropriate to specific ages (infancy, latency, adolescence and adulthood).*

Klein designated these mental states as '*positions*', which Waddell explains were intended as '*perspectives from which someone might view himself and his relationships with the world*' and facilitated a shift away from notions of treatment as cures for presenting symptoms to one of '*developmental possibilities… in the person as a whole, in relation with prevailing mental states*' (p.6). Waddell defines the terms paranoid-schizoid and depressive, in relation to states of mind. Paranoid-schizoid is a crucial state of mind in infancy when the infant '*does not yet have the capacity psychically to digest by himself*' (p.7). Conversely the depressive position is linked to feelings of concern for the other, guilt and desire to make reparation. These feelings are '*organized around an experience of the other as separate from the self, as being a whole person, possessing his or her own independent life*,' (P.7).

Waddell explains another psychoanalytic way of conceptualising these shifts in states. It could be primarily narcissistic, to object-related, states of mind. She suggests the shift between states of mind is a task requiring a '*repeated response throughout life*' (p.8). There are fluctuations during times of stress, intensified anxiety or fears of separation. Waddell explains that Bion felt the movement between the two '*attitudes*'

was more of an '*immediate kind of to-and-fro*', and that he posited '*every move forward in development entails a degree of internal disruption and anxiety which temporarily throws the personality into disarray… into a more chaotic state of mind*' (p.8). Bion's conceptualisation included a moment-by-moment oscillation between different temporary states of mind as well as more broad developmental phases. Klein and Bion's ideas of continually changing states of mind offered a way of thinking about development and growth where '*constant interplay between developmental phases and within each, between paranoid-schizoid and depressive positions*' exists (P.8). This is not bound to chronological age but is impacted by '*nuances of internal and external forces and relationships*' (p.9).

Waddell suggests,

> *Trying to determine with any precision which state it is that holds sway is often hard, but necessary in order to identify those experiences which are meaningful to the growing self and how they may, as a consequence, promote development'* (p.9).

Waddell shares clinical examples which illuminate how shifts can occur between states of mind suggesting '*under the sway of anxiety, thinking becomes separated from its emotional base and irrational or rigid ideas and attitudes begin to supervene*', rather than states of mind where '*"thinking" is taking place of a realistic kind, one which is linked to the known-self*' (p.12). The impact of difference in, and movement between, states of mind and views of oneself in the world are complex, in part due to not necessarily being linked to chronological age or developmental stage (Waddell, 2002; Horne, 2009). Lanyado (2009) shares clinical material which indicates a relationship between the number of cases with early or developmental trauma in the

background, which are often referred for assessment in CAMHS, and are assessed as presenting with attachment difficulties (p.193).

Waddell seems to suggest, it takes a mind, to know a mind:

> *If someone has had the experience of an external observing and containing mind, available to discriminate between which part of the self may be "in charge" at any one time, that person will derive from the experience a measure of some similar "holding" function, one that can then enable the different parts of the self to be in touch with one another. For if the various mental states are felt to be received, held and somewhat understood, the intense feelings, whether of rage, fear, anxiety, jealousy or passion, can increasingly be recognized for what they are. They can be known about and assimilated into the personality* (2002, p.13).

On the notion that it takes a mind to know a mind, Horne concludes, '*Winnicott, after all, in 1971 described psychotherapy as 'done in the overlap of two play areas, that of the patient and that of the therapist*' (2009, p.37).

The term 'internal world' was used frequently by participants. Walker describes this this as '*a picture of the world that the child has in his or her mind*', explaining:

> *This internal world will be the result of an interaction between child and external factors, such as the early mother-child relationship, and between the child and his own thoughts, feelings, impulses and fantasies. Factors such as age, gender, culture and family history have an impact on all of this as well as any past traumatic events, illnesses or physical disabilities* (2009, p.16).

Schultz links the concept of an '*inner world*' to psychoanalytic models of the mind, explaining in Freud's structural model (1923), humans:

> *…live in two worlds: in our inner worlds of internalised object relationships and in external reality with relationships to other people. There is permanent exchange between inner and outer worlds, and between the inner worlds of different people (through language and other informational and emotional exchange). Our inner world is very much shaped and modified by our experiences with persons in the external world… The reverse is also true: our relationships in the external world are very much shaped and modified by our internal objects and internal relationships. This is what we call transference* (2014, p.8).

Shultz concludes the therapist needs to know the '*basic characteristics'* of contemporary models of the mind when offering psychodynamic assessment and treatment. He names the main *'four psychologies of psychoanalysis'*:

1. The theory of drives and emotional conflicts
2. The theory of ego, superego, and ego ideal functions
3. The theory of narcissism and self-psychology
4. Object relations theory.

Shultz suggests these '*belong together'* each providing different emphasis of perspective, concluding '*a formulation in terms of object relations may be most helpful to understand the patient's inner world and the problems in his relationships with others*' (2014, p.10).

2.8 Summary

The literature search aligned with my instinct that the area of psychoanalytic State of Mind Assessments, as an integral and vital part of the child psychotherapist's offer in current CAMHS, is under-recognized, explored and researched. A question that remains is, why? It appears from the results summarised that the SoM Assessment is

described in some general works about psychoanalytic assessment, yet not named formally in the literature often. This contributes to a sense of mystery about the assessment, which was articulated by participants in their curiosity about where the name of the assessment came from. Ricky Emanual's explanation is strikingly pragmatic. It might be interesting to consider what the profession does with the tension between the more ordinary aspects of our identity (day-to-day function), and those more complex elements that being psychoanalytic practitioners can conjure up (what lies beneath). If there is a challenge in maintaining both a straightforward, down-to-earth identity alongside a psychoanalytic identity, perhaps this is sometimes communicated to our MDT's - a point further considered in participants' views on The Psychoanalytic Voice in the MDT, as seen through SoM Assessments, which is presented in the Findings.

Justification for this Research Study from Results of the Literature Review:

1. There is a scarcity of literature focused on the SoM Assessment. Only one dedicated explanatory paper was found. Petit and Midgley's 2008 study demonstrated that the majority of assessment work carried out by CAPPTs in CAMHS at that time was SoM Assessments. As such CAPPTs both qualified and in training would benefit from further literature on this assessment.

2. Petit and Midgley (2008) and Crockatt (2009) argue that the CAPPT's relationship to the MDT is of vital significance for the team's understanding of complex patients, assisted by a psychoanalytic perspective. This study explores the SoM Assessment as part of the contemporary psychoanalytic voice.

3. The literature review demonstrates that flexibility of approach is vital for the CAPPT to respond attentively and intuitively to the patient but also to make use of the range of available theoretical frameworks and psychoanalytic techniques to understand a child's particular difficulties and offer formulation through assessment (Winnicott, 1971; Green, 1995; Rustin, 2004a). This study explores the of SoM Assessment as part of CAPPT's 'flexible' means of understanding.

4. A psychoanalytic perspective is unique in CAMHS for being able to offer an understanding of emotional and developmental difficulty through the lens of object-relations, bringing to the fore in the MDT the inner world of the child, illuminating the relational link to their external world – arguably the important remit of the SoM Assessment.

3.0 METHODOLOGY

3.1 Aims

This study aimed to open a conversation about the psychoanalytic State of Mind Assessment. It sought to do this by gathering qualitative data from semi-structured interviews to provide a snapshot of the current understanding, clinical and learning experiences, and reflections of trainee and qualified CAPPTs within CAMHS services in one NHS Trust. Further, it aimed to add to the current literature available on SoM Assessments by discovering how this specialist assessment is thought about, approached, and experienced by CAPPTs, considering the relationships between clinical experiences, pedagogical learning and the development of personal theories about the SoM Assessment.

The five CAMHS clinics within the specified Trust involved offer treatment to children and young people from the age of 0-18 years. Consequently, the thinking and experiences of carrying out SoM Assessments focus specifically on those carried out with this population of service users.

I was aware as a CAPPT training within one of the Trust's CAMHS services during the period when interviews took place, that my dual position of trainee and interviewer/ researcher, might impact the interviews undertaken in different ways. I considered some potential participants might find it comfortable to talk to me as a known colleague and local trainee, while others might find it harder to speak with me for the same

reasons, or as a member of a particular clinic. The risks and benefits of my dual position is considered in Ethical Considerations and within data analysis and Findings.

3.2 Epistemological Stance

Reflecting on my philosophical assumptions within the project, my methodology was informed by a belief that there must be more to know about the SoM Assessment, due to the sparsity of published literature about it, it being a Core Competency for the child psychotherapist meaning every CAPPT must have experience of carrying it out on a regular basis, and informal musings about the assessment which I had become aware of over my years of training. I wanted to illuminate what else there is to know about this particular assessment, from within the minds of others offering it, aware I was developing my own views about the potential richness of the assessment within CAMHS.

I drew upon a constructionist epistemology predominantly, with an experiential orientation to the data, prioritising the relationship between experience and language. Meaningfulness, as deemed by me in response to the interview data I gathered, was influential in the development of codes and my interpretation of themes. I was keen to understand the story that each participant told me about their experiences, and to use this to develop my findings. An experiential orientation to the data emphasises meaning and meaningfulness as ascribed by participants (Hesse-Biber, 2017). This felt appropriate to the research endeavour of this project as the aim was to explore

CAPPTs own understanding and experiences of the SoM Assessment as described by them.

Both inductive and deductive analyses were used when examining the data. In keeping with an inductive approach, data was open-coded, in order to best represent the meaning that participants communicated. An inductive analysis is aligned with a constructivist approach. In addition to this, I drew upon a psychoanalytic theoretical framework, in order to explore the data, in particular the relationships between data sets, to identify recurring commonalities and or differences, in response to the research question, as I judged it to be relevant. In keeping with this, both semantic and latent coding was utilised.

In the writing up of this project, I was keen to avoid using a language that did not belong to the participants. As such, whilst I have been thoughtful about all decisions made which contribute to the project presented, I have deliberately avoided a language of research at times, as this was not the language in which participants shared their experiences, thus not a language in which I tended to think as I navigated how best to represent their data; their personal experiences and thinking.

3.3 Design

Through semi-structured interviews, this project gathered qualitative data about participants' learning and thoughts about psychoanalytic State of Mind Assessments in CAMHS, and their experiences of carrying them out. Interviews were carried out

prior to any transcription. All interviews were transcribed by hand by the researcher which contributed to familiarisation with the data. Transcription was engaged with as a distinct and new phase of the research process, as was each subsequent phase of data analysis.

Interview data was analysed using reflexive thematic analysis (Braun & Clarke, 2006, 2018, 2020b) because this method '*emphasises the importance of the researcher's subjectivity as analytic resource, and their reflexive engagement with theory, data and interpretation*' in generating, developing, and reporting themes among participants (Braun and Clarke, 2020a, p.3; 2017). In keeping with this, the study includes reflection of my position as a training CAPPT with developing thoughts and experiences of SoM Assessments, but also as interviewer and researcher of the project. I kept a log of notes related to collecting and analysing the data, utilising some of this within my Discussion. I wanted to learn from others but also acknowledge that my opinions and experiences impact how I interpreted the contributions of participants.

All CAPPTs within the Trust's CAMHS teams were invited to partake in one semi-structured interview. The schedule of interview questions was informed by my own experiences of carrying out SoM Assessments, relevant literature, and conversations with colleagues, and research and clinical supervisors during my training (Appendix C).

The schedule included:

- Open questions to elicit how participants conceptualise the SoM Assessment based on their professional training and clinical experience.

- Exploration of participant's personal thoughts around the type of case presentations referred for this assessment (or not) and why this might be.
- Opportunity to reflect on individual experiences of carrying out SoM Assessments.
- Opportunity for participants to reflect on how the assessment is conceptualised or understood by MDTs within CAMHS, and any implications for practice.

During the process of preparing my interview schedule, I carried out a mock interview with a fellow trainee, which helped refine my wording, determined the order of key questions, and time needed for interviewing.

The semi-structured interview facilitated participants to explore SoM Assessments as relevant to them and their experiences. As researcher, I attempted to encourage an atmosphere of relaxed engagement, retaining a flexible approach to allow for asking follow-up questions to explore what emerged, in more depth. Participants were asked to share a single lived experience of carrying out a SoM Assessment with a self-chosen patient. This was to offer an opportunity to think in depth about one specific experience of offering a SoM Assessment, to see if this elicited further or different conceptualisations of the assessment. I was curious about if, and how, thinking about a particular experience might influence the participants capacity to formulate their thinking about the assessment, and their capacity to articulate their thinking.

3.3.1 Setting and Procedure

The study took place within the NHS Trust in which I trained. The decision to use this setting was made during the Covid-19 Pandemic, when all Trusts were responding very differently to rapidly changing circumstances. I felt it would be more manageable

to gather data from within my own Trust at this time as I had greater awareness of clinical changes and restrictions to work there, hopefully minimising potential disruption to the project.

I decided not to share the interview schedule prior to interview, nor to ask participants to prepare for the interview, because I was curious about what participants might draw upon spontaneously. I was curious to experience how participants shared their thinking about the assessment, in an organic sense, rather than in a prepared or premeditated way. This was in part because I have encountered struggles personally and for our profession, in being able to explain the SoM Assessment clearly and succinctly. I wanted to consider what might contribute to this and how the capacity to share our understanding of our work develops. The intention was to discover what was drawn upon by participants as they thought, for example specific experiences, clinical or pedagogical learning, or something else, and what perhaps participants might feel was missing from their knowledge and understanding, if anything. My intuition was that speaking from an abstract or theoretical point of view might be harder than speaking from the personal experience of carrying out a SoM Assessment. I wanted to test this out.

Interviews commenced with an explanation of the five key areas of interest, each with its own initial question. I explained I might ask questions to clarify or facilitate a more elaborate response. I let participants know at the start that the third question would be asking about a particular SoM Assessment they had carried out, and as such they

might like to consider who to speak about as we progressed towards this phase of the interview.

Interviews were carried out in person and audio-recorded, or due to the Covid-19 Pandemic, online and video-recorded. Interviews were arranged according to participant's preference for time and method (online or face-to-face) to minimise disruption to clinical work. Interviews were later transcribed verbatim, following data collection of the entire sample group.

3.3.2 Participants

All CAPPTs, those in training and qualified, from across the five CAMHS clinics within the Trust were invited by email to participate (Appendix D). A participant information sheet (Appendix E) and consent form (Appendix F) were included. I asked those interested to contact me directly by email. Six prospective participants did so quickly. Five knew me, either professionally or through being a trainee at the same institution. All commented on responding to my recruitment email that they felt the topic of SoM Assessments was pertinent to their work/training.

I sent a second recruitment email a month later, and a further two participants responded. I now had four out of the Trust's five CAMHS clinics represented. I purposefully contacted the team lead of the 5th clinic to invite their team to be included. A final participant from this targeted team responded, wanting their team represented.

3.3.3 Inclusion Criteria

Participants needed to be CAPPTs, ACP registered, and with experience of carrying out at least one SoM Assessment in CAMHS, to have direct clinical experience of the assessment to draw upon. Ideally, I wanted the sample of participants to represent male and female CAPPTs, trainee and qualified, with varying lengths of experience in their role. Representation of ethnic and cultural diversity was hoped for, but these were not specified as required qualities for participation.

Nine participants were recruited. Although eight participants had been agreed in supervision as the optimum number for a small-scale study of this size, in discussion with my supervisor we agreed it was pertinent to make direct contact with the final unrepresented clinic to re-offer the opportunity to participate in the study. My intention was to ensure equity across the CAMHS services in terms of their voice being heard. My direct invitation resulted in full representation of the clinics across the Trust.

Seven female and two male CAPPTs were interviewed. Participants differed in age, experience, and position within their teams. Three participants were trainees, six were qualified with varying levels of experience. Two participants held Leadership positions within the Trust. All participants were Caucasian. Seven participants had English as a first language with two having other European languages as their first language.

3.3.4 Data Analysis

The data was analysed using rTA (Braun & Clarke, 2006, 2020) in generating, developing, and reporting themes among participants. Braun & Clarke's six-phase

process for data engagement, coding and theme development follows, with my own notes about each stage shared briefly:

1. Data familiarisation and writing familiarisation notes

   (I transcribed each interview myself by hand, and then read and re-read each one prior to beginning coding, during which time I made notes in a separate notebook of thoughts generated during the process.)

2. Systematic data coding

   (Each interview was read and re-read as codes were assigned. Familiarisation of each interview was vertical, working from start to finish of the interview. Coding was done horizontally, assigning codes for 'area 1' for each participant before then moving onto 'area 2', and so on.)

3. Generating initial themes from coded and collated data

   (A document was compiled that contained all codes for each interview. Each coded section of interview was stored with corresponding relevant quotation from the original transcript.)

4. Developing and reviewing themes

   (A giant hand-drawn mind-map was created to show links between codes and initial themes across the interview areas. This was revisited many times to refine initial themes and gather these into more overarching themes. This took much consolidation and reviewing.)

5. Refining, defining, and naming themes

   (This iterative process was engaged with for a period of more than four months. It required rethinking, revisiting groups of coded data, and discussions with my supervisor to fully develop and finalise names of themes.)

6. Writing the report

   (This process was also iterative and involved both writing each chapter as distinct parts of the whole project, and then bringing these together to develop a cohesive response to the research question at the centre of the study. The initial draft of the final report had to be significantly reduced to comply with the scope of the project.)

3.4 Ethical Considerations

This project was approved by TREC following all necessary permissions from the NHS Trust in which participants carried out their clinical work (Appendix G). Consideration was given to the impact of my dual position in the study, that of being both a CAPPT training in the Trust, and as being interviewer/ researcher. These facts were transparent to participants in my recruitment email and information.

3.4.1 Informed Consent and Right to Withdraw

Participants were required to sign the consent form after reading the project information sheet, which was returned to me prior to interview and saved. Participants were made aware they could withdraw from the project up to two weeks after the interviews without any consequences. After two weeks analysis may have begun and therefore it would no longer be possible to withdraw.

3.4.2 Confidentiality/ Anonymity Procedures

Informed consent gave me permission to de-identify participants for the purpose of the project. In order to further protect anonymity of participants and patients, the Trust is

not identified. Participants were aware I was only recruiting CAPPTs from our own Trust and as such, there was a risk they might be identifiable by colleagues that knew where my training placement was. Consent was gained for information regarding cases they may choose to discuss on a general level to be used in the project. Participants agreed to be responsible for anonymising patient's identities during interview.

3.4.3 Debriefing

Participants were all part of a team and had their own support structure and supervision that they were encouraged to make use of if needed. All participants were given a debrief letter (Appendix H).

4.0 FINDINGS

In response to the research question, how do CAPPTs think about psychoanalytic State of Mind Assessments and what are their experiences of carrying them out, the participants interviewed answered by thinking about:

- How they learn what the State of Mind Assessment is.
- How they do them, which leads more broadly into thinking about the voice of child psychotherapy within CAMHS.
- How they feel the State of Mind Assessment is relevant to the MDT.
- How to explain their thinking, which brought up reflections on language and communication.

The findings are presented within three main themes, each containing subthemes:

1. Knowing What the psychoanalytic State of Mind Assessment is
    1. '*Formal learning*'
    2. Supervision: '*We learned a lot*'
    3. Personal Development: '*It's who I am being*'
    4. Relational Learning, Experience, and Expertise: '*It will continue to grow*'

2. How Child Psychotherapists carry out State of Mind Assessments
    1. The Core Components: '*Framework(s)*', '*frame*', and '*tools*'
    2. An Act of Creativity: 'Everyone has their individual way'

3. The Contribution of the Psychoanalytic State of Mind Assessment to Contemporary CAMHS
    1. '*Brief*' yet '*rich*'
    2. The '*hidden gem*'
    3. The Psychoanalytic Voice in the MDT: 'It's about talking in a non-jargon kind of way'

4.1 Knowing What the Psychoanalytic State of Mind Assessment is

I reframed this theme as 'knowing' rather than 'what is' the State of Mind Assessment in a deliberate attempt to evoke Bion's concept of '*The K Link*', an active and relational linkage between cognition and **something felt**, something one must experience to understand, '*the link that is germane to learning by experience*' (1962, p.47). The responses of participants involved a sense of 'knowing in relation to…', be that knowing in relation to the cognitive taught offer from training institutions, through influential relationships with supervisors and colleagues, through development of their professional identity, or through an experience with the patient at the centre of a SoM Assessment. The decision was further made as a deliberate attempt to model language choices as meaningful. It also signifies the attempt of the CAPPT to learn about the child or young person at the focal point of the assessment, with the intention that this experience together might be meaningful, directly to the patient or in relation to the network around them, and for the therapist's formulation.

Data presented exemplifies the ways in which participants have come to know what the SoM Assessment is. This included experiences of cognitive learning, supervision, personal development, and relational encounters with patients and their families.

4.1.1 'Formal learning'

Three of the nine participants were trainees at the time of interviewing. They brought something palpable about the training process; about how learning takes place for the CAPPT. There were reflections and questions about the effectiveness, helpfulness and applicability of student and trainee experiences to the work of child psychotherapy in CAMHS, by qualified and training therapists. They considered the impact their training had had upon the roots of their psychoanalytic thinking, their professional development, and their current thinking about the SoM Assessment:

> *… there was a module there which you were required when I was training, you were required to actually have experience and write up, a State of Mind Assessment, to a particular standard as part of your core training. So it feels as though it's a fundamental part of a child psychotherapy training.* (P8)

Another added,

> *We spent a semester thinking about psychotherapy assessments, and State of Mind Assessments, and I think my thinking is heavily influenced by that.* (P4)

The training generated awareness of all that is not yet known and differences in experience, consistently reaffirmed, as one participant new to the training articulated:

> *…it's something that I've discussed with um, my supervisor, and with colleagues, psychotherapists, mostly, um, I think there's been some kind of general discussion with classmates, I suppose, again, there's this, there are different ideas about what a State of Mind Assessment*

> *is, um, who does one, and then whether we need to kind of, to have the class before we do them, and I think it is, it seems like there's a lot of uncertainty amongst my classmates, you know, different people doing different things.* (P2)

This participant brought into the spotlight something of the uncertainty about the SoM Assessment, which perhaps they were more freely able to voice on behalf of CAPPTs due to being less experienced, less knowledgeable about the assessment, as they shared honestly and delicately:

> *Yeah, so, ah, so I suppose, at this stage I have a bit of a question about -because we often refer to them as psychotherapy assessments, um, and is that the same thing as a State of Mind Assessment, um…* (P2)

This participant's struggle to conceptualise the difference between a SoM Assessment, and a psychotherapy assessment, could be put down to the participant's self-labelled '*greenness*', their infancy in the training or lack of experience. However, another qualified participant, remembering the confusion, implies a lack of clear communication about the SoM Assessment also contributed to the ambiguity of coming to know it:

> *I think I was very confused about what a State of Mind Assessment was, initially, and I think as a trainee, erm, it wasn't something that was perhaps spoken about until later down the line, I remember it being this elusive kind of thing, State of Mind Assessment…* (P1)

This hazy sense of learning what the SoM Assessment is, was shared by another participant's memory of the assessment workshop. This participant shared feeling somewhat un-helped by the cognitive teaching, suggesting there was more to learn, than the assessment workshop offered:

> *…there's something about assessment I think maybe in year two. But yeah, I think it's good to be a requirement* [to do them] *but… erm… I think that the assessment seminar was, probably wasn't that helpful, given what I'm saying about my last my most recent one, like I, the degree to which it helped me understand them, either it wasn't enough or I didn't retain it,* (P5)

Another participant acknowledged the dearth of literature and research available:

> *… in terms of sort of how to und -sort of how I gained an understanding of State of Mind Assessments, so, I erm, it all again it was all very informal in the way it came to be, I think someone recommended I think it's Petra* [mistaken for Peta] *Mees, yeah… I think that's her… has written something in, in one of the ACP journals, about State of Mind, Assessments, and that's really… I mean I haven't looked extensively but as far as I'm aware that's sort of, you know there's not an awful lot more about what they are...* (P3)

Participants agreed the SoM Assessment is an important and worthwhile offer but acknowledged it can be hard to explain exactly why, which seemed linked in several participants' minds with a struggle to feel clear about how learning takes place:

> *I think it was, I don't think something had been taught definitely, I don't think it ever was, it feels quite hard to trace that knowledge or trace that kind of… when did I first understand this is how I would be doing it.* (P7)

Participant 9 suggested, '*There could be more thought about it in the training*.' Another asked me directly, '*I'm curious have people been giving very different answers?'* (P4). Some expressed a sense the training should or ought to enable them to know the SoM Assessment:

> *I think that probably in terms of really formal learning, I can't think… there's been an awful lot of that… erm, and it's such a shame because, I mean it's a shame because it makes it even more elusive, erm, this sort of thing that we're supposed to know how to approach and what*

> *to do erm, but we don't really have a lot of space to think about it I think…* (P3)

Only one participant expressed finding the workshop pivotal in their learning:

> *…the way that we thought about State of Mind Assessments in the training was an opportunity to think, to get a little bit of a snapshot, if that makes sense, erm, of the way that someone… what's happening internally, how they relate to someone else, how they relate to their internal objects, er, and make a more… psychoanalytic formulation, er, using observation, psychoanalytic, erm, er, to explain the symptoms and to have a more… er, …er, er, I guess to have more of an opportunity to explore in depth what's happening for the young person internally, er, I think that's how I have er, and maybe some people have something completely different, about how they define State of Mind Assessments,* (P4)

This participant intimated that inherent to their institutionally-led learning was an understanding that CAPPTs will develop different conceptualisations and understandings of the assessment. Differences are valid. For several though, a lack of clarity about the assessment stirred up something more daunting:

> *I'd heard the kind of term State of Mind Assessment thrown around a lot and… was maybe quite intimidated, and, didn't quite know how I would go about it, what I would even be able to see from it or… gather from it.* (P7)

Reflecting on their experience of a different era of the training, one participant asserted,

> *… it's such an important skill… I think there might be a sense sometimes, that psychoanalytic work is so complicated, and there so, because it's difficult to actually think about intrapsychic and interpersonal at the same time, and you know, thinking about the place of the internal objects and the the, you know the inner world, that sometimes, child psychotherapists feel it's too complicated, to be able to express to a, an audience, what is actually going on for that child but I think that we need to do that, as child psychotherapists,* (P8)

There appears to be a difficulty around the SoM Assessment, or as participant 8 alluded, more broadly around the struggle for the CAPPT to explain the nature of what they do and how they think, to share their psychoanalytic perspective succinctly.

4.1.2 Supervision: 'We learned a lot'

Supervision was viewed as an integral part of the CAPPT's SoM Assessment. Six of the participants reflected on taking SoM Assessments to supervision, two reflected on carrying out SoM Assessments jointly with a supervisor, and one reflected on offering supervision of the assessment to other CAPPTs.

In early experiences of offering SoM Assessments, supervision provided essential help, participants describing struggles that were alleviated by the support and insight of supervisors:

> *I think when you're meeting a child, as a stranger and they, they don't really wanna be there, erm, or at least they don't wanna talk to you, yeah I struggle with that role… you know I struggle with the task of, of a State of Mind Assessment and so I needed quite a lot of support er, from* [supervisor]*, I think with all of them really, the supervision is, crucial,* (P5)

Gaining experience seemed to facilitate an exploration of being less reliant on supervision for several participants, suggesting less help was needed over time:

> *I always felt invited to bring State of Mind Assessments to supervision, I think at the beginning I have done that much more, because I felt more, at a loss, erm, with them and, I think wasn't able to trust my view as much yet... I'd say I probably brought about 60% of my State of Mind Assessments to supervision at some point.* (P7)

Two participants reflected on the influence of supervisors upon their approaches to SoM Assessments:

> *… you know as with all of these things, sometimes it er, unfortunately relies on having a supervisor that's quite keen on them, or not, and er I think that certainly there was a culture in the clinic that we could see it was quite useful, to, to conduct them… then a supervisor, another supervisor gave me… and again all sort of erm… "Don't pass this on because I've only blanked out some of the information but this is one I wrote many years ago, if you want to see the format", and again that was extremely helpful,* (P3)

There is arguably a tension between being shown and being left to experience or work out the SoM Assessment for oneself, which participant 3 alluded to. Participants more confident in their knowledge of the assessment, tended to have increased experience of it, but also referenced having supervisors who valued them. Experiences of doing SoM Assessments jointly with supervisors during the training were reflected upon with gratitude at the opportunity to learn in tandem, '*we learned a lot*' (P3). Another explained, '*we had a hypothesis... between myself and my supervisor*' (P6), conveying a meaningful shared experience, which stood out in the data across interviews, where most participants described solitary experiences of doing SoM Assessments which were then reported to supervisors for their help.

One participant suggested it was the relationship between cognitive learning and the influence of a passionate colleague that developed their capacity to formulate. The strands of learning about the SoM Assessment, uniquely woven together by the therapist, create '*completely different styles*' and '*ways of doing this assessment*' (P4).

Another participant suggested the processes of being supervised and supervising a SoM Assessment are '*developmentally helpful*' (P8) for CAPPTs:

> *… you're always,* ***thinking***[2] *about, you know, what is happening to the internal world of the child, what is the nature of this child or young person's internal objects and how, how does that impact on their functioning. So you're always thinking about formulating psychoanalytically… when you have discussion in supervision or within multidisciplinary teams… it's an ongoing process… you might not have a module which says, 'formulation', but you're formulating constantly,* (P8)

Interestingly, when asked to speak about their understanding of SoM Assessments, no participants mentioned having discussed their understanding of the assessment in supervision. Rather, actual assessments were brought for discussion. One participant repeatedly mentioned, when explaining their conceptualisation of the assessment to me, '*this is not really based on a conversation I've had with anyone'* (P3).

4.1.3 Personal Development: 'It's who I am being'

Only two participants mentioned personal analysis as an element that played a part in the development of their thinking and the processing of clinical SoM Assessment experiences they shared. Personal analysis is an integral part of the CAPPT training, so it is noteworthy that it was excluded by most participants in relation to the contribution it makes to their professional development. Participant 4 suggested SoM Assessments are thought about (and therefore carried out) differently. The degree to which this may be attributed to the CAPPT's mind being in development through (and continuing after) personal analysis is of interest, because the SoM Assessment is a responsive offer by the therapist (created in the mind of the therapist) in relation to the

[2] Bold text used to show words emphasised by participants in interview.

unique patient they meet with for each SoM Assessment. The participant newest to clinical work spoke to this:

> *I found it actually came up quite a lot in my own analysis because it stirred up quite a lot in me, and um, I felt quite kind of, yeah I guess quite stirring, these sessions in particular with her.* (P2)

Participant 5 reflected on the impact of the CAPPT's own internal and external worlds upon offering a SoM Assessment:

> *I guess it fluctuates… and that's very much, I think, influenced by what's going on with me and like, how I feel and where I am, this week, this month this year… which, I'm not sure how much we really acknowledge that, I think that we like to think we er… are machines.* (P5)

Comparing the SoM Assessment to other assessments, participant 3 explained the difference in the SoM: '*it's who I **am being***,' another participant added, '*it's a very… intimate, assessment,'* (P4). These participants raise awareness of what can feel like an unmentionable strand of learning about the SoM Assessment. Yet participants agreed personal analysis is core to their professional and personal identity. This in turn must be instructive in the development of the child psychotherapist's mind, and the engagement with their own internal worlds as resource, and thus their conceptualisation of the SoM Assessment.

4.1.4 Relational Learning, Experience, and Expertise: 'It will continue to grow'

Experiences of carrying out the SoM Assessment were argued to be the most important strand of learning in the development of individual conceptualisations:

> *Learning through the experience of doing it has been more, more important I think… there's not much to sort of go to, as a reference, in terms of State of Mind Assessments,* (P1)

Participants felt there is a need for both thinking about and doing SoM Assessments, to develop an understanding of them. A difference arose regarding the order in which this happens. Some participants were asked to offer SoM Assessments before the training assessment workshop space was offered, which has tended to occur in the third year:

> *Well oddly, I think the first piece of work I did was a State of Mind Assessment… I was quite daunted by it I think, it was a, I did feel erm, like, well it's quite an unusual assessment to do er, and I think perhaps in hindsight that was probably quite early to do that,* (P3)

Another explained,

> *Yeah, so I had one early on, within the first few months I would say of starting the training… I think there was a feeling to get me started early, erm, to get a taste of it early and then you know as they've come in they've been given to me,* (P5)

Participant 5 expressed a sense of being thrown into the deep end, as well as a sense of understanding developing over time, and with cumulative experience.

One participant indicated a split between the cognitive and experiential learning components, or their valuation of these different strands in their learning about the SoM:

> *I didn't… remind myself of anything that we were taught in the training, so can I just speak about, how I've done it?* (P7)

Five participants experienced the combination of the taught learning and their clinical experiences as cohering to shape their understanding of the SoM assessment:

> *I think my experience of **actually** doing a State of Mind Assessment, during the training and since, has helped me to consolidate and understand perhaps, in a more erm, useful way, what really are the benefits of it, and how it can be such an important offer really, in the context of current CAMHS,* (P1)

Participants agreed that understanding of the SoM Assessment is a developmental process:

> *… this is where I've **got** to, with my thinking about State of Mind but I don't think this is… I don't think that's how I was kind of understanding how to use them earlier on. But I think the more, the more I've done them the more I've thought that kind of these, something really quite useful could come out of them.* (P3)

Another added:

> *I think it's a very important thing to be able to um, to feel that you have proficiency in, as a qualified child psychotherapist, **and** it will continue to grow.* (P8)

A question was raised about levels and types of experience. Participants sought to clarify, '*So are you interested in my State of Mind experience… or more generally about my experience?'* (P4),

> *I think there's a difference between how I feel in doing the work generally, and how I feel in doing State of Mind Assessments. The last one I did I did feel inexperienced, it kinda hit me. Partly the case, and partly erm, probably not really having, not having done enough thinking about them.* (P5)

A question about when experience becomes expertise was raised:

> *… thinking about the whole life time of child psychotherapy, of a child psychotherapist, I feel very much at the beginning, but then within CAMHS I feel probably at this stage… maybe not experienced in terms of* ***years*** *but experienced in terms of thinking, in terms of complexity… in terms of comparison to like lots of other clinicians who come into the service, with erm, kind of less training, then I feel like I offer more expertise than them,* (P7)

Alongside this view, the importance of uncertainty and doubt in the work of a SoM Assessment was raised:

> *… I suppose one has to be mindful and not over, over emphasise what you know, but be, be uncertain.* (P9)

This participant suggested there is value in the CAPPT retaining doubt within the SoM Assessment, more so than taking a certain or rigid stance. The SoM Assessment raises interesting questions for the CAPPT and the profession, about our relationships to experience, feeling a level of expertise in comparison to some colleagues (which may stir up feelings of competitiveness and envy in the MDT), but also knowing that we learn more with an open, uncertain mind, in the SoM Assessment.

4.2 How Child Psychotherapists Carry Out State of Mind Assessments

This theme addresses the part of the research question that is concerned with what the therapists' experiences of offering the SoM Assessment are like. It presents data that coheres around therapists' ways of doing a SoM Assessment.

4.2.1 The Core Components: 'Framework(s)', 'frame', and 'tools'

Differences abound through the clinical descriptions of specific SoM Assessments brought for discussion. However, referenced by every participant were:

- '*The framework*', which I understood to relate to theoretical frameworks utilised.
- '*The frame*' a term I felt was used to describe the structure and setting.
- *'Psychoanalytic techniques'*, *'skills',* or '*tools*' (to my mind the therapist's internal resources), which the therapist makes use of within the frame.

Using a concept of my training supervisor, I am calling these three elements, the '*framework'(s)*[3], '*frame'* and '*tools',* the Core Components of a SoM Assessment. They were individually conceptualised by participants, with slight differences across the group, yet they are relational, underpinned by a shared subscription to psychoanalysis by ACP registered CAPPTs. The participant's unique application of the Core Components in each SoM Assessment was considered. Some participants held clear distinctions between the Core Components, for others the concepts were merged or overlapping. During the process of coding, I made three tables compiling aspects of each component, as identified by me from participant's descriptions (Appendix I). The Core Components underpin the CAPPTs approach to the SoM Assessment:

> *… we try to understand unconsciously what's happening in that person, what's hidden behind the behaviours, that are difficult to make sense of…* (P4)

[3] Multiple frameworks are available to the CAPPT including psychoanalytic, developmental, attachment, neuroscientific, emotional. Multiple frameworks can be made use of for a single patient or case.

> *… what you're looking for in a State of Mind is* ***what have they made of their experiences****… how do they see the world really, and I suppose that's the focus, erm, er, you know that you bring,* (P9)

Participants shared an understanding of the cumulative effect of experiences upon developing one's conceptualisations of the Core Components. Some participants discussed conscious alterations to the frame, being willing to alter the location of sessions (markedly during the Covid-19 Pandemic to remote platforms), some the timings, others the resources on offer and the use of directive instructions. There were differences in the number of individual sessions offered, ranging from three to six, how feedback was given to families and reported to networks, and the degree to which individual CAPPTs formulated openly with their patient, or internally and in supervision. What all participants brought to attention was nuanced difference, in style, and method, in how they carry out SoM Assessments. To many this was not only acceptable, but in fact considered a strength, acknowledging each CAPPT will develop their own understanding:

> *I think the State of Mind assessment is* ***informative****, about the presentation, normally the outward symptoms coming, that you can see... That's* ***my*** *understanding.'* (P6)

A quarter of participants shared experiences of being pulled to alter the frame. This was different to a justified choice to alter the frame and was mostly linked by participants with feelings of anxiety or struggle:

> *I did feel for those four sessions I was just giving him a really hard time and I wondered if I had maybe just said let's do thirty minutes of this rather than fifty, (laughs), it felt very tempting um… so yeah there are definitely times when I feel… sticking to you know the frame, what I said can be quite difficult.* (P7)

Several participants described something unexpectedly beneficial occurring when a decision was made to alter the frame. For one participant it related to offering the assessment jointly and in the patient's home:

> *I remember coming to it thinking, "Gosh, you know, I'm just going to meet this child five times, or you know however many times and, erm, kind of ascertain er… their state of mind from that meeting…" I was in the patient's home, er, my supervisor was there… I did have the sole responsibility for er it in the sense that I was paying attention to the child and er, kind of thinking about this child, but my supervisor could kind of er…* ***support*** *the conclusions I was coming to, erm, which was helpful* (P3).

Participant 3 identified that the child psychotherapist is a part of the assessment, creating the SoM through their psychic interplay of theoretical frameworks, the setting, and their psychoanalytic techniques. This was described as a key difference to the psychiatric mental state examination:

> *… a mental state examination feels much more medicalised in a sense that sort of it's not so much to do with the clinician, much more to do with the patient, whereas I think the State of Mind Assessment is more, I'm using myself as a -not a tool but a sort of* ***I'm part of that****, in terms of their ability to relate or not to me, and that would feed into how I would understand them, their state of mind.* (P3)

This might be a difficult concept to explain to those not subscribed to a psychoanalytic framework, without sounding omnipotent perhaps, which is a point to notice given the anxiety expressed by some participants in the study about being perceived in hostile ways within CAMHS.

4.2.2 An Act of Creativity: 'Everyone has their individual way'

This subtheme speaks to a tension between an anxiety present about conforming to '*a way*', a sense of safety and belonging in sameness, but also for some an understanding of inherent difference in how a SoM Assessment is done which reflects that CAPPT's minds are all unique. It also speaks to the uniqueness of each patient referred. Another tension exists between following what has been taught or passed on about how to do one, and what the CAPPT senses for themselves is how they want to approach the task, based on experience and the use of psychoanalytic tools such as observation and countertransference:

> *There's kind of two parts of how I would approach it which is what I've been **told**, and then sort of what I've learnt from experience and my own sort of, erm, **intuitive** or might not intuitive but my own sort of… **feeling** of what is required in a State of Mind Assessment. Erm… which is I suppose, starts with a question of sort of what, what am I trying to do here?* (P3)

Every participant considered the question, '*what am I trying to do here?*' Each had a different starting point: *'Everyone has their individual way…'* (P6). Table 3 captures the first sentence or key phrase of each participant's response to show the range and breadth of ways in which the SoM Assessment is approached.

Table 3

Participants' initial responses to the question, 'What are you doing in a SoM Assessment?'	**Participant**
I think over time the main thing… that I want to get a handle on would be… you have to start with interest and attention, and offering that	7

interest and attention to a young person and see what they do with it… so in a way how do they use an attentive, kind, interested, adult, erm…	
*I think it's helpful because **it is** a **context**, it's not a, not like a kind of idea of attachment theory, you know where you might say a child's got this, it's an attempt to say you know **at the moment**, at this point in time, this is the issue for this child…*	9
*I should probably say that I don't think I've ever had this conversation with anyone, but my **sense** of a State of Mind Assessment, at least how I think they can be used is, that I'm very interested in what, not just what their mind is doing at that moment, but what are the patterns -what gets done with thoughts, in the mind…*	3
So the State of Mind, I think, allows you to look at the particular anxieties, that are at play, unconscious, and conscious, and then I think it helps you to sort of see what the defences are, against those anxieties…	6
*… it's as if someone is trying to get someone under the microscope and see what's happening **really happening** for this young person…*	4
I s'pose there's a question about how they, how they might use me, um, how they might interact with me in different ways, or not, um, or invite me to interact with them, um…	2
Yeah (big breath in and looks up) er… I guess the first thing is about being asked by someone to clarify something for them, like a colleague, er, the referrer… that you're sort of responding to the referrer more than the child in some ways…	5

I think I would define it as, a view of the child, um, a view of the internal world really, of the child and how their internal world might then relate to their external circumstances, erm.	8
I think a State of mind Assessment is much more organic… in that you see what comes up in the session, you don't put your own expectations or er, desires into the session, or you try not to, you see how it unfolds…	1

Range of CAPPTs' responses when describing their task in a SoM Assessment.

The range of different starting points in response to the task is illuminating. The CAPPT shapes their SoM Assessment in accordance with their own experience and identity as a psychoanalytic psychotherapist, and in response to the question of the referrer. The assessment frame enables an attuned creative response by the therapist to the patient, making use of their internal resources or tools, aided by their use of relevant frameworks, to develop a formulation. A table was constructed to help consider the links between presenting difficulties, participants' countertransference responses, and outcomes of the SoM Assessment (Appendix J). The flexibility of the SoM Assessment, in terms of the types of case presentations it can be suitable for, became evident.

Participants identified the most important part of the assessment being the feelings they experienced in the room with the patient, and described how they then used these to develop their understanding of the child, in relation to their external world:

> *I was left with this feeling of not wanting to claim this boy, not wanting to do this assessment, but again in combination with what he'd made*

> *me experience in the assessment, I thought wow this is such important information about wanting to disown him, and erm, so you can think then again about transference, and countertransference… I was able to sort of link those experiences with how he was emotionally presenting* (P6).

Participants unanimously felt that the SoM Assessment provided scope for an assessment process tailored to the individual:

> *I very carefully choose, how to start, depending on the case I've got. I wouldn't have in my mind a formula that goes, this is how I go ahead and do it, I would start off by thinking, you know what's what… what would be the best place to start… it's helpful to then sort of think, is this the child that they* [parents/carers] *have in mind or have I got a different child?* (P9)

Eight participants identified the strength of the SoM Assessment to be its adaptability:

> *I think the great thing, is they're so versatile, State of Mind Assessments and I really think we should use them much more, because they are the perf -you know… so many cases are so complex that we have, and it's just not clear what is going to be good for them… It's really helpful to have flexibility.* (P3)

Participants reflected on SoM examples in which they did something '*a little bit different*' (P8), which they felt was important to the individual they were assessing. One participant related this to the recommendations in the report, explaining, '*I don't think that's necessarily* ***always*** *a part of a State of M Assessment*' (P8). Another explained '*I wrote a report that I shared with my colleague* [case manager] *… and I said, "It's* ***your*** *decision* [what to share]"' (P4). Several participants discussed not doing '*a nice pure kind of three sessions State of Mind*' (T3), adapting the frame to add or reduce sessions. Across the cases shared, it transpired that SoM Assessments have been

offered with U5's, latency, and adolescent age groups, with whole families and groups of siblings. SoM Assessments have been carried out in clinical settings, in homes, and online. Participants discussed the range of benefits from their SoM Assessments, stating that in addition to helping the young person or child in almost all cases, the assessment had been tailored to help parents and carers, schools, social care, paediatricians, local authorities, professional networks around a child or family, courts, and MDT colleagues.

Some participants shared more exceptional adjustments, needing to do something '*out of the frame… I had to be a bit more* ***creative*** *working,*' (P6). For several this related to SoM Assessments offered online:

> *I did do a State of Mind on zoom but that's because he couldn't bear being in the room with me, he was so agitated that we had to find the right distance. And I suggested doing that which worked really well for him. Again a person who would talk rather than play. Yeah. But that was not because of Covid, it was just how he felt safe.* (P7)

4.3 The Contribution of the State of Mind Assessment to Contemporary CAMHS

One participant stated the demand upon CAMHS at present is '*almost unmanageable*' (P1). The reasons for this are not the focus of this project, but the potential role of the SoM Assessment in attempting to alleviate some of the current strain, is in the minds of participants. What follows are therapists' views on the ways in which the SoM Assessment currently does contribute to the CAMHS offer or could further do so.

4.3.1 'Brief' yet 'rich'

The scope of the assessment was described:

> There's something about a State of Mind Assessment being er… almost like a bigger package… you're not just working with a young person, but you're kind of working with the network around the child, the parents, erm, and the, yeah the other professionals around the young person, to try and understand something about a young person's internal world, their emotional state of mind, erm… you're offering both a kind of treatment-intervention, but also something more like a… consultation almost, so you're using what you, what you gather about a young person to help you consult to the network… it's not a big resource, and that's gonna be popular with team managers and commissioners… (P1)

Eight participants commented on the brevity of the assessment compared with the depth of outcomes; '*it has an important role in potentially clarifying things, quite quickly, quite economically*' (P5), '*it just feels like a really sort of clean piece of work'* (P3):

> *It's um… a really valuable source of information gathering, erm, in a short space of time. It allows erm, you know, our, our really kind of complex understanding of erm, intrapsychic processes, erm defences anxieties all of that, to kind of be, our understanding of that to be kind of applied, in a more… short term way, which can give something quite palatable.* (P6)

Four participants mentioned the current pressure in CAMHS, and the benefit of slowing things down that the SoM Assessment brings, leading to one participant calling it, '*a luxury resource*' (P3), creating opportunity to think:

> *… it's very helpful to, to kind of slow things down, to think and reflect and to understand what is the child asking you to carry… it kind of, yeah it turns things into a different… it creates an opportunity to create a different lens.* (P6)

Many participants felt the SoM Assessment was therapeutic as an intervention in itself:

> *… there's definitely a value in the way that we do get to see er, an aspect of the child or a, a kind of, a deeper level of the child which I think, parents and carers, I think it can, contain them and calm them, er, in a valuable way.* (T5)

Some viewed the assessment as a taster of what child psychotherapy can offer:

> *I think very often it does feel really helpful for the young person, it gives them a flavour of something… of having sort of that close observation and having that kind of undiluted attention to something* [they are] *trying to communicate…* (P1)

The SoM Assessment was valued for its capacity to provide personalised recommendations. These were felt to be useful within CAMHS and MDTs but beyond with other professionals:

I think it's helpful for a State of Mind Assessment to produce recommendations… what I think I want to get to is something that is kind of digestible for whoever needs to read it, but might actually give them insight into what this child, what might be good for this child. (P3)

4.3.2 The 'hidden gem'

All participants agreed there is already, to varying degrees, value in the SoM as part of the CAMHS offer. All felt it has potential to be further utilised.When asked about limitations of the assessment, five participants suggested the main limitation was a lack of knowledge of the SoM Assessment in the MDT meaning it is not requested or used frequently, '*it's not quite got a profile, I would say'* (P5):

> *I'm going to be really honest, because I think that's the point of these things, that I don't think that State of Mind Assessments are something that are in the mind of the team, sort of enough really…* (P1)

Another participant suggested:

> *… they might sort of have heard of it, when you name it, in terms of that might ring a bell, but certainly I think something that they know that, you know, an option that they are aware of, within, clearly in the mind, I don't think that's, I don't think it's very well publicised or understood, because I think we don't, as a profession, we haven't crisped it up enough to kind of understand it.* (P3)

In contrast, three participants felt the SoM Assessment was held in mind in their (three different) MDTs:

> *I've never had to promote myself as someone who could maybe do a State of Mind if that would be helpful… my impression is that if other clinicians are stuck they feel comforted that we could give this to a child psychotherapist and they do a State of Mind and this kind of feeling that there is still someone who could figure this out, and, and er, hope that something about the case could be, become less stuck… people would approach in a very keen way, like would you be able to see this young person, because I really want to* ***know****, what you make of him.* (P7)

The SoM Assessment was described as '*a bit of a hidden secret or gem, potentially,*' (P5):

> *… there's something about it in terms of… bringing clarity, potentially, and addressing that sense of perplexed-ness and… puzzle, mystery that I think some young people er, confront us with.* (P5)

Participants unanimously agreed that with experience of the assessment, the MDT '*do value it… do appreciate it*' (P5), and '*with repeated experiences of that working, they will come back*' (P8). Through the SoM Assessment the psychoanalytic voice is heard and becomes known, over time becoming embedded in the MDT mind, increasing demand for it:

> *… they've only become more aware that this is something they can request through, you know, getting the feedback, from them, I think before that it's just this thing, that they didn't really have this sort of* ***felt sense*** *could be useful,* (P6)

Stating the SoM Assessment is '*a useful offer, right now, really so crucial*' (P1), many participants suggested it has a potentially further valuable role within

Neurodevelopmental assessment, where children with multiple co-existing developmental and relational difficulties are often referred:

> *That is often a referral reason… is this attachment or is this ASD. Yeah… clarifying attachment and ASD kind of, muddle of concerns.* (P7)

> *I think for young children in particular, unpicking, to be able to signpost kind of, is this ASD, is this not ASD, what's going on here…* (P3)

4.3.3 The Psychoanalytic Voice in the MDT: 'It's about talking in a non-jargon kind of way'

Of key relevance to CAMHS is the CAPPT's capacity to offer formulations and recommendations within the MDT, that hold and contain the emotional load usually experienced in complex and confusing cases with high levels of co-existing presenting difficulties. Some participants suggested the MDT feels supported by the contribution of a psychoanalytic voice in offering SoM Assessments to these more '*perplexing*' (P5) cases, offering '*a kind of authority*' (P7) when the team can be struggling to know what to do. Other participants assert the SoM Assessment (and the psychoanalytic voice) '*is not in the mind of the team*' (P1), and thought is given as to why.

Details of wide-ranging presenting difficulties were given by participants as features regularly seen in cases referred for SoM Assessments. This is not an exhaustive list, but participants identified the SoM Assessment as most frequently requested for a psychoanalytic perspective on:

1. Stuck cases:

> *I think what they have in common is that the other clinician, or other clinicians, don't know what else to do... I think a big relational component where the child does something, really expressive, or affective, within a relationship -whether that's withholding or extreme behaviour and it leaves the other person just stuck, or not knowing what else could be done.* (P7)

2. Confusing presentations:

> *I think they're probably put on a waiting list for erm, a State of Mind Assessment, for many reasons but I think the primary one is when there's a confusion, about the presentation, erm, from the assessing clinician normally.* (P6)

3. Communication difficulties:

> *… they're children who don't communicate… if you ask them a question they're not going to give you, they might not know the answer but they might also be frightened to give you an answer or, or, they might feel that they've got to say a particular kind of thing. Erm, so they might be the children who don't necessarily communicate in a straightforward way.* (P8)

4. Looked After Children:

> *You know the kind of experience they* [LAC] *give professionals, in the context of the trauma, and relational erm, difficulties that they've had in their life, they, they have a way of really -yeah, getting under the skin of the professionals, erm to the point where professionals sometimes want to give up, or just sort of turn their back on it, erm, and, it's almost like a State of Mind is, like, "Please come and save me!", like, "Give, lets can we have some sort of fresh ideas about this child, can we try and see it from a different perspective".* (P1)

5. Risk assessment:

> *… there is often risk involved I think, in in the kinds of cases that come through, because people are very anxious, about these cases, so there is often an element of risk that might be around, emotional risk to the child, possibly physical risk… people want to, sometimes they do want to know what to do, about a case, so they might be cases where some action, is needed…* (P8)

6. Unpicking ASD, trauma, and attachment difficulties:

> *I've often ended up with State of Minds, quite varied age groups, erm but the question, there's often a kind of question of… is it ASD, is it trauma, is it attachment stuff?* (P3)

7. Systemic difficulties:

> *… in that first session I observed quite a fiery very close kind of engaged with each other's emotions, or involved with each other's emotions, type of relationship… it gave a real impression of their homelife I guess and their family life… conflicts they run into…* (P7)

8. Making sense of powerful projections:

> *… that question was I think clarified very clearly, through the State of Mind Assessment, in terms of references to killing people but that being very much about… not just fantasy but also I guess projecting anxiety into people and expressing fear.* (P5)

During the coding process I created a table to illustrate the range and quantity of co-existing presenting difficulties from the SoM Assessment examples shared in interviews (Appendix J). In all cases the CAPPT was required to develop formulations that unpicked multiple presenting difficulties for a single patient, using primarily observation, countertransference, and personal intuition, which they then shared with colleagues:

> *I think a State of Mind Assessment does that, coz we, you get that opportunity to really observe a young person and put in place your observational skills and share with the team, you know share that kind of different perspective,* (P1)

All participants encountered a struggle to articulate their theoretical conceptualisations and understanding of the assessment succinctly in interview, on more than one occasion. This struggle was demonstrated by incomplete sentences, hesitation, '*um's* and *erm's*', and repetition, which were coded as attempts to 'fill the space' (Appendix K). I noticed a pattern: a wish to 'fill the space' was coded with increased frequency in responses answering objectively the questions related to 'What is a SoM Assessment?'. Most participants spoke in increasingly technical language in response,

distancing me, communicating explicitly or implicitly this was hard to answer. Some acknowledged resorting to '*the jargon*' (P8). This was illustrated by participants when explaining the SoM Assessment:

> *I guess it's not really about trying to establish something around psychosis or relation to reality it's more erm, the unconscious erm, mmm, dunno. It's hard, hard to sort of describe it without slipping into our jargon, but, but erm, trying to pick up on unconscious motivations, unconscious preoccupations, erm….* (P5)

Another shared:

> *It's interesting because obviously it's not very clear in my mind and as I'm describing it I realise it… you observe, and you notice and you formulate in a way that's not interpretation, if that makes sense, am I making sense?* (P4)

I wondered what this struggle with language when attempting to describe the SoM Assessment in objective and theoretical terms might be communicating, and what impact, if any, this might have upon the perception of the psychoanalytic voice as brought to the MDT, through the SoM Assessment. If part of the psychoanalytic voice is the capacity to hold that which is perplexing or complex, to digest and make sense, maybe we sometimes continue to perplex through our language choices to buy ourselves a space to hold something that is difficult to formulate.

Two thirds of participants held a belief that, '*there is this sort of mystery often around*' (P1), in relation to the SoM Assessment and child psychotherapy more broadly in CAMHS. These participants wanted to shed light on a lack of clarity: '"*State of Mind" doesn't mean anything… er… er, phhh, I don't know. But that's interesting… it is*

confusing…' (P4) perhaps indicative of professional collusion with the air of mystery, resorting to a kind of 'Private Language' in some situations:

> *It's so psychotherapy-like isn't it, to kind of, it's just such an elusive title, sort of (using soft voice and finger quotations to say) "State of Mind Assessment", and erm, I just think that kind of erm… you just think, well this sounds very kind of* ***important*** *and* ***thorough****, you know, but* ***how*** *on earth is that being conducted and what comes out of it really… and sort of professionals feeling a bit irritated that we're (laughing), we're kind of just er… a bit lofty I think, we kind of don't need to tell you what it means, coz* ***we kind of know*** *what it means.* (P3)

It was suggested the struggle to use a shared or accessible language occurs for the CAPPT when speaking about working with the unconscious:

> *… I think sometimes it can be difficult for child psychotherapists to explain er, what they're doing, to explain their thinking, and to share their thinking, er, erm, because I think somewhere there is a fear that they won't be understood… I think somewhere there is a fear to use the word unconscious in the clinic, you know, I think there is a fear to use the word unconscious… I'm not sure if that's our fear that it will be rejected er…* (P4)

The CAPPT's fear of being rejected, or attacked, was palpable from another therapist, *'…you are trying to bring things into a hostile environment (laughs), you know, CAMHS can be a hostile environment to child psychotherapy*' (P9). Every participant used the emphatic phrase '***you know***' repeatedly with me when struggling to articulate conceptual thinking, suggestive of a wish for solidarity in the struggle, and/ or as a way of 'cutting corners' with me conceptually because as a fellow CAPPT I 'get it'. Every participant asked me at some stage, '*Am I making sense*?', '*does that make sense?*' or '*I'm not sure if that made sense?*' indicative of an anxious state of mind that the CAPPT can encounter when trying to explain their work. One participant shared they use '*psychodynamic*' rather than '*psychoanalytic*' because it is '*more palatable*' (P8).

Another voiced uncertainty about their communication of the assessment to the MDT and patients, explaining sometimes their explanations felt '*a bit too vague*', the participant unsure '*whether anything more technical is erm, is a bit too complicated*' (P3).

Such anxieties were not present when therapists shared their clinical case examples with me. Participants were able to talk about a particular SoM Assessment that came to mind for each with comparative ease and clarity. They were more articulate in case presentations, illustrating clinical experiences vividly, with straightforward and sensitive language that engaged me in a more meaningful or evocative way than the language of their conceptualisations achieved. It is my sense that the relational encounter with the patient is experienced, thought about by the CAPPT, and articulated by them in a language evoked by the experience, meaning that it almost instinctively can be shared in a more accessible, but also more emotively meaningful language, which others (patients, families, MDT) can connect with too. It is this language of digested experience which enables the psychoanalytic voice to be heard and assimilated:

> *There was a 12 year old boy, who had a series of very serious overdoses, and the family was under a child protection plan; there was violence in the family from the father… towards the mother, and sometimes emotionally abusive towards the young boy… the parents were so loud in the family, there were so many complications, that it seemed like his* [boy's] *voice wasn't really heard… he talked about very serious stuff… but also he was* ***tiny****… his whole play was about a very violent father, him trying to save himself and his mother… he needed to silence himself in the play… on top of the violence his mother had also experienced cancer. He didn't want to go to school, he was very low, I think it was really helpful for someone to understand what was really going on in the house, but also how worried he was about his mother… it seemed whenever he failed to protect his mother or himself against his father, that was when he would take an overdose, like he felt so incompetent.* (P4)

For the SoM Assessment, and the psychoanalytic voice to become better known in the MDT, the psychoanalytic voice needs to be accessible:

> *I think historically people have been, child psychotherapists sort of keep themselves to themselves, and so I think it is about really yeah, talking about it in a really kind of non-jargon way.* (P1)

> *I hold this opinion in terms of a lot of things child psychotherapy in the sense that there are times for things to be very vague and stay with the not knowing but I think that there are times when you could kind of firm up something a bit more, and I think it would be incredibly helpful to have a kind of erm, a kind of relatively basic description, or piece, information sheet that you know, the ACP could put on their website, as a resource people could use… you could adapt if you needed to I mean it doesn't need to be too rigid…* (P3)

It seems the work of speaking in a more accessible, less jargonistic way, is primarily needed within the MDT context, and amongst our own professional group, where the data suggests resorting to '*the jargon*' can occur to prevent professional anxieties or uncertainties being exposed, and/or to communicate membership of the CAPPT group.

5.0 DISCUSSION

This chapter considers the prominent findings within each of these three themes and attends to the relationships between them. I draw together reflections on my experiences of being the researcher, which are interwoven throughout the project. I acknowledge the limitations of the study and consider scope for future research.

Synopsis of Themes 1 - 3

1. Knowing what a SoM Assessment is, in the sense of Bion's relational sense of knowing through felt experience, is a process of learning (1962). Learning contains multiple strands which are in relationship with one another. For the SoM Assessment, the CAPPT makes use of academic, supervisory, personal

development (analysis), and experiential (clinical) learning. Learning and knowing are dynamic processes. They are demanding yet rewarding. There is exploration of the tension between learning through the experience of doing, and through the more formal or academic routes to knowing what the SoM Assessment is. The strands that contribute to knowing what the SoM Assessment is are valued to different degrees by CAPPTs. There is an acknowledged and shared view that there is a lack of literature about the SoM Assessment. It transpired that none of the participants knew about the origin story of this assessment, as depicted by Ricky Emanuel in personal communication to me.

2. How CAPPTs carry out SoM Assessments is varied yet underpinned by what I am calling 'Core Components'. These Core Components comprise of three fundamental elements of the SoM Assessment: the '*frame*' or setting, theoretical '*frameworks*', and psychoanalytic '*tools*' or techniques. The Core Components are drawn upon by the CAPPT to create the SoM assessment in a responsive and flexible manner, to suit each patient and the request of the referrer. The inherent flexibility and creativity of the SoM Assessment means it is possible to have a primary conceptualisation of it, based around the Core Components, but for CAPPT's conceptualisations to continue to evolve, as a result of the cumulation of experiences of offering the assessment, and I would suspect, as a result of their developing identity as a child psychotherapist. A philosophical debate arises regarding the notion of evolution and development - can the SoM Assessment remain known as a SoM Assessment, if it is created flexibly each time? There are tensions both within the model of the SoM Assessment itself with regards to the scope for creativity and flexibility on the

part of the child psychotherapist, and alongside with personal desires to '*get it right*', combined with the uncertainty of knowing what a SoM Assessment is.

3. The contribution of the SoM Assessment to contemporary CAMHS generated both some mixed views and firm responses from participants on how well known and used the assessment is by the MDT. There was unanimous agreement that it could be further utilised and that this is timely for CAMHS given the increasing pressures upon services. The SoM Assessment is a specialist assessment. It assesses a young person in an in-depth manner, offering understanding of their internal world, interpreting developmental and emotional difficulties, and making recommendations. The SoM Assessment offers an opportunity for the psychoanalytic voice to contribute to MDT discussions about complex cases. Participants raised a difficulty that the profession has in communicating what it is that we do and how, without '*resorting to the jargon*', which can be felt to be '*off-putting*'. This is an interesting complexity, as the purpose of offering a SoM Assessment, in my mind, is to come to know a patient - the nature of their very particular difficulties, and to communicate our understanding of them. We are offering ourselves as capable of making such communication, and I believe, we are usually very good at doing so. But there is a struggle to articulate our theoretical conceptualisations succinctly. Conscious and unconscious motivations behind what we do with language are considered. This speaks to an additional tension experienced within the MDT context, illuminated when differences between the CAPPT's training is considered alongside the trainings of MDT colleagues.

5.1 Theme 1: Knowing What the Psychoanalytic State of Mind Assessment is

All participants commented on their experiences of learning from their training school, the impact of supervisor(s) or supervision, and learning through the experiences of '*actually doing*' the assessment, as contributing factors to their knowledge of the SoM Assessment. Two participants referenced their own analysis and personal development as part of their learning, and by virtue of the other participants not mentioning this at all, and a developing impression of my own about the innate creativity of the SoM Assessment as an attuned response to a troubled or troubling young person, this also became a subtheme in my mind. The final subtheme captured within this theme considers the relationship between experience, and something called '*expertise*' by one therapist, which I understood to relate to their sense of something specialist that grows out of the combined and cumulative experiences of learning to become a child psychotherapist, which includes learning about and developing one's own conceptualisation of the SoM Assessment. The subthemes were presented as relational to one another. Participants felt certain strands of learning provided more than others.

Identified by participants as the most important aspects of learning about the SoM Assessment were the experiences of doing them and the supervision received. However, it was the combined effect of all strands of learning that enabled an understanding of the assessment to develop over time. Although Bion's work did not come up during the literature search, during this study I have increasingly felt his theories about 'K', the learned kind of 'knowledge' gained through experiencing something in a felt way (1962), are deeply relevant both to the aims of the SoM

assessment, but also to individual CAPPT's ways of conceptualising the assessment. Personal development is an integral aspect of the therapist's identity and learning. As Winnicott said, '*I am not like what I was twenty or thirty years ago*' (1962, p.169), reflecting on what he called '*the personal growth process which, we hope, never stops*' (1971, p.2). Personal growth links directly to the use CAPPTs can make of their own internal worlds and internal objects, which is fundamentally what CAPPTs rely on and make use of in the SoM Assessment, for the benefit of understanding the patient's struggle, which needs to be achieved swiftly on the part of the CAPPT in the brief SoM Assessment (Winnicott 1971, Rustin, 2004a).

Using Bion's concept of knowing as a relational link between thought and a felt experience which results in emotional meaning (1962), I would argue the SoM Assessment is a meaning-full assessment, where the CAPPT is attempting to develop a sense of meaning with the patient, for the patient (and/ or network), as the CAPPT uses their own mind in formulating an understanding from the experiences of being with the patient, which can then be shared. The SoM Assessment is '*very personal… intimate*', a process of knowing '*who I am being*' with the patient. Understanding of the patient, or learning the language of the encounter (Dufresne, 2017), becomes possible through the CAPPT's experiences with and of them in the assessment. The CAPPT uses their mind (their internal world) to come to know the mind of their patient (Hinshelwood, 1991; Green 1995).

The SoM Assessment was described as a developmental opportunity for both patient and CAPPT, constructed through a relational experience together. Like an attuned parent might use their mind, to come to know the mind of their infant, helping the infant to become known to themselves and others and simultaneously developing the parental mind through the experience (Stern, 2002). Yet unlike the parent-infant experience, the SoM Assessment offers something different in being a stand-alone experience. The potential of the encounter is finite. There is arguably more impetus for connection and meaning to develop. To my mind this adds a pressure but also a necessary freedom for the CAPPT to respond flexibly and spontaneously in ways that might not be so forthcoming in on-going treatment (Winnicott, 1971; Lanyado, 2009). Understanding can be thought about and shared between CAPPT and patient, and with the wider network as appropriate. Some CAPPTs suggested the MDT can also come to learn about the voice of child psychotherapy through the SoM Assessment, arguing from experience that the value and scope of the assessment grows in the mind of the team resulting in specific requests for it in time (Crockatt, 2009). This a parallel process. It is through a relational link between the CAPPT and MDT that this additional development occurs.

Some participants knew what the SoM Assessment is by knowing what it is not. These CAPPTs identified the SoM Assessment as distinctly different to generic assessment, assessments for psychotherapy, and psychiatric mental state examinations. The distinctions between assessments seemed to help form a clearer shape of the SoM Assessment in the CAPPT's mind, but all struggled to some degree to articulate their understanding of the SoM Assessment succinctly. Some participants were aware of

their uncertainty and doubt, and these CAPPTs tended to view uncertainty as a valuable part of learning and coming to know (Wittgenstein, 1975; Dufresne, 2017). Bion (1970) and Rhode (2004) urge the therapist to remain with not knowing, to remain tentative, making use of their uncertainties to revisit and revise their thinking along the journey with a patient. Certainty can close the mind to possibility, to the necessary internal flexibility required to respond attentively to the patient (Winnicott, 1971; Rustin, 2004b). One participant heeded, '*…one has to be mindful and not over, over emphasise what you know, but be, be uncertain*.' Uncertainty benefits not only formulations but also conceptualisations about the assessment, so that the SoM Assessment offered is responsive to the patient. This seems in keeping with Ricky Emanuel's conceptualisation of the SoM Assessment at its origin, in as much as it was developed in response to working with referrers (initially social workers or hospital staff), as a way of offering a psychoanalytic understanding as to why psychotherapy might not be indicated for some young people, and what instead might be considered by the concerned professionals in the role of supporting them. Uncertainty of knowing about, or conceptualising the SoM Assessment, could result from fear of being incorrect or thinking differently (implying a rigid approach or desire to be part of the group 'that know'), which tended to be voiced by CAPPTs with less experience, whether broadly in terms of child psychotherapy and/ or the SoM Assessment specifically. Conversely some therapists felt there must be differences in how the assessment is understood and carried out. This view seemed linked to a psychoanalytic understanding of human minds, where '*There is permanent exchange between inner and outer worlds, and between the inner worlds of different people… shaped and modified by our experiences*' (Schultz, 2014. P.8), and a philosophical

stance that a language of knowledge is experiential and contextual (Wittgenstein cited in Dufresne, 2017).

It is hard to pinpoint the moment of 'knowing' in the process of learning. It is experiential; it occurs over time; it continues to grow (Bion, 1962; Dufresne, 2017). One CAPPT said, '*… it feels quite hard to trace that knowledge or trace that kind of… when did I first understand*'. Most participants' conceptualisations of the SoM Assessment included the act of formulation and writing a report. The formulations participants offered about their patients in SoM Assessments seemed to be an expression of their understanding of how the patient relates to others (including the CAPPT but beyond this too), to themselves, to what is happening externally in their life, and the perception of the world that the child has in mind. The CAPPT '*uses her skills to build a picture of the child's inner world - that is, a picture of the world that the child has in his or her mind*' from which the therapist develops their formulation (Walker, 2009, p.16).

Ambivalent feelings were expressed about learning and knowing the SoM Assessment, because this takes time, and because our psychoanalytic training urges us not to become too sure, although this leaves the CAPPT in a place of tension when offering what is often requested as a specialist view, which can convey unconscious desires for certainty. Supervision provided a more personal support for most and was consequently held in higher esteem than the academic training workshops. One participant described being handed down a SoM report from their supervisor, a tradition of 'passing on' something precious, to be taken in, digested, and applied.

Interpretations of shared knowledge and experience led to one participant asserting, '*people must have completely different styles, and ways of doing'* this assessment.

No therapists reported using their supervision to explore their conceptualisations of the SoM Assessment. This is striking given the difficulty voiced and demonstrated by some CAPPTs in being able to explain their thinking, and how the supervision space could support conversations that might be developmentally crucial for the therapist's capacity to develop skills and a language to share their psychoanalytic thinking. All therapists had conceptualisations to share, yet as one therapist articulated for the group, '*this is not really based on a conversation I've had with anyone*'.

The SoM Assessment is inherently creative. Each one an attuned response created subjectively by the therapist in relation to the patient. Yet a tension arises because there is a need to know: oneself and one's contribution to the assessment outcome (helped by analysis and supervisions), and how one comes to know that the thing being offered is indeed a SoM Assessment, if each can have degrees of difference. This philosophical question can be thought about through the first century metaphor known as 'The Ship of Thesus' (cited in Mesku, 2019): new and stronger timber was used to replace weakened parts of the boat, so that it was possible to retain its purpose. Some argued the ship remained the same, it was successfully used for the same purpose. Others contended it was now a new ship, visibly altered from the original. We might consider this debate with regard the SoM Assessment. Although it was hard to trace the history of developments in both knowledge of what the assessment is and how it

can be carried out, an origin story from Ricky Emanuel only coming to light in the last weeks before this project was completed, testifying to the SoM Assessment as a creative offer from a child psychotherapist, we might question how flexible the CAPPT can be with the assessment and yet agree it remains a SoM Assessment. In response to this I have worked with a concept of my training service supervisor, which he referred to as the 'Core Components' of the SoMA, and analysed the data to suggest what these might include. The Core Components can be considered as guiding principles or features of the assessment that CAPPTs currently feel are integral; what aspects can be variable, what is envisaged as being consistent across SoM Assessments from one CAPPT to another. Whilst the concept of Core Components is identified in response to this philosophical debate about how the CAPPT knows what the SoM Assessment is, how CAPPTs make use of the Core Components is considered within the next theme. This concept thus straddles both themes which are in close relationship with one another.

Whilst the emergence of the origin story of the SoM Assessment came late in the day, post data collection and analysis, it does confirm the innate creativity of this assessment which potentially sheds some light on the lack of published literature. Not until this story was shared by Ricky, was it confirmed how integral both flexibility and creativity on the part of the therapist are in this offer, at origin. Both flexibility and creativity could have been used as search terms in hindsight, but these features also speak to the subjective on-going developmental element of this assessment, which might make it hard to write about objectively, contributing to the lack of available literature. Perhaps without knowledge of 'the beginning', Ricky Emanuel's origin story,

it has been hard if not impossible for many CAPPTs to feel they can know much about the SoM Assessment, with confidence. This seems to speak to the air of mystery or '*aloofness*' that some participants spoke of, and that it is felt some CAPPTs can perpetuate in CAMHS, when resorting to '*the jargon*'.

5.2 Theme 2: How Child Psychotherapists Carry Out State of Mind Assessments

This theme considered how CAPPTS carry out the SoM Assessment. This is directly related to knowing what the SoM Assessment is and is therefore also subjective. In explaining how they do SoM Assessments, therapists confirmed through their descriptions that there is no uniform way of doing one. There were widely held assumptions about a general structure which included an initial or introductory meeting with the referrer, and then with the patient and family, followed by a series of individual sessions (most commonly three) for therapist and patient, and finally a feedback or review session in which the report was discussed and often shared. This format concurs with the original '*5-session model*' as described by Ricky Emanuel. In devising a SoM Assessment, the CAPPT needs to know the underpinning features of it, the Core Components, to be clear they are indeed offering a SoM Assessment. The Core Components included: '*Frameworks*'; the '*frame'*; and psychoanalytic '*tools*' (skills or techniques). These three spheres of the Core Components of the SoM Assessment are in relationship with one another. For each SoM Assessment the therapist draws upon the Core Components to construct the assessment in response to the particular patient. I argue it is the therapist's unique utilisation of the Core Components, which contributes to their own 'Act of Creativity' in composing the assessment, through

attuned experiences with the patient and thoughtful consideration of how to come alongside them in order to understand the view of the world that the child has in mind.

I understood the '*frameworks*' to encompass underlying psychoanalytic, attachment, developmental, and neuroscientific frameworks familiar to CAPPTs. The predominant framework was a psychoanalytic framework, subscribed to and made use of differently by participants and referenced explicitly or implicitly when explaining their formulations in case presentations. One participant referred to '*Memory and Desire*' (Bion, 1970) and another '*a sort of second-skin containment*' (Bick, 1968). No other specific theoretical references were made, but concepts named included: transference, countertransference, projection, symbolism, containment, attachment, and I felt projective identification was described. Frameworks were made use of intuitively, sometimes in sessions with the patient, but most commonly cited as drawn upon in supervision or personal reflection post-sessions.

The '*frame*' or setting was considered and settled upon to a large extent prior to the assessment beginning to '*minimise the unexpected*' (Beveridge, 2004). This included the CAPPT's way of setting up the assessment: how many sessions, the frequency and format of meeting (in person or online), the location/ room and resources that would be made available. This also included gathering a developmental history for the young person and information from the network about their perspectives on the young person and family. Final considerations related to how feedback was given, including the style of the report produced. It was not uncommon to finalise these decisions as

the assessment progressed but communicating this likelihood or need at the start, tended to be a part of preparing the frame, the more concrete containing aspects to the assessment. Participants newer to the profession expressed less certainty about the frame of their SoM Assessment, one continuing to offer additional individual sessions to a maximum of six. It is worth considering what may be lost and gained for the patient (and CAPPT) by meeting with a more certain or doubtful therapist in the SoM Assessment.

The final Core Component, psychoanalytic '*tools*', related to therapists' skills or techniques. The '*toolbox*' as coined by one participant, seemed to refer to the CAPPT's collective and selective capacities to make use of: close detailed observation, countertransference, transference, play, attention, listening, interpretation, formulation, reflection, questions. Intrinsic to every case study presented was use of observation, transference, and countertransference. Not all participants referenced all of the '*tools*', but most did. These psychoanalytically informed apparatus were seen mostly as distinct to and different from theoretical frameworks. The '*tools*' were made use of by the CAPPT, according to their clinical judgement of the experience with the patient being assessed, in conjunction with a developing hypothesis about the patient through the CAPPT's understanding of psychoanalytic theory.

Making use of theoretical frameworks and psychoanalytic '*tools*' or skills was not reported to be premeditated in ways that the frame was. Rather, tools and theoretical frameworks were expressed as being utilised instinctively, as part of assessment

sessions and in supervisions, and in response to what the patient brought. The Core Components of '*frameworks*', a '*frame*', and psychoanalytic '*tools*' are a part of every SoM Assessment, but there is, perhaps inevitably, variation within each. Each CAPPT has their own understanding of these components and makes judgements about what they hold of import or value, in each assessment scenario. A written report including a formulation or '*summary*' is viewed as a core outcome of the assessment.

It was fascinating to examine how participants approach carrying-out a SoM Assessment (Table 3). Each described a different starting point or way to begin. This demonstrated how uniquely responsive the CAPPT is to the patient in a SoM Assessment. The SoM is versatile yet through its Core Components it is robust enough to be utilised and adapted to meet the specific needs of the patient. This feature is evident from the earliest conception of the assessment, whereby the assessment was used not only with LAC children to help social workers, but also with dying children in hospital to support the staff working to care for them.

The degree to which CAPPTs view this assessment as one in which they have scope to respond creatively and flexibly develops with experience. There is a move away from wanting to '*know the protocol*', to a feeling that '*everyone must have different ways of doing*.' The participant who said, '*this is how it might play out in **my** mind*', demonstrated an awareness of the interplay of Core Components together with the referrer's question, and an understanding of the importance of responding freely to the patient, all resulting in that particular SoM Assessment. We can understand the value

accordingly of not being too certain or rigid in how one does a SoM Assessment. Opportunities to learn from, with, and about the patient, might be missed if the CAPPT were to adopt a 'one size fits all' approach. Lanyado's 2009 reflections of Winnicott's *Therapeutic Consultations in Child Psychiatry* (1971), suggest that Winnicott was thinking about a flexibility or creativity that is essential and valued within a psychoanalytic perspective. Although every SoM Assessment is unique, the endeavour as described by participants continues to be shaped by principles of evaluating pathology (in my training placement called 'presenting difficulties') '*against a background concept of age-appropriate developmental status in many areas of psychological growth*' (Edgcumbe 1995 as cited by Green 1995. p.176). Green's 2009 chapter suggests that Anna Freud's *Developmental Lines* (1965) and *Provisional Diagnostic Profile* (1965) '*still influence and anchor*' the ways in which many CAPPTs undertake assessments, albeit in a modified or updated form (p.178). Most therapists reported enjoying and valuing SoM Assessments for the freedom they afford to respond thoughtfully to the patient. Miller suggested the combination of '*anxiety-provoking brief work*' underpinned by '*psychoanalytically-based training and a background of work in depth*'… '*greatly add to our capacities to assess a child*' (2004, p.117), which seems to speak directly to the SoM Assessment.

This theme considered how CAPPTs carry out the SoM Assessment. I have suggested this relates to knowing what the SoM Assessment is, which is subjective, and has been further complicated without a published story of origin, until now. I suggest this subjective knowing is in part due to the individual use the CAPPT makes of their own internal world or mind in the assessment, the impact of their on-going personal growth, the cumulative experiences of doing the assessment, and what I suggest is a final yet

crucial aspect of this subjectivity -the CAPPTs flexibility and creativity in the spontaneous relational experience between child psychotherapist and patient in the SoM Assessment. It is the part described by one participant as '*who I am being*' and '*This is how it might play out in **my** mind*'. Both responses indicative of the flexibility and creativity of the SoM Assessment, because it is how one therapist makes use of their wide-ranging, continually-developing, internal resources, to meet with and attempt to relate to a patient in difficulty. Symmington's book, *Becoming a Person through Psychoanalysis,* came to mind. Symmington explores aspects of the analyst's and patient's development, suggesting '*the patient makes the analyst*', referring to Kant's assertion that '*in imagination lies the core of understanding*' adding '*imagination is **the** tool of the analytic endeavour*' (2007, p.29). Symmington posits there can be '*an inner act of freedom*' on the part of the analyst in response to the patient, understood by me as a kind of spontaneous intuitive response made accessible through '*analytic technique*':

> *… the soul of analytic technique is to free analyst and patient from the normal social constraints and so favour development of the inner world… My contention is that the inner act of freedom in the analyst causes a therapeutic shift in the patient and new insight, learning and development in the analyst… the essential agent is this **inner** act of the analyst and that this inner act is perceived by the patient and causes change (2007, p.58).*

In the case of the CAPPT's SoM Assessment this could be thought of as the way in which they make use of their '*toolbox*' and the Core Components to respond freely to the patient. Thus, the SoM Assessment is a precious commodity in current CAMHS, being the only assessment I know, to provide an opportunity for a flexible, creative, and attuned response to the patient. When the therapist is free to respond, there can

be an experience between therapist and patient, who for Symmington (2007) comprise '*a single system*', in which the therapist is helped by the patient to understand something of their predicament and can respond spontaneously such that this understanding is then felt to be understood by the patient (Bion, 1962) -the value of which is experienced by the child and network, in a SoM Assessment.

5.3 Theme 3: The Contribution of the Psychoanalytic State of Mind Assessment to the Current CAMHS Offer

CAPPTs views about the contribution of the SoM Assessment to contemporary CAMHS held a sense of urgency: the SoM is a unique and valuable assessment for the MDT and greater use could be made of it. The SoM Assessment brings a psychoanalytic voice to MDT discussions about complex patients, benefitting colleagues, patients, and services by bringing an added depth of perspective through a brief intervention (Mees, 2017). In the current CAMHS climate which is overwhelmed with referrals and struggling with issues around capacity, waiting times and staff retention (as seen through my own experience in CAMHS), the SoM Assessment can get to the core of complexity quickly (Lanyado, 2009; Rustin, 2004a), offering a detailed formulation for professional networks and recommendations in the best interest of the development of the young person and family. As a parallel process the assessment was identified by participants as key to offering the MDT insight into how the child psychotherapist thinks and works (Petit & Midgley, 2008; Crockatt, 2009). There was a sense of this being achieved to varying degrees, which participants wanted to reflect on. My observations and reflections about how the CAPPT uses language, as demonstrated in interviews about the SoM Assessment, felt pertinent to this complexity and consideration is given to the dynamic between the contribution of the SoM

Assessment to the MDT and the voice of child psychotherapy in CAMHS. As generalised by one participant, '*we would do well to crisp it up… to have some simple explanations of what we do.*' Participants suggested it is important to be able to put into words succinctly and straightforwardly what the psychoanalytic perspective offers. There is a need for the SoM Assessment and child psychotherapy more broadly to be accessible and integral to the MDT and CAMHS.

The SoM Assessment is described as '*a bigger package*' because it offers a therapeutic experience to the patient and family, it offers consultation and recommendations to the network, simultaneously assessing the patient on multiple levels and offering formulation of complex difficulties (Mees, 2017; Hinshelwood, 1991):

The contribution of this assessment to contemporary CAMHS is relevant on many levels:

a) **Patient and family level**

   The therapeutic encounter offers containment, understanding, making links between the patient's past and their current presenting difficulties, offering a sense of hope through recommendations and liaison with the network (Rustin, 2004a). Several participants called it '*a dose of psychoanalytic treatment*'.

b) **Network and professionals' level**

   A psychoanalytic perspective is shared on complex, worrying, or stuck cases. Opportunity is provided for collaborative working, consultation, and advice, uniting professionals, providing hope and containment to the network.

c) **MDT level**

As for b) and additionally: It often reduces the need for on-going referrals; treatment plans are clarified; the MDT's workload of complex cases is shared meaning clinicians feel supported; provides an alternative when other things have been tried.

d) Personal (therapist) level

A source of CPD; develops capacity and confidence in using one's own internal resources; provides opportunity to work and learn collaboratively; provides opportunity to communicate a psychoanalytic voice.

e) Service level

Benefits from the MDT feeling less stuck/ unable to make treatment offers; morale and capacity improves when clinicians feel supported by colleagues; reduction of some waiting lists - due to recommendations made and/or SoM being '*therapeutic in itself*'; relationships with other agencies and professionals nurtured; timely and cost-effective as '*brief yet rich*'.

Participants held a strong shared belief that there is significant untapped potential of the SoM Assessment which caused one therapist to refer to it as a '*hidden gem*', due to the multiple levels of contribution it makes and comparative under-use of it at present. The SoM Assessment was described as reflecting on the internal world of the child, their external environment and circumstances, their relationships (interpersonal dynamics) their capacity to think and make links (intra-psychic processes), their capacity to relate to the therapist and their understand of their own difficulties and their sense of self. Additionally, it considers those caring for the child, their ways of perceiving the child, the developmental history of the child, paying attention to

experiences which might have been traumatic for the child and/ or their family. The CAPPT's assessment and formulation from these multiple spheres of the SoM Assessment and importantly the interplay between them, were identified by participants as qualities no other assessment in CAMHS offers, providing a depth of understanding needed to unpick the more complex cases in CAMHS enabling informed treatment offers (Davids, Green, Joyce, McLean, 2016; Rustin, 2000).

All participants agreed that those MDTs who have experienced referring a patient for a SoM Assessment have developed a '*felt sense*' of the assessment, an understanding more broadly about the work of the CAPPT, an interest in the psychoanalytic voice. Experience of it brings requests for the SoM assessment for other patients, colleagues feeling aided by the thoroughness of it, the formal feedback, and recommendations. Participants agreed the MDT needs the SoM Assessment offer, argued to be the only flexible and responsive assessment tailored to the patient in CAMHS, through which the CAPPT informs the network and consults to the referrer, thus contributing to the overall understanding of a case (Green, 1995; Crockatt, 2009; Emanuel, 2023, Appendix B). An assessment offered by a CAPPT in CAMHS is unique to assessment work undertaken by other professionals within the MDT (Petit and Midgley, 2008).

There is a tension here. CAPPTs have an extensive, rich, bespoke training, both pre-clinical and clinical years are spent developing professional and personal capacities, supporting the CAPPT to respond on multiple levels through extensive clinical experience, much more than most other mental health trainings allow. Yet in this

richness lies complexity as there is inherent privilege in the CAPPTs training in comparison to many other MDT trainings through the length and depth of it. To compound this, the CAPPTs ways of working often require more time than other MDT disciplines do. This in turn can breed competitiveness and envy, which can undoubtedly enter into an MDT '*entrenched*' state of mind (Waddell, 2002). It might be with this backdrop that some unconscious attacks are made on child psychotherapy, on perceived '*fancy ways and our fancy thinking*', so that the SoM Assessment and the psychoanalytic voice '*needs to be promoted*' within the MDT.

The most commonly cited reason for a SoM Assessment was to unpick '*the ASD/ attachment/ trauma muddle of concerns*', but closely following this were requests for the SoM to offer a formulation of what might be causing communication breakdowns or regressions, offering an understanding of alarming or risky behaviours, and offering opinion on what might be needed with regards to placements for LAC. The range of case presentations was illuminating due to the breadth of wide-ranging presenting difficulties and the high level of co-existing difficulties within a single case example. Appendix J details presenting difficulties and participant's descriptions of how it felt being with their patient. These descriptions of CAPPTs' countertransference conveyed a sense of their engagement with and understanding of the patient, which through the SoM Assessment, was shared with the MDT.

Rhode's paper, 'Assessing children with communication disorders' (2004), explains the CAPPT's capacity to identify and assess symbolic levels of communication is

particularly relevant to young people on the neurodiverse spectrum, of whom a large proportion of SoM Assessments are offered to. In citing Alvarez, Rhode suggests that through assessment, '*the symbolic level at which the child is operating at any moment*' can be assessed, which in turn enables the CAPPT to '*phrase our own communications in ways that he* [patient] *can hear*' (2000, p.9). This places the SoM Assessment as an assessment not only able to help assess children with communication difficulties, as many children on the neurodiverse spectrum have, but vitally as an assessment by which the CAPPT can suggest how to communicate with these children, which many MDT colleagues voice a struggle to know how to do. Thus, the SoM Assessment can be the start of a treatment option, or a therapeutic intervention in itself, for a young person who struggles to communicate (for whatever reason in my view), who has therefore likely also suffered a deficit of being adequately responded to. The potential of the SoM Assessment in helping to identify not just if the presentation could be autism, trauma, or attachment difficulties (often it is combinations of these), but how to begin to make a therapeutic offer to these children, seems vitally important. The SoM Assessment in my mind holds great potential within the field of assessment of neurodiversity, as well as of trauma and attachment difficulties, and their overlaps, specifically due to the CAPPTs training which develops the capacity to respond making use of our own internal worlds, and as such is a response well-equipped to consider and assess '*elemental terrors to do with annihilation… the child's continued existence*', which are likely '*impossible to convey in words*' (2004, p.10) and often feature in non-verbal presentations or those with communication difficulties. An extended and sensitive assessment is essential for such complex situations.

It is agreed the '*idea of applied psychoanalysis remains central to psychoanalytically trained psychotherapist's approach to consultations*' (2009, p.195; Miller, 2004; Rustin 2004a) and offering short but timely interventions is often more powerful than being left on a waiting list for longer treatments. The SoM Assessment, which is both '*therapeutic in itself*' and consultative, makes this a viable possibility in CAMHS. Lanyado suggested timeliness is '*an important aspect of the "demand feeding" aspect of consultation work and the flexibility of approach it implies*' (2009, p.197). Mees (2017) suggested the contribution of the SoM assessment is specific to each request made for it, explaining the perceived usefulness of it to the referring colleague (and patient referred I would argue), will depend on the meaning behind the referral request. Rustin adds depth to this idea suggesting it is the essence of a '*shared task*' which can be the fundamental point of change -in the SoM Assessment the shared task is not simply between child, family, and consulting therapist, but the MDT and all members of a network around a child, getting '*to the heart of what matters at that moment*' (2004, p.2-3).

Limitations of the SoM Assessment were few in the minds of the participants. The emotional burden was acknowledged, '*I struggle with the task*', confided one participant, particularly the kind experienced with non-verbal patients as exemplified in case descriptions. Lanyado acknowledges how '*emotionally demanding*' aspects of consultation work can be, because the therapist '*must be highly attuned to the patient all the time, since the SOS can be weak and is not always easily recognised*' (2009, p.202). One therapist felt that although they didn't view the slowing down and '*time to*

think' afforded by the SoM Assessment to be a negative, there might be MDT colleagues who wanted action or a decision to be made, and as such might not appreciate this aspect of the SoM Assessment.

Every participant agreed greater use could be made of the SoM Assessment in their teams, although three did feel their MDT understood and valued the assessment highly, MDT colleagues requesting it independently now. Other participants felt the assessment was not well known or understood by their MDTs. Some described it being '*not really in the minds of the team*'. All participants agreed '*we need to talk about it more openly*'. This led me to reflect upon an interesting phenomenon in the interviews: When CAPPTs talked about their conceptualisations of the SoM Assessment, they all encountered a struggle to explain their thinking clearly at one or more times. Participants acknowledged and reflected on this to varying degrees. During this part of the interview, therapists often attempted to fill the space with '*ums*' and '*ahs*' and the oft repeated '***you know***' in a sort of pleading or convincing tone. I was frequently left feeling unclear, distanced, and as if the complexity of their thinking was impenetrable. In contrast, when I then asked them to share a clinical example of a SoM Assessment they had carried out, every participant captured my attention and conveyed a deep understanding of their patient through the case description. I felt I understood how they had come to their formulation and why they made the recommendations they did. I wondered what this might help me to think about in terms of the ways in which CAPPTs spoke about their conceptualisations of the assessment, versus the ways in which they spoke about their experiences with the patient in the SoM Assessment. The first left me feeling distanced and unsure, the latter engaged me and felt meaningful. I reflected

upon the language used by the therapists to talk about these two very different types of their understanding. I was left with a feeling that in talking about their theoretical conceptualisations, CAPPTs used a language that was different to the one they used to talk about their experiences (Dufresne, 2017). In sharing their theoretical thinking, their conceptualisations, their language became heavy with psychoanalytic terminology, or attempts 'to fill the space'. I found myself trying to keep up with individual word meanings and I lost a sense of the whole communication. It felt like a 'Private Language' (Wittgenstein cited in Candlish and Wrisley, 2019).

When participants spoke about their experiences with the patient, their language remained the kind of language I felt they would be talking to their patient in. They made word choices I didn't need to decode; it was accessible, straightforward, and importantly, I felt it was emotionally communicative about their patients. This finding developed into the final sub-theme, and left me considering, how does the CAPPT use language to communicate the voice of child psychotherapy in the MDT. It seems vital the CAPPT is supported to enhance their natural capacity to be communicative in a straightforward and meaningful way, not to resort to using '*the jargon*' but to use an 'Accessible Language', when offering the voice of child psychotherapy within the MDT through the SoM Assessment.

5.4 Reflexivity

I have included reflections on my role in the processes, decisions, and development of this project as they occurred chronologically, through the writing up of the final project.

Summarised now are conclusions drawn from these reflections about the experiences of conducting this study.

My initial project idea included an audit of SoM Assessment referrals in my service. I had wanted to interview referring colleagues, because I wanted to open something up; to approach the project not just from within the comfort of our private CAPPT world but to hear more from the MDT directly about how they understand and value the SoM Assessment, and the contribution of a psychoanalytic perspective, through this offer. I had wanted to explore demographic information of young people referred for SoM Assessments; participants anecdotally felt more boys are referred for the assessment, and of those most were thought to be from ethnic minorities -an exploration of demographic representation would be interesting in future research. A dramatic rethink of the project was required due to the impact of the Covid-19 Pandemic which resulted in a sudden unprecedented reduction then temporary cessation of referrals for the SoM Assessment in my service.

In the adapted research question that came to fruition and is the project here presented, I made conscious attempts to place to one side my personal experiences and feelings about the SoM Assessment, because I was curious to learn about the thoughts and views of other CAPPTs. Nonetheless my experiences and thinking will have impacted my assumptions and interpretations of the data, on some level, and to some degree. I find the richness of what can be offered by the CAPPT in the SoM Assessment to be unique to all other CAMHS assessment offers. I have experienced how helpful this assessment can be particularly with complex cases where it is hard to

unpick the *'muddle of concerns*', as identified, and confirmed by participants interviewed. Some participant's views spoke for my own. This made it difficult at times not to slip into a 'we' state of mind about the SoM Assessment, and I had to work hard to recognise these moments and to pull myself out again, as I attempt to retain a degree of impartiality from the data.

It has felt frustrating and confusing at times to be chasing a history. It is only within the final weeks of completing the project that I gained clarity about the establishment of the assessment as it is currently named, from Ricky Emanuel. I have wondered why it has been so difficult to trace a coherent story about the development of the SoM Assessment. I suspect there is an important link between my quest for an origin story, and some of the meta-themes within my discussion, namely the experiences of feeling uncertain or doubtful and the extent to which this fuels a necessary creativity or freedom for the therapist, tensions around knowledge and expertise with regards to our clinical offer, and the relationship between a frame or structure and the scope this allows for therapeutic flexibility, upon which a psychoanalytic endeavour relies. I have come to consider that it might in part be the inherent fluidity and creativity in our work as CAPPTs, but also the skills of working with both conscious and unconscious processes, and each particular CAPPTs ways of doing this, which make it difficult to put into words succinctly something that has to be experienced or felt to be known (Bion, 1962; Wittgenstein 2009). If that is the case, perhaps an effort can be made to cohere around such a statement, instead of maintaining elusive feeling mysteries about psychoanalytic psychotherapy through the SoM Assessment in CAMHS. Perhaps there is important value in being uncertain, which from my experience

promotes flexible and creative ways of thinking, allowing adaptation and exploration so that we each find our ‘own ways of doing’, which can be shared and utilised by others as a part of an on-going creative process of learning.

I have learned more about the inherent flexibility of the SoM, which has developed my confidence in creating the SoM Assessment that feels appropriate for an individual referral and patient. I consider the particular contribution of my training service supervisor, who suggested I undertake a SoM Assessment as my first piece of independent clinical work in CAMHS, to be pivotal. It was his understanding of the assessment and his help in supervision, that enabled me to learn not to fear the scope for flexibility and creativity that the SoM Assessment offers, but to embrace this and utilise this as a way of exploring and developing my own internal responses to a patient in order to establish a formulation. This learning was in turn something I could share with my MDT, bringing the psychoanalytic voice to our discussions about patients, which in my experience was received well.

I chose to include my observations about language being used differently by CAPPTs as an exploration of something personally meaningful that interviews illuminated. The concepts of a ‘Private Language’, and an ‘Accessible Language’, felt pertinent to my experience as a novice psychotherapist of feeling on the outside of a specialist world to which I was not sure I would gain access. In my previous career as a teacher, I learned the importance of and felt passionate about, being able to communicate straightforwardly. It mattered to me that languages of learning and understanding were

accessible. In CAMHS, I have been struck by language used that can feel exclusive, or accessible only to certain clinicians (arguably each MDT profession has a private language of their own). I have wondered about what this communicates about separate professional identities, professional relationships between disciplines, and how this may be reflective of certainty and doubt in professional attitudes and clinical work, which are important elements of MDT functioning.

Finally, through supervisory support, I have come to understand that my own countertransference to the participants and the meta-theme of 'us and them', is present within the project presented, as I actively wrote about my findings in language that I felt was true to participants and the case studies they shared. I consider this an attempt not to replicate an 'us and them' quality with regards to me-as-researcher and participants-as-psychotherapists, in the sense of private languages.

5.5 Limitations and Scope for Future Research

This project's contribution is both necessary and new. It speaks to how the SoM Assessment provides great scope within CAMHS, offering a depth and richness that is unique to other assessments offered at present. This is due to the inherent flexibility of the assessment, as well as the innate creativity of the CAPPT in the responsive offer, demonstrating attunement and attention to the individual patient's difficulties, as well as the problem or complexities faced by the referrer. Like the assessment itself, research on it could potentially go in many different directions. Different aspects will be helpful to different child psychotherapists. As participants interviewed have demonstrated and shared, it can be difficult to articulate working with unconscious and intrapsychic processes, utilising therapeutic intuition, and the development of and engagement with one's own internal world resources. These facts may also go some way to explaining the lack of literature available on the assessment. There has been something of a mystery about the origins of the SoM Assessment for these participants. The reasons for, and impact of how and why this may have occurred, would be worth exploring. Ricky Emanuel's explanation of the narrative of the SoM Assessment, identifies close links with the psychiatric mental state examination. It would be interesting to investigate this relationship, exploring the similarities and differences between the two types of assessment, and the roots of each which I sense are closely related. Perhaps again in ways which are hard for CAPPTs in their contemporary work to know about.

Several participants urged for a collection of case examples, a kind of reference point for the CAPPT where they might be able to gain more of a sense of how SoM Assessments are carried out, the degree to which there are variations in how they are done, and what contributes to this. A collection of SoM Assessment case studies would also demonstrate the range of presenting difficulties that the assessment can offer perspectives on, ways in which the assessment can be tailored to the individual patient, and ways in which each CAPPT makes use of their own internal resources in the assessment. It would also be interesting to collate and analyse a series of SoM Assessment reports, examining how formulations are developed and shared, identifying the 'Core Components' of reports too.

I maintain it would be valuable to gather data from referring MDT colleagues. Understanding how their clinical experiences influence them to refer for SoM Assessment (or not) and gathering their views on the contribution of the psychoanalytic voice through the SoM Assessment would be valuable to all CAPPTs interested in learning more about ourselves as a discipline, from the perspectives of our MDT colleagues. I think this is a vital avenue to pursue if we are to learn more about our position within the MDT and how we can facilitate a psychoanalytic perspective becoming further embedded in the MDT. Further investigation of the 'Private' and 'Accessible' language concepts, as demonstrated through participants speaking about SoM Assessments would be valuable to the profession, with regards to the role and function of the psychoanalytic voice in MDTs. My sense is that many of our MDT colleagues feel things in response to their complex and confusing patients, and I wonder about the CAPPT's capacity to share our thinking to support our colleagues in

developing their use of observation and the countertransference, in assessment of complex clinical situations. I believe there is helpful work we could do in sharing our psychoanalytic '*tools*' with our teams and services.

Finally in terms of future research, I believe there is a strong argument for the SoM Assessment becoming an integral part of assessment for neurodiversity. I have personally found this a helpful resource in unpicking the often-overlapping features of ASD, ADHD, attachment difficulties and trauma responses. Vitally and unlike much other assessment undertaken around ASD, the SoM Assessment does not aim to provide a diagnosis, but to offer a possible hypothesis and recommendations to the network about how to support emotional development. The SoM Assessment is thus a hopeful assessment as well as a meaningful relational experience, offering something quite different to patients with neurodiverse presentations, to the manualised ways of assessing for neurodiversity. The SoM Assessment makes an invaluable contribution to a holistic view of a child. This is helpful to the patient's experience of being understood, and parents and networks' experiences of having a child with difficulties that are hard to unpick.

It would be helpful to continue to add to the limited literature available about the SoM Assessment, both raising the profile of the assessment within the profession, and in turn raising the profile of the psychoanalytic voice within the MDT and CAMHS.

6.0 CONCLUSION

The aims of this research study were identified as follows:

1. To understand how CAPPTs think about the psychoanalytic SoM Assessment.
2. To explore CAPPTs experiences of offering SoM Assessments in CAMHS.
3. To understand if there are identifiable aspects of case presentations that make them particularly suited to a SoM Assessment.
4. To add to the literature available on the SoM Assessment.

All four of these aims have been achieved within the scope of this small-scale research project in which nine participants shared their understandings and experiences of the SoM Assessment, through their training and in work in CAMHS. The SoM Assessment is a critical piece of work offered by CAPPTs: providing a psychoanalytic way of understanding the child's view of the world, gathered through the experience of being with them and in connecting with the network around them. It results in formulations and recommendations that can be shared, which may be particularly potent when a patient is perceived to be developmentally 'stuck'. A chief conclusion is that there is more to be explored in relation to the SoM Assessment, detailed in: 'Scope for Future Research'.

The findings of this project confirm there are multiple strands that contribute to the CAPPTs thinking about the SoM Assessment. These different aspects are in relation to one another, and each is valued and helpful to the therapist in different ways. There is no set protocol, or single way to carry out a SoM Assessment, but there is an original '5-session model' as depicted by Ricky Emanuel (Appendix B private communication

2023). Understanding that there is and will continue to be development of the assessment, due to variety in ways of learning about the assessment, the extent to which each child psychotherapist makes adaptations to the assessment as they develop individually, and because each CAPPT responds to each referral and patient spontaneously, is a crucial part of knowing the SoM Assessment. There is a shared sense the assessment has a structure that takes hold and remains in the mind of the CAPPT, over time and with experience, which I have suggested can be known as 'Core Components' of the SoM Assessment. These Core Components currently include: The '*frame*', theoretical '*frameworks*' drawn upon by the CAPPT, and psychoanalytic '*tools*' utilised by the CAPPT. The Core Components are made use of subjectively by the child psychotherapist to shape the SoM Assessment for each patient referred, in response to the referring question.

Doubt and certainty are necessary sides of one conceptual coin. One participant named '*not being too, too certain*', as an important stance within the CAPPT. Participants with less clinical experience were keen to ask me, '*is an assessment for psychotherapy the same as a State of Mind Assessment?*', and '*I'm curious, have people been giving very different answers?*' There is an inherent openness and curiosity in these questions that I would argue is a vital part of a psychoanalytic approach. This uncertainty or curiosity was evidenced less in interviews with more experienced clinicians.

Most participants indicated an awareness of something we do with language that turns it into 'the *jargon*', when speaking about conceptualisations. Many shared making active choices to not use some words and terms including '*psychoanalytic*' and '*State of Mind Assessment*' for fear of being unpalatable, or '*fear of being rejected*'. In omitting words and explanations, or by resorting to '*the jargon*', it is my perception that we risk perpetuating a kind of distance between us and the MDT, repeating a kind of aloofness. Some therapists in this study are calling for a shared and straightforward language, instead of a private language, which we can use with families and colleagues alike, making what we do, and psychoanalytic thinking, more accessible: if *'they* [CAPPTs] *are to be able to share their understanding*' (Petit and Midgley, 2008, p.151). In this assessment it is the therapist's capacity to communicate what they learn through the experiences of being with the young person at that point, that is pivotal. This feels something of a paradox when the project has unearthed something complex about the nature of how we use language, both to maintain difference and a separate professional identity, but also to bring together concerned parties around a child and ease suffering. It seems the CAPPT uses language in both defensive and developmental ways. This is in turn often felt and experienced very differently by those on the receiving end of how the CAPPT communicates.

Implications for practise:

1. For the SoM Assessment and the psychoanalytic voice to be integrated further into MDTs, CAPPTs need to develop and maintain accessible language to share our understanding.

2. The SoM Assessment is an important resource for contemporary CAMHS, suitable for wide-ranging clinical complexity, supporting the MDT with '*perplexing*' cases, and providing opportunity for the CAPPT to work creatively.
3. Whilst the SoM Assessment is a flexible assessment, it can be known by its 'Core Components'. This way of conceptualising the assessment can be shared with teams, illuminated by clinical material, which the CAPPT is skilled at sharing.
4. Offering a SoM Assessment as a brief yet timely intervention is perceived to have the power to result in '*big shift*' (Rustin, 2004a). It is developmentally helpful to both patient and child psychotherapist, as well as referrer and the wider network around the child.

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APPENDICES

Appendix A - Acronym List

Full title	Abbreviated acronym
State of Mind Assessment	SoM Assessment
Child and Adolescent Mental Health Services	CAMHS
Child and Adolescent Psychoanalytic Psychotherapist(s)	CAPPT(s)
Multidisciplinary team	MDT
Association of Child and Adolescent Psychotherapists	ACP
Looked After Child/ren	LAC
National Health Service	NHS
Reflexive Thematic Analysis	rTA
Revised Provisional Diagnostic Profile	RPDP
Continued Professional Development	CPD

Used interchangeably:

child, young person, patient

Appendix B – Personal Communication from Ricky Emanuel

Summary of personal communication with Ricky Emanuel in March 2023:

Through personal communication with Ricky Emanuel, I have recently understood that the idea of this type of assessment came out of two sources. The first was during the early 1980's, when Ricky Emanuel was head of child psychotherapy services in Camden and Islington community, and a project was set up with social services in Islington whereby Ricky and his child psychotherapy colleagues were trying to define what a child psychotherapist could offer to social workers in order to integrate CAMHS thinking into social services. These child psychotherapists thought it would be helpful if social services could have some idea about the state of mind of the children they were wanting to place, as therapy itself could not be offered in such uncertain environmental circumstances. A kind of protocol was established whereby the child psychotherapist would meet with the people asking for the assessment, and then see the child on their own 3 times, and then meet with the referring people to feedback at the end. In all a 5-session package. Ricky Emanuel came up with the name of the assessment then. There was a desire to distinguish what child psychotherapists did from Psychiatry, who did mental state examinations or assessments following a standard protocol. The words were switched around to distinguish the two types of assessment. It became popular with social services but also with child guidance as it was called then, where two types of assessment were offered by child psychotherapists. One was for the suitability of psychotherapy, and the other a State of Mind, to be used in another decision-making process which may or may not include therapy as a recommendation. This model was also used at the Royal Free in liaison

work on the ward where children undergoing bone marrow transplants and other invasive procedures and who were sometimes too ill to use standard therapy. It was felt to be helpful to have some insight into how they were experiencing their world and the treatment, and the meaning they were making out of being so sick and sometimes going to die. This became another popular use of the child psychotherapist's State of Mind Assessment. Ricky is glad it has been adopted fairly widely.

Appendix C - Semi-Structured Interview Schedule

The Tavistock and Portman NHS
NHS Foundation Trust

Semi-structured interview schedule for psychoanalytic Child and Adolescent Psychotherapists about their thinking and experiences of State of Mind Assessments

Title: How do psychoanalytic Child and Adolescent Psychotherapists think about State of Mind Assessments and what are their experiences of carrying them out?

Welcome: explanation of it being a semi-structured interview lasting approximately 60 minutes. Remind them that they are welcome to talk freely about the topic: their personal thinking, reflections and experiences of State of Mind Assessments in their clinical work. Explain that there will be an opportunity to reflect in more detail about a specific case (past or present) that may feel relevant/helpful to the wider context.

Defining State of Mind Assessments:

- How would you describe a psychoanalytic State of Mind Assessment?
- Personal opinion? Institutional?
- What is your understanding of it? The purpose? How different from a generic assessment? From a psychiatric mental state examination?

Thinking about State of Mind Assessments:

- Based on your training and experience, how do you think about State of Mind Assessments?
- What do you value/ not value about State of Mind Assessments?
- This may not be the same for everyone?
- How has your thinking changed/developed/refined -as a result of what?

Your experience:

- Have you experienced any increase/decrease in the number of referrals coming in for State of Mind Assessments? What are the contributing factors?
- How are State of Mind Assessments allocated to CAPTS within your service/team? Rationale?
- Can you think of a specific case, historic or recent, and tell me a little bit about your understanding of why this particular CYP was referred for a State of Mind Assessment?

Features present in case presentations for referrals of State of Mind Assessments:

- Is it possible, from your experience/ practice, to identify any aspects that are common among case presentations referred for State of Mind Assessments? What do you make of this?
- Do you have any personal hypotheses about clinical case presentations that may/ may not benefit from this assessment in particular -what are these personal ideas based upon?

Carrying out a State of Mind Assessment:

Please think of and keep in mind one particular State of Mind Assessment that you have carried out:

- What was the reason for the State of Mind referral?
- Can you briefly outline the procedural steps/process? Was this 'standard' or different somehow; if so why?
- Does the sequence of the procedural steps have an impact upon the assessment? For CAPT or service user/patient? How so?
- How do you feel the CYP/their family understood the assessment and the reason for it?
- What was it like in the assessment sessions with the individual CYP?
- What do you as a CAPT bring to the assessment sessions?
- How was the report written up/ feedback given? To whom? What was made of this do you feel?
- Who is the assessment most useful for -referrer/CYP patient/ their family/ the team/service? Please explain.

Future:

- What do you feel is the value of this assessment? Are MDT clinician-colleagues aware of the assessment? What could be done to improve understanding of this assessment -including when/ when not a helpful clinical treatment offer; how well-informed services users are about what the assessment will entail before you begin?

End:

- Having had this opportunity to reflect and talk about their thoughts around psychoanalytic State of Mind Assessment, how would they now explain what a State of Mind Assessment is to someone who doesn't know -MDT colleague or service user/their family?
- Anything not asked but would like to mention?
- Thank them for taking part.
- Any questions or want any further information to contact me.

- Signpost them to colleagues, supervisors and senior staff who are within the clinic at that time if they need support following the interview discussion. Send debrief out to them.

Appendix D – Recruitment email

The Tavistock and Portman NHS
NHS Foundation Trust

Dear colleague,

I am about to embark on my Doctoral Research Project as part of my Child and Adolescent Psychotherapy training at The Tavistock and Portman NHS Foundation Trust. I am contacting you as a fellow Child and Adolescent Psychotherapist working within [removed] NHS Trust CAMHS, to see if you would be interested in taking part.

The project title is: How do psychoanalytic Child and Adolescent Psychotherapists think about State of Mind assessments and what are their experiences of carrying them out?

I am interested in exploring your personal thinking about State of Mind Assessments and your experiences of carrying out the assessment within CAMHS. I hope the study will provide Child and Adolescent Psychotherapists, both trainee and qualified, with a space to reflect and share your perspective about this assessment, and to consider what it is like to engage in a State of Mind Assessment. The conversation may potentially benefit your own clinical practise by prompting further thinking about the value of this assessment within CAMHS, including when it might not be clinically indicated and why. I am also hoping to add to the available literature on this specialist assessment.

I would like to invite Child and Adolescent Psychotherapists who work within [removed] NHS Trust CAMHS and have experience of undertaking at least one State of Mind Assessment, to take part in a semi-structured interview to discuss your thinking and experience. These interviews will be guided by me and last approximately 60 minutes. The interview could take place within your usual place of work if it is possible to book a confidential space for the duration of the interview. If due to Covid-19, or a difficulty with your clinic accommodating the interview face to face, it is not possible to carry out the interview in person, the interview would take place by phone or video-call. All interviews would be audio-recorded and transcribed.

If you are interested and willing to take part, please find attached a participant information sheet and consent form. I look forward to hearing from you.

Kind regards,

Appendix E - Participant Information Sheet

The Tavistock and Portman NHS
NHS Foundation Trust

Participant Information Sheet

Title: How do Psychoanalytic Child and Adolescent Psychotherapists think about State of Mind Assessments and what are their experiences of carrying them out?

What is the purpose of this study?

The study is explorative and aims to better understand the perspective, experiences and personal thinking of psychoanalytic Child and Adolescent Psychotherapists about the psychodynamic/psychoanalytic State of Mind Assessments they carry out with children and young people in CAMHS.

This is a specialist assessment carried out by Child and Adolescent Psychotherapists which usually takes the format of an initial appointment with the referred child or young person and their family or carers, followed by three individual sessions for the child/ young person, concluding with a final joint appointment with the child/ young person and family or carers during which feedback is shared by the assessing Child and Adolescent Psychotherapist.

The project is not exploring psychiatric state of mind assessments.

Who is conducting the study?

My name is Laura de Graaff.

I am a Child and Adolescent Psychotherapist in doctoral training at The Tavistock and Portman NHS Foundation Trust. I work in CAMHS within [removed] NHS Trust. This project is being sponsored and supported by The Tavistock and Portman NHS Foundation Trust as a part of my doctoral qualification and is going through all relevant ethics approval (TREC). This course is overseen and certified by The University of Essex.

What's involved?

Explanation: purpose of and background to research

The project seeks to find out how psychoanalytic Child and Adolescent Psychotherapists think about State of Mind Assessments, and what their experiences

of carrying out this specialist assessment are. The study aims to explore if there are specific aspects of Child and Adolescent Mental Health (CAMHS) case presentations which make them particularly suitable for this type of assessment; when, how and why this assessment might be carried out, and what the experiences of doing so can be like for the Child and Adolescent Psychotherapist.

There is a gap in the current literature available about psychoanalytic State of Mind Assessments. It is hoped that the study will be able to contribute to the literature available, and that it will also benefit the CAMHS services which participants work in by providing an opportunity for Child and Adolescent Psychotherapists to reflect upon their clinical practice, and consider aspects of resource use (and potential gaps in the use) of State of Mind Assessments.

What will participating in this project involve?

Child and Adolescent Psychotherapists working within Child and Adolescent Mental Health Services (CAMHS) in [removed] NHS Trust, both qualified and trainee, will be invited to participate in an individual semi-structured interview that will last up to 60 minutes and will be audio recorded. The intention is to conduct these interviews face to face, however, if this is not possible due to Covid-19, they will take place via telephone or video link and be recorded. I am willing to meet clinicians at their clinic for a mutually agreed time in order to minimise disruption to their working day. If interviews take place via phone or video link I am willing to meet at agreed times outside of the clinical working day. A one-off time-limited interview is the method of data collection, therefore potential involvement should not take away from patient care.

All participants need to have carried out at least one State of Mind Assessment within the NHS Trust CAMHS in which I trained and they were working at the time of interview.

Participants can withdraw without giving any reason at any time up to two weeks after interviews. This timescale has been decided as the data will then be being processed and analysed. If participants decide to withdraw all data collected will be destroyed confidentially.

Criteria to take part in the study:

- Currently working as a qualified or trainee Child and Adolescent Psychotherapist within NHS Trust CAMHS services.
- Experience of carrying out at least one psychoanalytic State of Mind Assessment within the NHS Trust CAMHS teams.

What will happen to any information given?

The Tavistock and Portman NHS Foundation Trust is the sponsor for this study based in the United Kingdom. I will be using information from participants in order to undertake this study and will act as the data controller for this study. This means that I am responsible for looking after participant information and using it properly. I will keep identifiable information about participants from this study for 5 years after the study has finished. The interview will be audio recorded and transcribed by myself.

Rights to access, change or move information are limited, as I need to manage information in specific ways in order for the research to be reliable and accurate. To safeguard the rights of participants, I will use the minimum personally identifiable information possible. I am the only person who will have access to information that identifies participants. I may be assisted in the analysis of this information by senior colleagues, but they will not be able to identify participants.

Quotes from the transcript will be used in the write up of the project but these will be de-identified. However, please note, it is possible that other colleagues within the Trust in which I trained and participants worked, may recognise colleagues in some of the quotes used, although every effort will be made to prevent this. Any extracts quoted in the research report will be anonymous.

All electronic data will be stored on a password protected computer. Any paper copies will be kept in a locked filing cabinet. All audio recordings will be destroyed after completion of the project. Other data from the study will be retained, in a secure location, for 5 years.

If you would like more information on the Tavistock and Portman and GHC privacy policies please follow these links:

https://tavistockandportman.nhs.uk/about-us/contact-us/about-this-website/your-privacy/

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

You can find out more about the legal framework within which participant information will be processed by contacting the sponsoring Trust's Clinical Governance and Quality Manager, Irene Henderson: IHenderson@tavi-port.nhs.uk

There will be limitations to the confidentiality of information provided if it is deemed anyone is at risk.

What will happen to the results of the project?

The results of this study will be used in my Research Dissertation Project and Doctorate qualification. It may also be used in future academic presentations and publications.

I would be happy to send participants a summary of the results if they wish. They will be invited to contact me to request this if it is of interest.

What are the possible benefits of taking part?

By taking part in the study, the interview could be potentially helpful in terms of providing a space for Child and Adolescent Psychotherapists to consider and reflect upon their professional practice in relation to clinical work undertaken within CAMHS. This may in turn benefit their teams and service users.

Are there any risks?

No, there are no direct risks. A debrief letter will be given following the interview that will outline steps available should participants want to discuss anything raised in the interview.

Contact details

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

Laura de Graaff

Email: [removed]

Alternatively, any concerns or further questions can be directed to my supervisor:

Dr Laura Balfour

Email: [removed]

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

Thank you for taking the time to read this information.

Appendix F - Participant Consent Form

The Tavistock and Portman NHS
NHS Foundation Trust

Research Participant Consent Form

Project title: How do psychoanalytic Child and Adolescent Psychotherapists think about psychoanalytic State of Mind Assessments and what are their experiences of carrying them out?

Name of researcher: Laura de Graaff

- I_____voluntarily agree to participate in this research project. ☐

- I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

- I understand that my participation in this study is voluntary and that I am free to withdraw, without giving a reason, at any time up to two weeks after the completion of the interview. ☐

- I understand that the interview will be digitally recorded and transcribed as described in the participant information sheet. ☐

- I understand that the information I provide will be kept confidential unless I or someone else is deemed to be at risk. ☐

- I understand that direct quotes from the audio recording may be used in this research study but will be made anonymous to the reader and held securely by the researcher. ☐

- I understand that it is my responsibility to anonymise any examples referring to cases I choose to discuss during the interview. ☐

- I understand that the results of this research will be published in the form of a Doctoral research thesis and that they may also be used in future academic presentations and publications. ☐

Contact details:

Researcher: Laura de Graaff Email: [removed]

Supervisor : Laura Balfour Email: [removed]

Participant's Name (Printed):_____

Participant's signature:_____ Date:_____

Thank you for agreeing to take part in this study.

Your contribution is very much appreciated.

Appendix G -Trec Approval

The Tavistock and Portman NHS
NHS Foundation Trust

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

Tel: 020 8938 2699
Fax: 020 7447 3837

Laura De Graaff
By Email

01 April 2021

Dear Laura,

Re: Research Ethics Application

Title: How do psychoanalytic Child and Adolescent Psychotherapists think about State of Mind assessments and what are their experiences of carrying them out?

I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee your application has been approved. This means you can proceed with your research. We would like to remind you that for information governance purposes and in line with the Trust policies, please be advised that in order to conduct research/interviews using online video conferencing you must contact TEL unit to set up a zoom account.

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

I am copying this communication to your supervisor.

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

Yours sincerely,

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

cc. Course Lead, Supervisor, Course Administrator

Appendix H -Debrief Letter

The Tavistock and Portman NHS
NHS Foundation Trust

Dear….

I am writing to thank you for your contribution to my Doctoral Research Project. I found my time with you interesting and informative. I hope you found it a positive experience too.

If following taking part there are any issues that concern you, I hope that you can access the support network around you (colleagues, supervisor and service manager). However, if this is not possible, or for any reason insufficient, there is a personalized wellbeing and psychological support service for all NHS Trust staff, which is open and free for NHS staff working within the trust, which you are encouraged to access.

Details of wellbeing and psychological support service included in original letter

They accept referrals from anyone (including healthcare professionals). All support is free and confidential using NICE recommended treatments. The treatment is delivered by trained professionals with a wealth of experience working with common mental health problems.

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

Email: [removed]

If you have any concerns about how the study has been conducted please contact myself, my supervisor Laura Balfour [removed] or Paru Jeram, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk).

Kind regards,

Appendix I - Tables to show Core Components of Psychoanalytic State of Mind Assessments, as referenced by therapists, explicitly or implicitly in interview

Aspects of the '*the frame*' identified by participants (explicit or implicit references to):

Aspects of 'the Frame'
Consistent place for assessment sessions
Consistent time for sessions
Structure communicated at the start Usually 5 sessions: introduction, 3 individual sessions, feedback
Clear boundaries: time; safety
Consistent therapist(s)
Introductory meeting
Being alone with the patient
Liaison with family members
Liaison with network/ professionals
Verbal feedback meeting with patient and/or family
Resources or toys provided by therapist/ resources requested by therapist to be made available at home for online SoM Assessments
Written report Format commonly described: precis of each session, formulation drawing on evidence, conclusions, recommendations
Recommendations

Frameworks utilised by the therapist (explicit or implicit references to):

Theoretical frameworks
Psychoanalytic
Attachment
Developmental
Neuroscientific

Psychoanalytic '*tools*' or skills (explicit or implicit references to):

Psychoanalytic 'tools' referenced in interview
'Observation'
'Attentive listening'
'Transference'
'Countertransference'
'Interpretation' (not always shared aloud)
'Formulation'
Play
Identify anxieties
Identify psychological defences
Evaluate patient's relationship to others (including therapist)
Evaluate patient's relationship to self/ sense of self
Evaluate developmental phase or stage -emotional, physical, psychological
Provide containment

Offer receptivity
Offer attunement
Evaluate patient's relationship to endings, breaks, gaps and links
Evaluate how the individual child views the world around them
Unconscious communications
Conscious communications
Symbolic meaning/ representation

Supervision is identified as straddling or perhaps bringing together the Core Components by virtue of being a part of the frame for almost all participants, and internal resource drawn up on by many therapists, and a process by which theoretical frameworks are explored in relation to the clinical work presented.

Appendix J – Presenting Difficulties of SoM Assessment Case Examples, Participant's Countertransference Responses, and Outcome of SoM Assessments

Participant presenting SoM Assessment	**Presenting difficulties of the case as identified by participant**	**Key words/ phrases used by therapist to describe *how it felt* to be in assessment sessions with the patient** **Primary tools in use: observation and countertransference**	**The outcome of the SoM Assessment: did it progress the CAMHS care plan? Treatment recommended?**
1	Anger and aggression; history of domestic violence (DV) in the home; parental mental health difficulties; parental substance abuse; parental imprisonment; communication difficulties; cultural identity uncertainty; emergency hospitalisation in infancy; query ASD; co-sleeping; separation difficulties	*'a really difficult experience'; 'made me feel very uncomfortable'; 'sense of invasion'; 'something quite frightening about it'; 'confused'; 'it was really unpleasant';* '*I kind of never quite knew what was going to happen next, I felt this sort of unpredictability about the way he could sort of be'; 'I sort of felt under threat'*	Yes -individual psychotherapy & network liaison
2	Early trauma; parental separation; parental imprisonment; death of a parent in infancy; parental substance abuse; parental addiction; physical abuse from parent; self-harm; suicidal ideation; depression	*'like a bit of a flood'; 'uncontained'; 'overwhelming for both of us'; 'rejected'; 'ridiculed'; 'I felt much less kind of confident'; 'I did struggle'; 'I felt very kind of unprepared for this kind of… real breakdown, and outpouring of emotions and the overriding sense of from that was one of despair'; 'it kind of caught me very unexpectedly'; I kind of felt despairing and hopeless and unable to really, do, to offer anything to alleviate that feeling*	Yes -individual psychotherapy and network liaison
3	Query ASD, trauma, or attachment difficulties; parental mental health difficulty; speech and language assessment because not talking; referral to paediatrics regarding developmental concerns; network concerns about abuse/ neglect	*'it was when I first looked at her, erm, and it was like er Medusa I think… it was like something had kind of shot into her, erm, and she just froze absolutely solid, sort of she turned away, it was really very memorable, turned away and it was like she just was sort of freezing as she turned and completely like a statue'; 'it was extraordinarily sad, to watch'; 'very very painful';*	Yes -individual psychotherapy and network liaison
4	Domestic violence; physical abuse; emotional abuse; violent acting out; parental physical health concerns; suicide attempts; separation anxiety; school avoidance; on a CP plan	*'very powerful'; 'so rich'; 'very painful'*	Yes -MDT & network liaison

5	Not talking; in foster care; sexual abuse, domestic violence, removal from birth family; parental mental health difficulties; trauma; controlling behaviour	*'a lot of deskilling'; 'a challenge'; 'quite overwhelming'; 'sense of struggle'; 'getting in touch with feelings feeling quite er, dangerous, quite overwhelming, erm… and an a sense of needing to not overwhelm him and not… subject him to too much, er emotional contact'; 'I was also very conscious of the sense of... being a police person and him being compliant and sort of… the sense of power erm, and that kind of weighing heavily…'*	Unsure -YP moved to a new placement by LA
6	Gender identity confusion; parental separation; anger and aggression; emotional dysregulation; network worried; maternal MH difficulties; enmeshed with mother; unknown father; single-parent family; DV during pregnancy	*'I felt utterly out of my depth and erm, quite in touch with something quite mad'; 'I started to really experience that'; 'I actually just didn't want to be with him at all, in the room, I wanted him out, er, because he was causing utter chaos'*	Yes -individual psychotherapy and network liaison
7	Potential risk to child's safety; separation anxiety; single-parent family; family issues; enmeshed relationship with mother; low mood; anxiety; highly expressed emotions; Oedipal conflicts	*'flooding experience'; 'busy and rich conversations that felt hard to write up'; 'very immersive'; 'hard to make sense of'; 'painful'; 'compelling to be with him'; 'in the moment it was so hard to make sense of, just how much was going on'*	Yes -confirmation of stuck-ness, elimination of certain options, family therapy considered
8	Potential risk to child's safety from parent; not a talker; school refusal; absconding from school; parental mental health difficulties; conflicts in network;	*'real complexity'; 'potential danger'; 'he kept me out… made me feel quite stupid'; 'intense feelings of rejection'; 'feeling I wasn't getting it right'; 'I felt something very strong coming from this boy, in terms of erm, feeling rather, sort of disheartened, by connections, but… something that was still wanting to be er, brought to life'*	Yes -informing court about advised contact arrangements
9	In foster care; exposed to domestic violence before being removed from birth family; YP reported the DV to police and YP and siblings were removed as a consequence; going into Care for first time	*'I was gonna have to go quite slowly'; 'we weren't going to think about difficult things'; 'she didn't like questions'; 'I felt a bit trapped'; 'it was all kept very, very very nice, and we were all given sweet things to eat'; 'in conflict… how am I going to help?'*	Yes -family therapy

Table to show links between presenting difficulties as described by participants, observations and countertransference response of participant, and outcome of the SoM Assessment.

Appendix K: Example of Data Coding with 'Wish to Fill the Space' highlighted

P	Data extract	Initial codes
_.2.3	Um, and I still feel like I have a lot to, to learn about ah, how to, how to conduct a, those, but that's been, my experience has kind of been through three sessions to think about whether or not psychotherapy is the right thing for these young people and, if, if they can make use of it.	- "a lot to learn" - official/ formal learning vs experiential learning - impact of experience upon understanding -perceived hierarchy of knowledge -is psychotherapy the 'right thing' for patient?
_.2.4	[I say: it sounds like to me a little bit, that in your service currently, there's sort of, I don't know if I'm getting this right, but maybe a bit of an overlap, or that a state of mind assessment could be called an assessment for child psychotherapy? (Participant nodding and makes 'Mmmm' noise [affirm my reflection]) I guess I'm wondering if there is a distinction in your mind between the two?] Yeah, I think for me that's the, that's still a question, coz they kind of seem to get used interchangeably. Um, here, so um, yeah again, my, my assessments may be quite different to some of the other people's that you interview, who are kind of more experienced, or have a more clear kind of protocol for, for how a state of mind assessment works.	- psychotherapy assessment & SoM - an overlap? -Affirmation with 'Yeah' - Distinction left unanswered - tentativeness with 'um's and yeah's and wish to fill the space - anxiety: who else am I seeing - recognition/ anxiety about difference? - who is more experienced (closeness) - 'protocol'; something that could be given? - some have it/ some don't; does it exist? -perceived hierarchy of knowledge - a 'right way'/ protocol?