An exploration of child and adolescent psychotherapists' experiences of offering Short Term Psychoanalytic Psychotherapy (STPP)

Danny Isaacs

A thesis submitted for the degree of Professional Doctorate in Child and Adolescent Psychoanalytic Psychotherapy

Department/School: Tavistock and Portman NHS Trust

University of Essex

Date of submission for examination: 6th January 2020

Date of re-submission with corrections: 1st September 2020

Contents **Page Number**

Acknowledgements

Special thanks and gratitude go to:

Jos Catty, for her integral role as my doctoral supervisor; her patient encouragement and guidance, even at times of little progress, have been so helpful.

Emil Jackson, for his support, guidance and encouragement during my training as a Child Psychotherapist, and in qualified life.

Nick Midgley, for inspiring me to explore this area for my doctoral thesis, and for supporting me to analyse some of the data from IMPACT-ME.

Gianna Williams, for her kindness and generosity over the years.

Ricky Emanuel, without whom I may never have pursued a career as a Child Psychotherapist.

And finally, to my analyst.

This work is dedicated to my family, for always believing in me and helping me to believe in myself.

Abstract

Psychoanalytic psychotherapy is often thought of as a long-term treatment, however there is a rich history of short-term treatments in psychoanalysis and psychoanalytic psychotherapy. Short-Term Psychoanalytic Psychotherapy (STPP) was found to be as effective for the treatment of moderate to severe depression in adolescents aged 11-17 as CBT and a brief psychosocial intervention (BPI) (Goodyer et al, 2017), and the evidence base for time-limited psychoanalytic treatments with children and adolescents continues to grow. However, to the author's knowledge there are no existing studies exploring child and adolescent psychotherapists' experiences of offering short-term psychoanalytic treatments. The current study set out to investigate this topic by using qualitative data exploring child and adolescent psychotherapists' experiences of offering STPP as part of a large randomized controlled trial (RCT), the IMPACT study, collected as part of the IMPACT: My Experience (IMPACT-ME) study (Midgley, Ansaldo & Target, 2014). Further qualitative data regarding the experiences of six child and adolescent psychotherapists offering STPP as part of everyday clinical practice was also collected, via a semi-structured interview developed from the interview used in the IMPACT-ME study. The two data sets were analysed using thematic analysis and interpretative phenomenological analysis, respectively. Child and adolescent psychotherapists offering STPP both within an RCT and everyday clinical practice reflected on their experiences of working with the time-limit, working with the STPP manual, and the roles of parent-work, supervision, and assessment. They also questioned: for which patients STPP might be a good fit; what STPP might be able to help with; how different STPP is from open-ended psychoanalytic psychotherapy, and how the profession might think about time and duration. They also reflected on the potential role of STPP in helping to manage resource and service-based pressures, and the influence an RCT might have on the experience of offering STPP. The experiences of the participants seem to suggest STPP could be helpful and valuable treatment option for children and adolescents with a range of mental health difficulties, and that STPP remained true to the core principles of psychoanalytic work.

Interpretative ways of understanding the participants experiences are considered, along with the implications for the use of STPP within mental health services in the NHS.

Keywords: psychoanalysis, child and adolescent psychotherapist, experience, time-limited, short-term, psychoanalytic psychotherapy

Introduction

The following dissertation sets out to explore child and adolescent psychoanalytic psychotherapists' experience of offering a relatively new and potentially important psychoanalytic treatment, Short Term Psychoanalytic Psychotherapy (STPP) (Goodyer, Reynolds, Barrett, Byford, Dubicka, et al, 2017), both within the context of a randomised controlled trial (RCT) and also in what the author will refer to here as 'everyday clinical practice'. For brevity, the title 'child psychotherapist' will be used from here on.

The dissertation will begin with a literature review that explores the history of short-term and brief treatment in psychoanalysis and psychoanalytic psychotherapy, including the limited published data on the efficacy of short-term psychotherapy; particularly for children and adolescents, the development of STPP as a treatment, and the relationship between adolescent development and time-limited treatment.

Following the literature review, the methodology of the study will be presented. This involved thematic analysis of pre-existing data from interviews with child psychotherapists who had offered STPP as part of the IMPACT study (Goodyer et al, 2017). This data was collected as part of IMPACT: My Experience (IMPACT-ME) (Midgley, Ansaldo & Target, 2014), a large qualitative sub-study, and analysed using Thematic Analysis (TA). A small sample of six child psychotherapists were recruited for the current study and interviewed using a semi-structured interview schedule based on that used in IMPACT-ME. This data was analysed using interpretative phenomenological analysis (IPA). The findings from both sets of analysis will be presented, including the overarching themes relating to child psychotherapists' experiences of offering STPP in an RCT and everyday clinical practice.

The findings will then be discussed and considered in relation to the literature presented in the literature review. The limitations and strengths of the study will be considered, before the implications and conclusions of the study are drawn out.

Literature Review

Short-Term Treatments in Psychoanalysis and Psychotherapy

Psychoanalysis is traditionally thought of as both long-term and intensive, with patients being seen for many years and attending sessions five times-per-week. However, there is a rich, and perhaps at times forgotten, history of short-term and time-limited treatment in psychoanalysis and psychoanalytic psychotherapy, starting with Freud himself and continuing with psychoanalytic pioneers such as Jung, Klein and Winnicott (Searle, Lyon, Young, Wiseman, & Foster-Davis, 2011).

It is important to acknowledge that psychoanalytic and psychodynamic psychotherapies are often presented as distinct, but the terms are used interchangeably; particularly in research. Both are types of therapy based on psychoanalysis; however, it is asserted that they are different in the following ways. Psychoanalytic psychotherapy is said to have a greater focus on the transference relationship, often coupled with treatment that is less frequent than psychoanalysis but more frequent that psychodynamic psychotherapy. Psychodynamic psychotherapy is said to have a more equal emphasis on the transference and the patient's external world, while using psychoanalytic theory to understand the patient, often at a frequency of once-weekly, and sometimes over shorter periods ("Psychoanalytic or Psychodynamic", 2019). These conceptual distinctions will be considered in more detail on page 14.

The following section will give a brief account of the history of short-term, time-limited and brief treatments in psychoanalysis and psychotherapy. Some evidence for the efficacy of short-term and time-limited psychotherapy will then be presented. Finally, some of the main questions that emerge from this literature will be summarized.

A Brief History

In his seminal paper *'Analysis Terminable and Interminable'* (1937), the founder and pioneer of psychoanalysis, Sigmund Freud, seemed to be grappling with thoughts about the ending of psychoanalysis and whether there are ways in which the lengthy process might be shortened. He discussed ideas related to setting an end-date in response to an analysis becoming stuck or "interminable", and to break through a patient's resistances. He seemed to conclude that whilst this was helpful in bringing some material to the fore, other material may become obscured. He went on to say that whilst it might be desirable to shorten an analysis, the aim of the analysis is only achieved when the ego has been sufficiently reinforced and developed, and not before, therefore implying that setting an end-date is complicated and not necessarily ideal. However, Freud himself saw patients for "short" periods of time, for example Dora and the Ratman, and used time-limits to try to work with resistance, for example with the Wolfman (Malan, 1963). Furthermore, a patient once described sessions with Freud as a "brief walk with the master around the Vienna woods" (Holmes, 1994). Whilst this was at a time when Freud was very much developing psychoanalysis, it is a far cry from the image of psychoanalysis as a long-term, intensive treatment.

Contemporaries of Freud, Otto Rank and Sandor Ferenczi were two of the first psychoanalysts to advocate time-limited treatment. Rank (1924) discussed the experience of birth and "primal trauma" as the source of neurosis and wrote that this could be focussed on and fixed with a shorter-term analysis. Rank stated that a time-limit could help the patient to confront reality and give up unrealistic beliefs and ideas. Ferenczi, in his work between 1919 and 1925 (Thompson, 1988), wrote about an "active" therapy in which free association was limited and commands were made to patients when necessary. An example given was that of a severely obsessional patient who tended to intellectualise excessively. Furthermore, in their book *The Development of Psychoanalysis* (1925), Rank and Ferenczi argued that there is a risk that the emotional investment of the patient is lost if analysis goes on too long and becomes too intellectual. From this they stated that the analyst must be active and maintain not only focus

but appropriate emotional tension, and at times may need to provoke, command or prohibit the patient in order to maintain such tension. They seemed to be arguing for an analysis with three main elements: a time-limit, focus, and active participation from the analyst/therapist. Interestingly, it may not only have been Rank and Ferenczi who were employing more active techniques. Gill (1982) reviewed Freud's techniques and suggested that Freud himself was more active than his writings may have suggested.

Melanie Klein, the pioneer of child analysis, alongside Anna Freud, was also known to work with children (and adults) over shorter periods of time than one might think. In *Melanie Klein Revisited* Sherwin-White (2017), drawing on archival material, gives a clear impression that Klein thought about the length of treatment very much in relation to the needs of the child, and their developmental stage. For cases with more severe neuroses and psychoses Klein reported requiring somewhere between one-and-a-half to three-and-a-half years of analysis for anxiety to be sufficiently modified to be in a position to bring the treatment to an end. However, for less severe presentations, eight to ten months could bring about development (Sherwin-White, 2017). Klein seemed to consider the length of child analysis in relation to questions about how "complete" an analysis could be for children considering the fact that they are still developing (1932a, pp. 52-53, 279-282). She stated that analysis, regardless of the length, could not guarantee that the child would be able to negotiate development without experiencing neurosis. This highlights that the developmental stage may be an important difference between adult and child analysis or psychotherapy for child analysts and psychotherapists to keep in mind, when considering the length of treatment.

Alexander and French, described as the pioneers of Brief Dynamic Psychotherapy in the USA (Holmes, 1994), developed the thinking of Rank and Ferenczi, and in 1946 coined the term 'corrective emotional experience', when identifying what they believed to be a key aspect of how dynamic therapy helps to treat patients. They described this as the reliving of previously disturbing or traumatic experiences in the therapy, and in relation to the therapist or another person in their life, but with, in simple terms, a better outcome (Alexander, 1925; Alexander &

French, 1946). The idea was that this would bring about the disconfirmation of previously held neurotic expectations. Horner (1994) writes that Alexander and French were suggesting that the therapist might manipulate the transference so as to take on a role that would be most likely to bring out this corrective emotional experience. Horner went on to say that at the time that Alexander and French were publishing these ideas, there was already some differentiation between psychoanalysis and psychoanalytic psychotherapy. These were being thought of as related but clearly distinct and separate treatments. This seems related to an important difference often suggested between psychoanalysis and psychotherapy in the present day. Psychoanalysis continues to be an intensive treatment in which patients are seen multiple times per week, compared to psychotherapy which is more associated with once or twice-weekly work, despite offering more intensive treatment such as three-times weekly. The differences between a time-limited psychoanalysis in which a patient might be seen five times per week for a number of months, compared to a time-limited once-weekly psychotherapy are worth of close attention (see page 14).

In 1963 Malan wrote the highly regarded *A Study of Brief Psychotherapy*. Malan reviewed psychoanalytic cases prior to 1914, although not Freud's, and found that many were not only brief, but also successful. From a technical point of view, there appeared to be focus given to specific childhood events and the groups of associations, memories and affects that came with these, and a mixture of "cathartic" and "analytic" responses. Malan was a member of the focal psychotherapy workshop facilitated by the psychoanalyst Balint at the Tavistock Clinic in 1955 (Balint, Balint & Ornstein, 2013). The workshop discussed a model of brief psychotherapy (Malan, 1976) which was characterised by the following: an extensive initial evaluation (what might be referred to as an assessment) in which interpretations were trialled and the patient's response to these noted, an exclusion of patients with serious psychopathology, requirement on patients to have some motivation for change, a pre-established ability to relate to the therapist, a limit of between 20 and 30 sessions depending on the severity of the patient's problem and the therapist's experience, and establishing a

meaningful focus such as loss. Standard psychoanalytic techniques were used, for example: interpretation of resistances and defences, and outlining the patient's internal conflicts via the transference and then relating it to their past experiences. Malan developed a 'two-triangle' conceptualisation of brief dynamic psychotherapy (1979), which had its roots in the work of Alexander, and Menninger's 'triangle of insight' (1958). Essentially what Malan was trying to show with these triangles is that in order, in brief work, to get to the true or hidden feeling, the therapist needs to confront the defence and anxiety in the here and now (transference), and also relate this to the patient's past (parents, family etc.), and also to relationships in the patient's life outside the therapy.

Findings from the work of Balint and Malan indicate that short-term or brief treatment can lead to longer-lasting improvements for patients with more severe presentations. Furthermore, interpretation in the transference, particularly in relation to the patient's parents was a key therapeutic technique and played an important role in improving patient outcomes. Malan coined the term 'therapeutic leap-frogging', by which he meant the way in which the therapist's response to a patient's material with a transference interpretation or a comment can lead to increased rapport. In turn this may lead to elaboration by the patient, such as an emotional response which then allows the therapist to respond to the affect and the patient's elaboration which further increases rapport, and so on. Of course, this is not exclusive to short-term treatments; however, it seems to be an important part of the clinical process when time is limited.

Developments of short-term psychotherapy continued into the 1970's. Sifneos (1972) developed Short Term Anxiety Provoking Psychotherapy (STAPP); a therapy based on an idea that patients with stronger ego functioning could manage a more forceful therapy. In STAPP, the therapist is encouraged to be active and robust and to maintain emotional tension, by confronting the patient's resistances, in order to overcome these. There is no specific time-limit, however the patient is told that the therapy is brief and no more than 20 sessions. The therapist expects that the patient would make external changes in their life during the

treatment and the following inclusion criteria were applied: the patient must be able to function in their vocation and personal life, they must present with fairly limited problems or symptoms, they need to be psychologically minded and motivated to work, and the symptoms should be some kind of derivative of oedipal conflict.

Mann (1973) also developed a time-limited psychotherapy in response to increasing waiting lists at psychiatric clinics at the Boston School of Medicine. This was based on the normal development of one's sense of time. Mann's idea was that as time is finite and life inevitably comes to an end, therefore a time-limited therapy could help patients to come to terms with the reality of time. This seems linked to the writings of Money-Kyrle (1971) who in the 'Aims of Psychoanalysis' argued that the inevitability of time passing and of death is one of the basic facts of life. Mann developed a 12-session model in which the beginning phase focussed on the patient's positive feelings about coming into therapy and amelioration of symptoms, the middle phase focussed on the reality of the impending ending and the subsequent disillusionment and ambivalence felt by the patient, and the final phase focussed on separation and realisation of the nature of time. Focus is given to a central issue, identified by the therapist's understanding of the patient's history, which is then presented to the patient as a conscious feeling connected to their symptoms and underlying internal conflicts. Mann stated that this was not a suitable treatment option for psychotic or borderline patients. As with other short-term therapies discussed here, interpretation of defences and impulses, as well as attention to the time-limit and its relationship with the central focus and the transference, seemed to be the foremost technical considerations.

Mann's work was developed by both Marmor (1979) and Davanloo (1980). Marmor addressed the factors that characterize brief psychotherapy and that distinguish it from analytically-oriented psychotherapy. He wrote that brief psychotherapy has different selection criteria to longer-term therapy; the time-limit should be set out from the beginning of the therapy and should be somewhere between 12 and 40 sessions, and the therapist must be more active both in relation to confronting resistances and to getting the patient to participate in the therapy

as a collaborator not just a recipient. Davanloo developed a time-limited therapy of 5 to 40 sessions, again depending on the severity of the patient's psychopathology and the therapist's experience; however, the time-limit was not set definitely at the start. Focus was given to resistances, particularly in relation to the therapist, and the affects that often accompanied these, for example anger when the resistances were challenged. Davanloo wrote that the expression of these affects, through challenging resistances, could lead to a reduction in resistances, and subsequent emergence of underlying conflicts which could then be explored with familiar psychoanalytic techniques. Davanloo assessed patients with their responses to the challenging of resistances in mind. Patients observed to regress were not selected for treatment. The patient's intelligence, ego strength, psychological mindedness and apparent object relations were also considered.

Some Evidence for the Efficacy of Short-Term Psychotherapies

An implicit theme of much of the clinical literature discussed above seems to be whether the outcomes of time-limited psychotherapy are as good as, or perhaps even better than, the outcomes of the more traditional open-ended psychotherapy. Whilst there remains a lack of peer-reviewed published research exploring the efficacy of short-term or brief psychodynamic or psychoanalytic psychotherapies both for children and adolescents, and adults, the evidence base is growing, and is briefly explored here.

Howard and colleagues (1986) conducted a meta-analysis on the dose-effect relationship in psychotherapy. Using data from over 2400 adult patients, collected over a period of over 30 years, they found that the greatest therapeutic benefit during a therapy is in the first 25 sessions. In fact, they found that 29-38% of patients showed symptom improvement within the first three sessions regardless of the overall length of treatment. There were a number of factors limiting the reliability of the comparison of treatment effects across studies, for example: variety of settings, variety of modality or approach, and the use of a range of outcome

measures. However, these findings do seem to indicate that time-limited and shorter-term treatments could be just as effective as longer-term treatments in initial symptom improvement, given that the majority of improvements in this meta-analysis were found early in the treatments. This seems contrary to the idea that longer-term psychotherapy leads to better treatment outcomes. One might question, however, whether symptom improvement in the short term is the same as deeper seated change over time that longer-term treatments might offer.

Alan Abbass and colleagues have carried out a number of meta-analyses investigating the efficacy of short-term psychodynamic psychotherapy with adults. In an analysis including 23 studies and 1365 patients they found that for treating short-term psychodynamic psychotherapy was significantly more effective than control conditions for treating depression, and demonstrated large pre-post treatment changes in levels of depression (Driessen, Cuijpers, de Maat, Abbass, de Jonghe & Dekker, 2010). Furthermore, Abbass, Rabung, Leichsenring, Refseth and Midgley (2013) carried out a meta-analysis of 11 studies, including 655 child and adolescent patients receiving short-term psychodynamic psychotherapy (defined by 40 or fewer sessions) for a range of conditions including; depression, anxiety, anorexia nervosa, and borderline personality disorder. They found that short-term psychodynamic psychotherapy was associated with moderate to large improvements in outcomes measures for mood, anxiety, somatic problems, personality and behavioural problems, and overall outcomes, and therefore may be beneficial for children and adolescents with a range of mental health conditions.

Another model that has been evaluated empirically is the Young People's Consultation Service (YPCS) at the Tavistock Clinic (Searle et al, 2011). This a four-session psychodynamic consultation service for young people aged 16-to-30, developed in 1961 for young people whose difficulties were part of the maturational process rather than pathological. It was set up to enable these young people to access the service without a formal referral. The service now sits within the Adolescent and Young Adult Service (AYAS) at the Tavistock and Portman NHS

Foundation Trust and is served by clinicians and clinicians-in-training from a range of disciplines (child psychotherapy, psychoanalysis, clinical psychology), all of whom are working psychodynamically in some capacity. As demonstrated by Searle et al (2011), YPCS is predominantly consultation rather than psychotherapy, with the intention however of being therapeutic. The young person is seen for four 50 minutes appointments, with all session dates and times being given at the start of the consultation. Focus is placed on the young person's current situation and life circumstances. Space is given for the young person to explore their difficulties and concerns in such a way that encourages internal growth but does not foster dependence. This requires careful and skilled clinical judgement on the part of the psychotherapist in order to determine when to make observations and interpretations in order to support the young person's growth, but also when it may not be appropriate to begin to explore unconscious feelings and conflicts, for which there would then be insufficient time for working through and containing. This contrasts with some of the other time-limited models discussed above, in which emphasis is placed on taking up feelings, conflicts, anxieties and resistances quickly and directly. However, YPCS is only four sessions. Searle et al (2011) found that the clinical severity of presenting problems for YPCS clients significantly decreased for all clients, and particularly for those with internalising (emotional) difficulties, in comparison to those with externalising (behavioural) problems. This suggests that models of brief psychotherapy might be more beneficial for those with difficulties of an internalising nature. This is supported by the work of Howard et al (1986), Fonagy and Target (1994), Holmes (1994), and Baruch and Fearon (2002). Importantly, none of the young people in the study showed deterioration over the four sessions, suggesting that the model did not unhelpfully unravel pre-established psychic defences to an extent that was harmful for the young people.

Finally, von Klitzing and colleagues (2011; 2014) developed 'Short Term Psychoanalytic Child Therapy for Anxiety' (STPCT or PaCT). This consists of 20-25 weekly play-based sessions that attempt to identify and modify the central conflicts that are contributing to the child's anxiety. The parents are invited to attend every fourth session, during which the therapist will

discuss with them their understanding of the meanings of the child's symptoms, as understood through the sessions. The therapist attempts to create a joint and shared understanding of the difficulties that the child is experiencing, and that also exist in the parent-child relationship, via the use of the transference and countertransference, and finding ways to communicate this to parent and child. In turn this helps the child to begin to relinquish some of the defences that may have been interfering with ordinary development, and also helps to support the parent-child relationship. Gottken, White, Klein and von Klitzing (2014) found that STPCT significantly reduced symptoms when compared to children on a waiting list for all primary and secondary measures of anxiety. Improvements were also measured across a range of informants (parents, children themselves, teachers). Furthermore, it seemed that this could be an effective treatment for children with internalising and externalizing co-morbidity; a particularly difficult group to treat. Effects were found to maintain at six months post treatment on parent and teacher reports. However, there was no evidence of further improvement, and child self-report did not show maintenance at six months, suggesting a potential need for further treatment.

As noted, the evidence base for time-limited psychoanalytic therapies is growing but limited. Some of the evidence available is for models of therapy that are in some ways based on psychoanalytic principles, whilst also incorporating elements of other types of therapy. Two examples of these kinds of therapy are Interpersonal Therapy (IPT) (Klerman, Weissman & Rounsaville, 1984; Fairburn et al, 1993; Weissman, Markowitz & Klerman, 2007) and Cognitive Analytic Therapy (CAT) (Ryle, Ponton & Brockman 1990; Calvert & Kellet, 2014).

Due to the brevity of this review, IPT and CAT will not be covered in more detail, however discussion of these models returns us to an important question: how different and distinct are these types of therapy from psychoanalysis, psychoanalytic psychotherapy and psychodynamic psychotherapy? And in fact, how different are these three aforementioned therapies from one another? The professions of psychoanalysis and child psychotherapy seem to make strong assertions about the differences between these. One might argue that

the differences seem to be based on value judgements about how traditionally psychoanalytic the approaches are, with an idea that greater frequency, no time limit, and a greater focus on interpreting the transference and defences make the therapeutic work better or superior. Of course, the traditional psychoanalyst might want to argue this point out of passion for the lengthy training that they have undertaken and the work that they do. However, to the psychodynamic psychotherapist, IPT therapist, or CAT therapist who is busy considering the transference, working with defences, holding in mind the patient's external world experiences, working to a time limit, and holding in mind other therapeutic tasks or aspects of the model they are working with, this might seem like a deep undervaluation of the work they are doing. And in fact, when one reflects on this list of tasks above, are those not the same key elements of therapeutic work that run through both psychoanalysis and psychoanalytic psychotherapy? Moreover, the use of terminology here can become politicised. To adopt the broader term "psychodynamic" emphasises commonalities with a range of clinical work and may make links too with research projects using that term: in this context, the breadth of the term may be regarded as more expedient than the narrower and arguably more rarefied "psychoanalytic". These competing priorities have led to a number of anomalies when the literature is surveyed as a whole; for instance, psychoanalytic psychotherapy as practised in a significant study of child psychotherapy based at the Tavistock Centre among others (Trowell et al, 2007) is labelled as "psychodynamic", as is the treatment model used in the IMPACT Study in one key publication in a leading North American journal (Midgley et al, 2013). The question of how different and distinct STPP is from open-ended psychotherapy will be returned to in the findings and discussion.

Emerging Questions

The literature presented above highlights some important questions for the psychoanalytic and psychodynamic professions in relation to short-term and time-limited treatment. Firstly, does one have to modify psychoanalytic technique in brief work and if so how; for example,

does the therapist need to be more or less active? For whom is time-limited or short-term work a good or better fit, and does this relate to the severity of presentation and other patient variables such as age and developmental stage? Does short-term psychoanalytic treatment have a place in assisting with managing service and resource-based pressures? Should we expect modest outcomes from time-limited psychotherapy, or might we expect equal or perhaps even better outcomes, and if so, what is it about time-limited treatment that might lead to better outcomes? What might be lost when we limit the length of treatment and does this dilute what the patient receives? And finally, how as a profession, do we think about and understand time, and its passing? These questions will be returned to in the discussion, in relation to the data collected in the study presented here.

Where Are We Now? The Development of Short-Term Psychoanalytic Psychotherapy (STPP)

In 2007, Trowell and colleagues carried out a randomised controlled trial (RCT) exploring the effectiveness of individual psychodynamic psychotherapy and family therapy for depression in children and adolescents. 72 patients were allocated to either psychotherapy or family therapy. Individual psychodynamic psychotherapy was in fact psychoanalytic psychotherapy as practiced at the Tavistock Clinic, however the broader term ‘psychodynamic’ was used to achieve parity with the wider research literature. The model offered 30 50-minute sessions plus 15 sessions for parents. A mean of 24.7 sessions were attended by patients in the psychotherapy arm. Family therapy consisted of 14 90-minute sessions, with a mean of 11 sessions attended. Both treatments were offered over a nine-month period. They found that this form of shorter-term psychodynamic psychotherapy was as effective as family therapy at the end of treatment, with three-quarters of the patients no longer meeting criteria for depression. However, when measured six months after treatment ended, psychotherapy actually continued to alleviate the symptoms of depression, whereas family therapy did not.

This was named a “sleeper effect”, following the precedent set by adult psychoanalytic psychotherapy outcome studies (Bateman & Fonagy, 2001) and suggested that short-term individual psychodynamic psychotherapy may in fact be as effective as other established treatments for improving childhood and adolescent depression in the short term, and possibly more effective in the long term.

Following on from the findings of the Trowell et al (2007) study, the Improving Mood with Psychoanalytic and Cognitive Therapies (IMPACT) study (Goodyer et al, 2011; 2017) was set up as a national multi-site pragmatic observer blind RCT, which aimed to explore whether Short Term Psychoanalytic Psychotherapy (STPP) was more effective at alleviating symptoms of moderate to severe depression in adolescents aged 11 to 17, compared to Cognitive Behavioural Therapy (CBT) or a brief psychosocial intervention (BPI; support and psycho-education offered by a psychiatrist or mental health nurse). STPP consisted of 28 weekly sessions of 50 minutes with a child psychotherapist (qualified or ‘approaching the end of training). A parent-work session was offered every four sessions, totalling seven parent-work sessions. A descriptive treatment manual was developed for STPP as part of the development of the study (Cregeen et al, 2017), meaning that not only was IMPACT one of the largest RCT studies exploring the effectiveness of different psychological treatments for adolescent depression, but it was also ground-breaking in its demonstration that short-term psychoanalytic psychotherapy can be successfully manualized. The study found that STPP was as effective as CBT or BPI at alleviating symptoms of depression in adolescents, with no differences in maintenance of reduced depression symptoms at 12-month follow up between the three treatments. Goodyer and colleagues (2017) recommended the implementation of all three treatments for adolescent with moderate to severe depression in CAMHS.

Patients’ and Psychotherapists’ Experiences

As part of the IMPACT study, a qualitative arm was set up to explore the experiences of those who had taken part: IMPACT-ME (Midgley et al, 2014). The young people, parents, and clinicians participating were interviewed about their experiences of different aspects of the study, and a number of papers have now been written and published from this work (Midgley et al, 2014; Midgley et al, 2015; Midgley et al, 2016; Midgley et al, 2016; Parkinson et al, 2016; Stapley et al, 2015; Stapley et al, 2017). However, partly because STPP is a relatively new treatment option for young people, less is known about STPP when it is offered in everyday clinical practice. In addition, one area that IMPACT-ME has not yet explored is that of child psychotherapists' experiences of offering and delivering STPP. This may offer valuable insight into STPP and may then contribute to the way it continues to be used and developed in everyday clinical practice across the NHS and the charity sector.

A search of the literature relating to therapists' experiences of offering psychoanalytic, psychodynamic and any other type of short-term and time-limited psychological therapy was carried out. The following search criteria were used to explore the literature across a number of databases (psycinfo, psycbooks, psycarticles, peparchive, SOCindex with full text) and returned very few relevant results. The search terms used were: "(therapist OR counsellor OR psychotherapist OR psychologist OR clinician) AND (experiences OR perceptions OR attitudes OR views OR feelings OR qualitative) AND (short term therapy OR time-limited therapy OR time-limited dynamic psychotherapy OR time-limited group therapy OR manualized therapy OR brief intervention OR brief therapy OR brief solution focused therapy OR cognitive behavioural therapy OR cognitive analytic therapy OR CAT OR interpersonal therapy OR IPT)". Whilst this search may not have been exhaustive, it was robust enough to indicate that there is very little literature about therapists' experiences of offering any type of short-term psychological therapy. The two results found from this search are explored below, neither of which are related to psychoanalytic or psychodynamic therapy.

Bengtsson, Nordin and Carlbring (2015) explored the experience of therapists when offering CBT either face-to-face or via the internet. The 11 participating therapists were interviewed

using semi-structured interviews. Thematic analysis of the interviews was then carried out. The authors found that therapists experienced internet-based CBT as more manualised than face-to-face CBT. Furthermore, internet CBT allowed for better management of time, but therapists felt that it was easier and quicker to establish a therapeutic alliance in face-to-face CBT. Thus, it seemed that therapists had more and less beneficial experiences of using both types of CBT, and this might contribute to future planning of how CBT might be used, such as consideration of whether there ways of making internet-based CBT more flexible and easier to individualise.

In her doctoral research, Osborne (2011) explored client and therapist experiences of sequential diagrammatic reformulations (SDRs) in CAT. She interviewed four clients and three therapists regarding these experiences, and analysed these interviews using Interpretative Phenomenological Analysis (IPA). Interestingly, Osborne also commented on the lack of research exploring therapists' experiences of this aspect of CAT. She found that client and therapist experiences were similar, and that these experiences seemed to focus around six main themes: 'Increases understanding', 'Facilitates conversations', 'Collaboration', 'Facilitates change', 'Impact of the SDR beyond therapy', and 'Doing it right'. She suggested that the findings of the study provided insight into the experience of using sequential diagrammatic reformulations in such a way that could have implications for the way this tool continues to be used in CAT, for example how therapists might maximise the potential benefit of this tool.

It is clear that there has been little research into therapists' experiences of delivering treatment, and that where studies have been conducted, they have focussed on the mechanism of delivery (face-to-face or online) or on particular techniques. No research to date seems to have explored therapists' experiences in a more open way, such as their emotional responses to, or experience of a range of aspects of, the treatment being offered.

Adolescent Development and Time

I shall now return to STPP and consider its particular relevance to the age-group for which it has been evidenced, namely adolescents. As can be seen, the evidence base for STPP (thus far) is for adolescents aged 13-to-17 with moderate to severe depression. Stringent measures were taken within the IMPACT study to try and ensure that those being treated with STPP (and the other treatment options) were presenting with depression. However, it is also known that depression has many comorbid mental health conditions, for example: anxiety and personality disorders (Cummings, Caporino & Kendall, 2014). It is also interesting to consider whether the benefits of STPP might extend to younger children, particularly in the context of the work by Von Klitzing et al (2011, 2014). However, there is perhaps something important in the relationship between adolescence as a developmental period, and the time-limited nature of STPP.

Waddell (2018, p.35) eloquently described the process of adolescence as:

> *…one of moving into a world where everything is in flux. At a time when bodies, feelings, impulses, familiar selves are all changing, these young people are also having to deal with the social changes and with new, exciting, challenging, and anxiety provoking responsibilities for organizing their lives and thinking about their futures. They are forming new relationships, making friends, facing big decisions. And all this is going on under the sway of the enormous hormonal upheavals of puberty and the resulting intensification of sexual and aggressive urges. The excitement and turbulence are extreme, both thrilling and also by no means always welcome. This essentially defines what adolescence is. It is a developmental process of working through endocrinological, physical, psychological, neurological change in the context of the wider social and cultural pressures.*

This vivid description gives a clear sense of the many transitions that adolescents go through, and also of the intense experiences that these transitions may give rise to, all played out within

their cultural context. The question of *"who am I?"* which Waddell addresses a number of times (e.g. p. 34), seems to be central, and can leave adolescents feeling confused, lost and on a somewhat desperate search for themselves; caught between the loss of childhood and search for adulthood.

In the search for an answer to this fundamental question, the adolescent attempts to separate more from parents, and move towards peers and towards independence. This can take many forms, for example: an increase in the importance of and focus on friendships, belonging to and identifying with groups, intimate and sexual relationships, the development of different and opposing views and beliefs to those held by parents. There is also the practical structure of the adolescent's life that must be borne in mind. In ordinary enough circumstances, this period of development coincides roughly with the progression through secondary school, and then for some through to University and the beginning of working life.

Current thinking and research indicate that, unlike the previously held beliefs that adolescence ends at age 18, the adolescent brain, mind and body are developing into the mid-twenties. Nonetheless, whilst adolescent states of mind can be re-experienced at any stage of life, if development proceeds in a healthy enough manner, adolescence as a developmental stage ends, and the working through of this leads to the beginning of adulthood (Waddell, 2018).

Thus, perhaps the potential relationship between adolescent development and STPP is built upon the fact that both are in essence a time-limited, and time-specific process. Thus, STPP could be felt to 'fit' conveniently into the structure of the adolescent's life, as well as giving them an experience of building a relationship with a parent-like figure, but within a short-term relationship that has the essential aim of helping them to separate and become more independent. Such ideas seem in keeping with Klein's views on the relationship between the length of treatment and the individual presentation and developmental stage of the patient, as described above (Sherwin-White 2017).

The Current Study

STPP, in its manualised form, offers a new and potentially important psychoanalytic treatment option that maintains the core principles of psychoanalysis; the transference and countertransference, projective identification, and defences and resistances (amongst many more) (Cregeen et al, 2017). Importantly, STPP also fits in with the current politically and economically charged movement to shorter-term 'evidence-based treatments' that are listed in the NICE guidelines, and essentially that commissioners are interested in funding. Even in decades gone by, psychotherapists were faced with the dilemma of pressure on resources and a need to find a way to treat more patients in shorter periods of time (as is indicated in the literature). With the onset of the 2008 recession in the U.K., and the subsequent austerity measures that followed, NHS resources are more stretched and pressured than ever. Therefore, it may be just the right time for an evidence based short-term psychoanalytic psychotherapy, such as STPP, to find a more established place in the range of treatments that we can offer to children and young people, particularly those with depression and the many accompanying conditions i.e. anxiety, eating disorders, OCD, self-harm, suicidality, and so on.

As can be seen, short-term psychoanalytic treatments are nothing new. Even Freud himself worked with some patients over short or brief periods of time. However, the literature cited and explored here also indicates that there are differing views and positions on the design of short-term psychoanalytic treatments, and the way in which these are used both within the NHS and the charity sector, as well as in private practice. The IMPACT and IMPACT-ME studies offer important quantitative and qualitative data relating to STPP, its efficacy, and the experience of those involved with it. However, very little is yet known about therapists' experiences of offering STPP, or in fact many short-term psychological therapies.

Method

Research Question

'What are child psychotherapists' experiences of offering and delivering STPP in everyday clinical practice and as part of an RCT?'

Aims

To explore child psychotherapists' experiences of offering and delivering STPP in everyday clinical practice and as part of an RCT. To explore the similarities and differences between these experiences. To explore the possible implications that these experiences may have for the development and delivery of STPP in ongoing clinical practice in Child and Adolescent Mental Health services (CAMHS).

Rationale

The author of the current study worked as a research assistant on the IMPACT-ME study and developed an interest in psychotherapists' experiences of offering STPP during this time. He maintained this interest whilst training as a child and adolescent psychoanalytic psychotherapist at the Tavistock and Portman NHS Foundation Trust, and himself has been involved in STPP and short-term psychotherapy: offering parent-work alongside an STPP case, and offering a number of shorter term psychotherapies to adolescents (though not strictly STPP). This has contributed to the decision to explore psychotherapists' experiences of offering STPP for the author's doctoral research, and as such this personal involvement and investment has been kept in mind in the collection, analysis and presentation of the results, and in the discussion section of this doctorate. This is explored further in the discussion.

Participants and Recruitment

Child psychotherapists participating in the IMPACT-ME study were interviewed about their experience of taking part in the IMPACT RCT. Part of these interviews focussed on their experience of offering STPP. Of the child psychotherapists offering STPP in the IMPACT study, 26 of them referred to their experience of offering STPP. As the author of the study had worked on the IMPACT-ME study, he was granted permission by the Anna Freud Centre (the research organisation responsible for IMPACT-ME, and to whom ethical approval was granted for the study) to use this data.

The author also wanted to explore child psychotherapists' experiences of offering STPP in everyday clinical practice and hoped to draw some comparisons between these experiences and those discovered from the IMPACT-ME data. Therefore, with the help of a senior clinician and researcher who had worked on the IMPACT study, he identified child psychotherapists who had offered STPP as part of the IMPACT study and were also involved in working with STPP in everyday clinical practice (either offering it themselves, or offering parent-work or supervision). The identified child psychotherapists were then approached via email and invited to participate. Attached to these emails were the study information sheet and consent forms (see Appendix A and B). Four child psychotherapists expressed interest in participating in the study. In discussion with the study supervisor, this was felt to be too small a sample, and recruitment was widened to child psychotherapists offering STPP in everyday clinical practice who had not participated in IMPACT. Psychotherapists from within the trust where the author works were approached, and this led to the recruitment of one more qualified child psychotherapist, and one child psychotherapist in doctoral training. It was decided that a sample of six participants would be sufficient given that the data from the IMPACT-ME study was also to be analysed, and it was also felt that it could be interesting and potentially fruitful for one of the six to be a trainee, as it might offer a different perspective. Informed consent was obtained from each participant before starting the interviews, and participants were informed that they had the right to withdraw from the study.

Data Collection

The data required to explore child psychotherapists' experiences of offering STPP in an RCT had already been collected, as described above, as part of the IMPACT-ME study. This was in the context of semi-structured interviews, ranging from 45 to 90 minutes, that explored each psychotherapist's experiences of a wide range of aspects of the IMPACT study. These interviews were carried out by research assistants, all of whom had received training in semi-structured interviewing. The interview schedules were based on a version of the interview protocol that had been developed for interviewing the young people and parents participating in the IMPACT study (Midgley et al, 2011, unpublished). The section of the interview schedule that explored psychotherapists' experiences of offering STPP was towards the end, and related to their experiences of participating in an RCT. These interviews had already been transcribed, and the author was given access to the transcripts of the 26 interviews. As this was the last section of the interview schedule, in many of the interviews less time and attention were given to these experiences. Therefore, this yielded a limited amount of data.

In order to explore child psychotherapists' experiences of offering STPP in everyday clinical practice, the author developed the aforementioned interview schedule (Midgley et al, 2011, unpublished), focussing more specifically on the following areas: the context and setting in which the psychotherapist was offering STPP, their experiences of STPP and different aspects of it (for example, parent-work, the manual, supervision, amongst others), and their reflections on how offering STPP as part of the IMPACT study and in everyday clinical practice might have been different (Appendix C). The interview schedule was tested via a pilot interview with a child psychotherapist who had experience of working with STPP. This pilot, and feedback from the participant, led to some changes in interview technique, but not changes to the schedule itself. Interviews with the participants lasted between 35 and 65 minutes, and as these were semi-structured interviews, the interviewer (the author) followed the content of the participant's responses and attempted to draw out as much detail about their lived experiences as possible, rather than rigidly applying the interview schedule. Five of the six interviews took

place in the clinic in which the psychotherapist was working, while one interview took place in the psychotherapist's home at their request. All interviews were audio-recorded, and the recordings were then transcribed using a combination of the Trint transcription software, and manual transcription by the author. The interviews were carried out between July 2017 and December 2018.

Data Analysis

In order to gather the relevant data from the IMPACT-ME psychotherapist interviews, a selection of search terms was applied to the transcripts of each interview (Appendix D), and the relevant data was highlighted and then compiled in a separate Word document for each psychotherapist. This ensured that all relevant data, including that which was not located in the final, most relevant, section of the interview, was gathered for analysis.

As the data was not particularly detailed and focused on psychotherapists' experiences of offering STPP, Thematic Analysis (TA) was used to explore and identify the predominant themes in the experiences of the psychotherapists. The Braun and Clarke' (2006) Six-Phase Framework for Thematic Analysis was followed. This involved: Step 1: becoming familiar with the data by reading and re-reading the relevant data for each psychotherapist; Step 2: generating initial codes that appeared in the data by marking relevant data and annotating the transcripts; Step 3: searching for themes that began to emerge from the initial codes, for example noticing that many of the participants reflected on the role of assessment in treatment allocation, and noting these on the transcripts (Appendix E); Step 4: reviewing the themes by listing all the themes discovered in all transcripts and assessing whether important aspects of the experience had been missed and whether themes could be condensed; Step 5: defining the themes by drawing a mind map of the super-ordinate themes and sub-ordinate themes (Appendix F); Step 6: writing up the thematic analysis. As discussed earlier, Bengtsson et al (2015) selected thematic analysis to explore CBT therapists' experiences of CBT, suggesting

that this would be an appropriate method of analysing the existing data from the IMPACT-ME study.

In order to explore the lived experiences of child psychotherapists offering STPP in everyday clinical practice, how they made sense of these experiences, and also to attempt to offer a deeper or more interpretative understanding of these experiences, it was felt that Interpretative Phenomenological Analysis (IPA) would be an appropriate qualitative data analysis methodology. In support of this, Smith, Flower and Larkin (2009) described IPA as a qualitative methodology for the purposes of exploring lived experiences, and as discussed previously, Osborne (2011) used IPA to explore the experience of clients and therapists of an aspect of CAT.

Larkin and Thompson's (2012) guide to IPA was used for the analysis. The following steps were taken: Step 1: reading and re-reading of each interview transcript followed by multiple coding's of the data, moving from a broader initial coding to a close line-by-line coding of the concerns, experiential claims, and understanding of the participant and initial thoughts and interpretations of the author; Step 2: identification of the themes emerging firstly within each individual transcript and then across the transcripts, paying attention to themes that seem to fit together and those that do not; Step 3: a more detailed interpretative account of the data, gathering up the themes and codes, the stated meanings for the participants, and the authors understanding and interpretation of the meaning of what has been said and experienced (see Appendix G for a transcript showing steps 1 to 3); Step 4: the development of an initial table of themes, in order to gather the super-ordinate and sub-ordinate themes, identify the extracts in the data that evidence the suggested themes (recorded in the table using the number of the relevant 'comment' from each transcript), and to demonstrate how the themes might relate to one another (Appendix H); Step 5: the development of a narrative of the data, which provides the reader with a theme by theme account of the data, and the author's understanding and interpretation. Supervision was used to develop a dialogue about the identified themes, and to test thematic coherence. The feedback from these conversations then contributed to the

development of the super and sub-ordinate themes, a final table of themes (Appendix I), and subsequently to the narrative of the data presented. Throughout this process, the author attempted to hold in mind their position and potential bias in relation to the data, their analysis and interpretation of this, and the way in which they might report and comment on the data.

Ethics

Ethical approval for this study was granted by the Tavistock Research Ethics Committee (TREC) (Appendix J). The application for this ethical approval covered a number of key ethical issues, outlined below.

All participants were asked to read a detailed information sheet (Appendix A) and then asked to give informed consent based on having read, understood, and having had the opportunity to ask any questions regarding the information sheet. This informed consent was gathered using the consent form (Appendix B). In addition, in a small-scale study such as this, where participants are reflecting on their personal experiences, it is important that confidentiality and anonymity is ensured. This was addressed through the careful storing of electronic (audio files) and hard copy (consent forms) data using encrypted folders and lockable filing cabinets respectively, and also through the removal of any identifying information from the quotes selected for inclusion in the study.

Furthermore, as the collection of data for a qualitative study such as this requires the establishment of a relationship between the researcher and participant, the impact of this relationship for both the researcher and participant needs to be sensitively borne in mind. It was possible that the topics of conversation could have been evocative for the participants, leading to experiences of distress or intense emotion. As such, all participants were offered the opportunity to debrief following the interviews, although none took up this offer. It was also possible that the interviews could have had a similar effect on the researcher. In turn this could have impacted on the way in which he interpreted the experience of the interview, and

therefore the data derived from it. In order to remain open to the possibility of this occurring, he discussed such issues with the doctoral supervisor prior to beginning the interviews and took time after each interview to reflect on the experience of the interviews, and consider whether there was anything that needed discussion with the supervisor. This was not the case in practice. An additional complication arose from the fact that the researcher knew a number of the participants in a professional capacity outside of the context of the study. This required the researcher to be all the more aware of issues of confidentiality and anonymity, for example ensuring that conversations about the interviews and the topics that had been discussed were not repeated or explored further outside of the interviews. The researcher also had to be aware of the potential influence of these relationships, and professional hierarchy on his interpretation of the data. This is addressed in more detail in the discussion.

Finally, due to the nature of qualitative data collection via interviews and IPA as a method of data analysis, the analysis and interpretations made by the researcher were inevitably subjective and potentially influenced by the researcher's own interests and biases. This poses a risk of inaccurately representing the lived experience of the participants. The measures taken to address this are described below, under 'Reflexivity'.

Reflexivity

A number of steps were taken to ensure that the researcher's own interests, preconceptions, and potential biases were considered, accounted for and reflected on. Firstly, throughout the development of this study, the construction of the interview schedule, the data collection, and data analysis, the researcher internally reflected on his personal connection to the research question (having worked as part of the IMPACT-ME study, and then trained as a child psychotherapist) and the potential influence of his own motivations for exploring psychotherapists experiences of offering STPP, for example promoting STPP as a treatment option, and/or wanting to promote the work of child psychotherapists. Furthermore, in the

process of data analysis, the researcher made notes of his emerging interpretations in the margins of the transcripts (Appendix G), as well as making notes regarding the experience of the data analysis in a diary, in order to reflect on the possible sources or motivations for these interpretations. Finally, during the data analysis there was a dialogue between the researcher and the doctoral supervisor regarding the emerging themes in both the TA and the IPA. This helped the researcher consider whether the themes emerging, and interpretations being made were driven by the data, or by his own preconceptions, and then adjust the analysis accordingly when there was a risk it was the latter. These points will be returned to in the discussion.

Findings

The analyses described above produced the following findings. The findings from the thematic analysis will be presented first, followed by those from the IPA.

The Experiences of Child Psychotherapists Offering STPP as Part of an RCT

Five overarching themes were identified during the thematic analysis of data from the IMPACT-ME interviews with child psychotherapists who had offered or were offering STPP to young people participating in the IMPACT study. The themes were: ‘The Length of STPP’, ‘The Role of Assessment’, ‘Experience of the STPP Model’, ‘Is STPP Different from Open-Ended Psychotherapy?’, and ‘The Impact of the RCT’. They will be described here, with material from the interview transcripts offered in support. The original IMPACT participant codes have been changed for the purposes of the current study.

The Length of STPP

Of all the themes identified, the time-limited nature of STPP seemed to be the aspect of psychotherapists' experience that most predominantly featured in the data.

Psychotherapists commented that they wished they could have offered more, that they felt the young person needed more, that it felt like an enormous task in the timeframe and wondered whether the task is possible in 28 sessions. It appeared that some therapists struggled to stick to the 28-session time-limit.

> *"I think that she could probably have benefitted… from a bit longer... I think I... clinically I would not have decided to end... at that stage I think I would have preferred to have seen her through into the 6th form a little longer I did feel a little bit... as if it was on the short side..." (Participant 1)*

On the other hand, psychotherapists reflected that despite having doubts they were surprised to find that 28 sessions were enough, and that the patient experienced a solid therapy. For some psychotherapists this seemed to leave them with more belief in the model, having perhaps doubted it previously. These experiences also seemed facilitate some desire to continue to offer STPP:

> *"I'd like to do more but, yeah I think it's really good, I think it's a really good model, I didn't believe it could work you know, that quickly, oh didn't believe that 28 was necessarily gonna to work but I think it's good. I found it incredibly helpful to… to see (Patient name), like I learnt loads from it and I'd like to keep practicing it… I know there's a few of us here who've had IMPACT cases who are kind of thinking we want to use what we've learnt and keep the momentum going…" (Participant 2)*

There also seemed to be some idea that the boundary of the time-limit could function in a helpful way for the psychotherapists, supporting them to not get pulled into a phantasy of being the one to pull young people out of depression, by offering more. This seemed to require them

to be more in touch with their difficulty in managing the feeling that no matter what one offers it may never feel enough.

> *"So I did think if I hadn't had that time-frame... I could easily have got drawn into… possibly seeing her for years and years and thinking (laughing), y'know... whatever you offer isn't enough... And also because she had… quite err… kind of a seductive pull. Y'know oh yes you… this is going to be very important to me, you're going to the person who helps me… um as long as I come here I'll be alright... Y'know, I don't know if I'd have got drawn into it, because I'm quite experienced, but I think there would have been a bit of a, risk of me having got… drawn… into seeing her for a very long time." (Participant 3*)

Furthermore, psychotherapists reflected that the time-limited nature of STPP seemed helpful in enabling young people to get in touch with reality of the therapy not lasting *"forever"*, which seemed to help them express more challenging feelings about their psychotherapists, for example anger and frustration. In psychoanalytic terms this is called the negative transference.

> *"I think it helped… it helped with umm… kind of knocking down in a good way, this idealised… picture. Because… it was very very difficult to get to the negative transference, and the only way we could get there was by… my making her acknowledge, that anger, which was then… her anger about the ending was very apparent… and could no longer be denied (laughs). So it helped with that y'know… I was no longer this ideal person, who was now going to, be there for her, forever, and she could just come and talk to me… and this… was going to sort her life out. It helped, um… diminish that, and for us to have a more real relationship, with me being actually quite a frustrating person as well. I was there, but I was only there for 50 minutes each week, I wasn't there when she was having her difficult times, and I wasn't going to be there forever." (Participant 3)*

There also seemed to be important questions in relation to how the length of STPP might be thought about. For example, is it actually a short-term treatment, or might it be longer than it seems and seem shorter due to comparisons with open-ended psychotherapy? This was apparent across a number of interviews, in which psychotherapists acknowledged that 28 sessions may not feel short to adolescents and actually 28 sessions might be quite an attractive offer to young people.

> *"…for a young person 28 sessions might be might feel like a lot… Um and it is probably quick in relation to what is being offered now." (Participant 4)*

There also seemed to be some acknowledgement of the potential helpfulness of the time-limited nature of STPP in the current climate of cuts and reduced resources in the *"a cash strapped NHS"*, whilst continuing to offer a treatments that are *"true to the principles training"* as a child psychotherapist.

The Role of Assessment

A question that seemed to come up frequently related to how psychotherapists might know which patients would suit or fit with STPP. Given that these psychotherapists were offering STPP as part of an RCT, and therefore had not done assessments to explore the potential fit or suitability, many seemed to reflect on the potential complications of not assessing for STPP first, and therefore on the need for assessments.

> *"Well I would have liked to assess him! Um and to discuss with him what it was that came out of the assessment and how he used the time and to be very clear about what I was offering… so that he had a taster of what it was like no? What the work was like… uuum because I think that you know in a way, it's always a bit of a blind… decision 'cause you don't know fully [what] you are get[ting] yourself (laughs as speaks) into… but I think the assessment does give you a taster know? What the work would be like. And so, he would have been at a conscious level giving his consent… I*

think with the study it was quite different… um… so I think that I would have done that differently." (Participant 4)

There seemed to be a feeling that without an assessment, important factors that could influence that a patient's engagement in STPP could not be explored, for example: attendance, the amount of support a young person has in their external world, what the patient might be able to manage, giving the patient a taster of psychotherapy and allowing them to consent to the treatment based on experience.

Experience of the STPP Model

Experience of the Manual

Child psychotherapists do not usually work to a manual, therefore the introduction of a treatment manual for STPP in the IMPACT study was a significant change for the participating therapists to adapt to. There seemed to be mixed experiences of and feelings towards the manual amongst the psychotherapists. Some spoke about the anxiety that the manual generated, which seemed connected to concerns about whether they were doing STPP in the right way, or *"by the manual"*, and others feeling that it was difficult to work to the manual with a patient whilst remaining truly psychoanalytic if the patient is ambivalent and resistant to treatment. Furthermore, one psychotherapist spoke about an experience that the manual felt *"alien"* to them because they had trained at a different school from where they imagined the manual had been written. However, the manual also seemed to be experienced as helpful.

"Really it's… enormously valuable and... I mean I would hope that I could continue to erm... make use of what I've learnt in working with depression with adolescents from the manual... It's… quite a lengthy document but it's so worth... erm using fully… as a manual... I mean for somebody who's a relatively recently qualified... as a child psychotherapist just in terms of thinking about depression as an illness in adolescents particularly... erm... and the different views of its origins... the different ways of looking at

its origins... erm... and the different things that one might expect to happen in working with an adolescent who's depressed erm and just dealing with the different stages of therapy erm beginning, middle, and end... erm and how to think about… initial formulation of the depression and the... the key ways of describing the pathology at initial stage and then modifying it... erm towards a final formulation... Erm just really helping me to think about... erm depression as an entity in adolescents and how to work with it... it's been invaluable." (Participant 1)

It seemed that the manual was experienced as a "*valuable"*, and "*important"* resource that they referred to when needed, for example when formulating the type of depression the young person was presenting with, or to help keep the number of sessions in mind (an aspect of the model that was less familiar to the participants).

Experience of Parent-work

The psychotherapists interviewed seemed to have a wide range of experiences of and thoughts about the parent-work. Some commented on how helpful the parent-work was for the parents themselves, for the young person and their relationship with the parents, and also for the work with the young person. For example, the parent-work was seen to help the parents with appropriate boundary setting for the adolescent, helping the parents to think about how their child might be experiencing adolescence, helping to mediate family and sibling relationships, helping to keep the young person attending engaged and supported in their therapy, and in providing an important link between the STPP and the parents, whilst also maintaining an appropriate amount of space for the young person

"I think the fact that the parents got very good work, at the same time. Y'know that they were going on a kind of parallel journey, um… So, there was a bit of mutual support… There were a lot of insecurities around, in the family, but they were managed. I think the communication between myself and the parent-worker was also um important. And

certainly, as a model in CAMHS, I think that er many of the er therapies that are successful, it's because the parents engage as well… So, y'know… she had lots of, encouragement to do the work. Um… whereas the one's, y'know the parents that say: take my child off and therapy them… but don't have anything to do with me those tend… not to be so… successful." (Participant 6)

It was also acknowledged that some young people in the IMPACT study, particularly towards the top end of the age range, did not want their parents involved or seen for parent-work, and that was a decision that they could make. Other young people seemed to feel more ambivalent about it.

"I think it actually… it was probably quite significant for her... because I think that it gave her... the feeling that... her difficulties... were being taken seriously... and that if her parents were being offered support and help... that meant that all the grownups were actually taking her depression seriously and I think that idea was very supportive... In her mind she was supported by that, although she said very little about it because I think she felt a bit awkward about it at the same time." (Participant 1)

Some psychotherapists reflected on the difficulties of setting up the parent-work, and of the ambivalence that some parents seemed to show regarding engagement with parent-work. However, it also seemed that some parents, despite being ambivalent to begin with, found parent-work helpful and may have even asked for more support after the study.

"…although there was no change in the family system all the way through the therapy, at the end of therapy… um it was after the end of the last session, um (adolescent's) mum did… contact the parent-worker and ask for more sessions for herself… to think about her parenting. So, it was quite an interesting thing. So something might have been triggered in mum that might mean that… y'know we could work with her in a different way." (Participant 3)

Finally, one psychotherapist reflected on how valuable it was to have an allocated parent-worker *"now-a-days in CAMHS"*, given the current pressures on services.

Experience of Supervision

Another part of the model that all STPP psychotherapists were offered alongside their work was supervision. Psychotherapists described their experiences of supervision in mostly very positive terms with words such as helpful, enjoyable, brilliant being used, and attention being paid to the fact that often qualified child psychotherapists do not get much supervision, and very rarely supervision devoted to one specific case.

> *"I really have enormously appreciated the supervision, that's gone with this. Because being someone who's y'know a senior practitioner, you tend to be dishing out the supervision to everybody else, but um... it has provided me with er... quite a lot of feeding through supervision. And er... that's been really helpful." (Participant 6)*

More specifically, the supervision seemed to help psychotherapists manage and think about the anxiety and projections that both they and the young people were experiencing during STPP, and also adapt their technique to find a way to reach the young people they were working with.

> *"I sort of changed my style quite a lot during the work with him that I started off by… kind of trying to explore well what do you want it to be about and… then through the help of my supervisor kind of became a bit more, well this is what it is, these are the kind of things you might want to talk about and actually giving him a bit of structure… I think it is very difficult for someone to come into a room… well what are they supposed to say?" (Participant 7)*

Psychotherapists also seemed to feel that the more they were able to *"bring in terms of the session material, then the more valuable supervision was"*, although this required extra work.

Is STPP Different from Open-Ended Psychotherapy?

As can already be seen in the data presented, there seemed to be questions about whether STPP is really that different from how one might work in ongoing psychotherapy. For example, psychotherapists reflected on aspects of the work, for example, thinking about and managing breaks, and seemed to feel that one would work with these in the same way whether doing STPP or ongoing work.

> *"We spoke a lot about, um… y'know the gaps between the sessions, the breaks for the holidays that are very significant, and y'know took up her negative feelings about the breaks. Y'know, what was I going off and doing, and would I still keep her in mind, and remember her? Because I think she was… y'know a girl who needed a lot of reassurance as well. I think because of um... her angry feelings, she also was in constant fear that people would desert her, or not stick with her or… abandon her, um… and that was what she deserved. So, when it came to holidays there was a lot of grist to the mill. Was she too much for me? Is that why I was having a holiday? Y'know, would I think about her kindly when we didn't meet and… remember that she was suffering in various ways? Would I… want to see her again?" (Participant 6)*

Furthermore, it seemed that even working to the manual might not make STPP that different from the way child psychotherapists might usually work.

> *"It wasn't so different to the way I was working anyway… the only difference really was the time-limited nature and that's quite easy to bring into a manual, so it was fine." (Participant 8)*

This also seemed to apply to the most fundamental of all psychoanalytic techniques; working in the transference. Many of the psychotherapists spoke about, or commented on the transference, and its place in their work with STPP. They referred to the "*positive"* and "*negative"* transference and the importance of being able to think about and take up both.

"I think she was looking for a relationship. Ermm... and the relationship felt like… everything. Y'know that was really at the core of it. And that was the important thing… really. I mean she talked a lot… she brought a lot of material, and y'know she perhaps got irritated with my talking about the transference… but I think it was a big part of it." (Participant 9)

This seems to suggest that working in the transference is as important in STPP, as it is in all psychoanalytic therapy, again supporting the idea that STPP may not be that different after all.

The Impact of the RCT

The final theme focused on psychotherapists' experiences of offering STPP as part of the IMPACT study. There seemed to be a great deal of anxiety about whether STPP was being done right and whether the cases were going well.

"I was extremely anxious that it should go well erm and that to may have been a contributing factor that you know my anxiety to get it right, erm recently qualified being an IMPACT clinician, being the first case you know wanting to do it, do it well… and that may have come across in the sessions." (Participant 11)

This seemed to be related to offering a therapy as part of a large RCT and the scrutiny that this might bring and linked to this the experience of being audio recorded and doing it *"right"*.

"Well, in the first session… I was really nervous… I just thought, oh my god I wouldn't do it like this, so I know I was although I've been taped before and videoed, but I did feel kind of nervous. So… just like getting the protocol right, had I said the wrong thing, you know, how many meetings was this, you know that kind of thing. (Participant 12)

There also seemed to be anxiety about who might be listening to the recordings, what they were going to think about what they heard, and whether the listener would be able to understand and pick up on the subtle nuance and context that is so much part of the work of child psychotherapists, through an audio recording. One psychotherapist described this as having the *"researchers on my shoulder"*. Another said:

> *"I struggled with the recorder. I did feel… erm… that there was a third person there… I found myself explaining myself much more than I would normally. Like sometimes you say something to patients and it's just something that states the obvious because of the atmosphere in the room, like the non-verbal, what you can just feel in the atmosphere… and with the recorder I felt that I had to explain much more where it was coming from so that people could, when they listened to it, they could understand my thinking." (Participant 13)*

However, other psychotherapists did not seem to find it quite so intrusive or problematic, seeming to feel that it had little impact on the work.

> *"I think because the recorders are so unobtrusive actually really… I don't think there was much of the sense of it really getting into the therapy at all actually." (Participant 14)*

Psychotherapists also seemed to have some strong feelings about the randomisation of the young people to treatment arms that was a necessary part of the IMPACT study. This links to the role of assessment for STPP, discussed above. They seemed to feel that randomization might not lead to an appropriate treatment allocation, so much so that some spoke of not signposting young people into the study when first meeting them due to worries about the randomization process and the young person not receiving the treatment that would be most appropriate.

"I couldn't bear to, signpost this one to IMPACT having done the assessment, generic assessment… because I didn't want to risk, randomisation to, either of the other two arms…and so withheld them from the study. Although they ticked all the boxes and would have been appropriate for IMPACT… I felt, no… child psychotherapy waiting list, even though they may have to wait. Um… and that's a bit of a… difficult call, in making that… ethical judgement." (Participant 15)

Finally, psychotherapists reflected on the lack of space and opportunity to work flexibly when offering STPP as part of IMPACT. There seemed to be a feeling of not being allowed to think outside of the structure of the RCT.

"One has to adhere to it and therefore somehow not think outside the IMPACT box but actually having been reminded... you know more than once by the IMPACT supervisor... erm who has been most helpful... one needs to be able to feel free enough to think about drawing in other CAMHS resources..." (Participant 1)

However, there did seem to be some space for thinking about the need for one to give oneself permission to work flexibly if it was in the best interests of the young person the psychotherapist was working with, for example taking up the role of case manager, as well as psychotherapist.

"…it's not that I bent the rules but I had to do a lot of SCC (Brief Psychosocial Intervention) um and I had to do some parent-work. I also went to the school a couple of times to meet with these teachers um which usually if there had been a parent-worker they probably would have linked with the network more but the linking with the network had to be done in his interest… So, I feel… I've done a lot of extra and my role was pulled in different directions. (Participant 16)

Thus, it appears there were mixed experiences of the impact of the RCT on the work of STPP.

The Experiences of Child Psychotherapists Offering STPP as Part of Everyday Clinical Practice

Two super-ordinate themes: **'Reflections on Experience of the Model'** and **'Questions'**, and eight sub-ordinate themes: 'Ending from the Beginning: Working with the Time-Limit', 'Descriptive Not Prescriptive: Working with the Manual', 'Working Alongside: The Role of Parent-work', '"Helping the Therapist to Maintain the Frame": The Role of Supervision in STPP', 'Who is "The Perfect Patient for STPP"?', 'What Might STPP Help With?', 'How Are Time and Duration Thought About?', 'Is STPP that Different from Ongoing Child and Adolescent Psychoanalytic Psychotherapy?', were identified during the interpretative phenomenological analysis of data from the semi-structured interviews. Two sub-ordinate themes: 'Managing Pressures on Resources' and 'Getting it Right', did not seem to fit into either of the super-ordinate themes but remained important findings, and so are reported under the heading '**Additional Themes'**. These super and sub-ordinate themes will be outlined, with supporting material from the interview transcripts. For clarity, each excerpt will be followed by a statement about whether that participant is referring to experience in IMPACT or everyday clinical practice (referred to as 'everyday experience'), or both.

Reflections on Experience of the Model

Ending from the Beginning: Working with the Time-Limit

Perhaps the most central aspect of the participants' experience of STPP was of the time-limit and set number of sessions, how they worked with this, and how they felt about it. Participants emphasised the pain of ending and the subsequent reality of loss and separation, as well as questions about whether 28 sessions were really enough, and even if it is enough for some patients, would it be enough for all?

> *"Some… child psychotherapists are quite reluctant at times also… When talking to qualified child psychotherapists you know they've had a lot of experience of offering*

the longer-term treatment and they don't like ending after a short period of time themselves. And it can feel quite painful. And we always worry whether it's the right time." (Participant 1, everyday experience)

This participant seems to be connecting such concerns and anxieties to possible difficulties in engaging with STPP as a treatment option. This seemed to resonate with the experience of another participant, who seemed to be struggling with conflicting feelings when coming towards the end of treatment with a patient:

"There were moments where I thought is this the right thing or does she need more… …It was hard to make the decision in the end. OK, it's 28 sessions, we're sticking to it because we've started, because the ending is there from the beginning, and you when you're getting to the end and you think oh maybe she needs more but she's already been working towards the ending. Then I felt I was conflicted about would I have offered more. But she was in an ok place to end…" (Participant 4, everyday experience)

On the other hand, each participant seemed to feel that something about the time-limit could be helpful and beneficial to the patient. For example, one participant spoke about how, despite their own anxieties about a lack of experience and skill to work within the time-limit, it helped them to get to the heart of things more quickly:

"Y'know pressure can always feel like a negative a lot of the time but actually in this case it was quite positive that there was a time-limit on it and we had to get on with things like we got to the heart of things quicker than we would have normally..." (Participant 5, everyday experience)

Another seemed to feel that STPP had helped them get hold of a patient who had not been attending sessions. It seemed that the time-limit had helped the participant to keep in mind the reality of limits and time passing, and then convey this to the patient in a way that helped

the patient become suitably aware and perhaps even anxious about this, so leading to improvement in their attendance

> *"I found myself seeing an STPP case alongside a similarly aged young woman for open-ended treatment. And at the beginning of both their treatments there were quite a number of DNAs (Did Not Attend the session without notice). And I found myself very aware of a kind of urgency with the STPP case, and that sense that well this time really counts. In a way that of course I felt with the other patient but perhaps not in quite such an explicit way. And I think that really helped me to get hold of that with the patient and to work with it. And… her attendance improved significantly, as she engaged… That took much longer with the other patient." (Participant 6, everyday experience)*

One participant made a link between the helpfulness of the time-limit, the aetiology of depression, and the role that loss and separation play both in depression, and in the ending of therapy:

> *"I felt as so often with depression, that loss… and separation is such a significant part of the kind of aetiology of depression… that for her I felt it was worth sticking with that ending, working with it…. And actually by the time I saw her for the review she was much much better and it felt like it was something that you know that she needed that period of difficulty for the ending." (Participant 2, IMPACT experience)*

Another spoke of the containment they felt had been offered by the model and the time-limit:

> *"Well the model was as you know there's 28 weeks, so it was time-limited. And I think that sort of contained things a little bit. She was very worried about things in the assessment when we were thinking about once a week that things were going to unravel and we wouldn't be able to put it back together so to speak if we if we had sort of long-term work." (Participant 5, everyday experience)*

Furthermore, one participant shared a passionate view about the need to stick to the model of STPP and not work with it too flexibly, suggesting a real belief in the model and its potential helpfulness:

> *"…we offer it and we stick to it and my sense is almost that if it works well enough that you stick with it 'till the end. But you know and not be too free with… you know 'it's not part of the study so we can do what we want'. And I think… we also have to put our belief in the fact that short-term work can be valuable and… that it is valuable to stick to the model." (Participant 3, everyday experience)*

On the other hand, it seemed that all participants could consider and foresee circumstances in which the patient's needs and ethical priorities would trump the need to stick to the model, for example by offering review meetings, or by offering further treatment, perhaps in spite of other factors such as pressures on resources, for example:

> *"I think you're always you're still led by the patient. You know and what they bring into the room and I suppose one has to be open that when you come towards the end of the STPP one doesn't know what may emerge from therapy. If it's indicated that more work is needed I suppose it can still come to the end of the STPP as an intervention and end it, but that it might be… clinically necessary and ethically important to talk to the patient about the fact that they may need something in addition to that. And what would that be. And they may have to embark on additional treatment… If more work is really essential, I think we will offer it." (Participant 3, everyday experience)*

Questions about technique and focus when working with the model also seemed to be present. This seemed to be most focussed around the use of Goal Based Measures, a widely used outcome measure in child psychotherapy which scores a patient's goals for treatment out of ten (ten being "completely met"). There seemed to be mixed experiences, with some participants stating that they did not feel that one had to work in a more focussed way i.e. by focussing on the goals set for treatment.

"I think some people feel that if you've got a time-limit on it you have to be a bit more goal orientated perhaps or choose what your focus is. I think some people do definitely feel that. I feel that less." (Participant 2, everyday experience)

On the other hand, one participant seemed to have found the goals particularly helpful in focussing the work.

"What was great about the short-term work was that she'd set up goals we looked at her goals, and we really focused on them. What was what was really affecting her in her eyes. Which I tended to agree with actually… so we focused on these three specific goals which of course… there were offshoots of this, but I think it really sort of set the frame right in a way that maybe more long-term sort of exploratory stuff might not have. So, I think she felt quite secure in that there was quite a purpose to the therapy from the start… and I think she felt quite contained by that." (Participant 5, everyday experience)

Thus, the data presented seems to highlight the complexities of working to the model and how each therapist might attempt to do this, whilst managing the difficulties that they and the patients might experience because of the time-limit, and also holding in mind the needs of the patient.

Descriptive Not Prescriptive: Working with the Manual

The conversation about how flexibly STPP might be used does draw attention to the manual, and child psychotherapists' experiences of using this, both in the IMPACT study and in everyday clinical practice.

There seemed to be some feeling and experience that the manual was a helpful description of STPP, and that one could learn about STPP and also about depression from reading it. In

addition, there seemed to be some potential benefit from the momentum that STPP might have as result of the IMPACT study.

> *"We have this other medium-term therapy which we still have but we've been really interested in bringing in STPP because of it being manualized and having particular sort of momentum potentially behind. And… I actually run the workshops fortnightly for lots people taking on STPP cases. Um so it's embedded. We are trying to embed it but it is new and it also feels a bit experimental. In terms of seeing you know we've looked at the book the idea of different types of depression… and there's an idea in it that narcissistic depression is harder to treat with STPP than… what's the other one called anaclitic depression." Participant 2, IMPACT and everyday experience*

There also seemed to be some feeling, perhaps linked to the time-limit and structure of STPP as described above, that the manual could offer containment both to the patient and to the therapist

> *"I mean I suppose in some way the manual can be seen also as it's good to have a framework for the kind of work that is done. So having a manual, having a model… like any kind of theoretical framework can um have a role, as in containing in itself. For the for the clinician… having a sense of there is a very particular model that's being worked in and there is a beginning and a middle bit and an ending can feel containing for the for the adolescent for the patient." Participant 3, everyday experience*

Whilst potentially also being experienced as restrictive:

> *"And then of course the other side of it is that it can then also become something that both the clinician and the patient may feel restricted by. If they want more or if they want something different." Participant 3, everyday experience*

The participants seemed to experience the manual as descriptive, not prescriptive, and perhaps really a description of what they feel they already do in psychotherapy, whether time-limited or not.

> *"Well the manual is descriptive and it's not prescriptive. So I think what was interesting is that you think about the different phases you know beginning, middle and end. I have to say to be honest I haven't looked at it recently.* ***Int:*** *But do you think it's necessary to sort of keep//* ***Ppt 1:*** *No. Because it it's a description of our work. It's a description of how we work usually… so, it's not a description of something that we don't do. You know it's describing our models of working, really. There might be technical issues you might need to think about in relation to short term work that people might thought about more. You know which might be like keeping the number of sessions in mind… when you might say something about the sessions and that might be related to you know what comes up in the therapy." Participant 1, IMPACT and everyday experience*

In sum, there seemed to be mixed feelings about the manual; it's potential helpfulness (particularly with keeping one's mind focussed on aspects of the model) and restrictiveness, and it's descriptive quality but which might leave one feeling it is less necessary to refer to.

Working Alongside: The Role of Parent-work

All participants shared experiences of the parent-work that is manualized to run alongside STPP on a monthly basis. Participants seemed to feel that parent-work had the potential to be meaningful and helpful for the young person and also the parents. An area that seemed important for all participants was the questions of age of the patient and how much or little the parents might be involved in work alongside STPP. There seemed to be a variety of views and experiences, with participants talking about the importance of parent-work and its role in supporting the young person in STPP to focus on their own difficulties not those of their parents (as the parents' are presumably being explored, in relation to their child, in the parent-work), in helping the young person trust that their therapy was a space for them and that this boundary would be protected by the parents being seen separately in their own sessions, the importance for some young people (particularly younger adolescents and children) of having

parents support them whilst they are in STPP; helping them to attend sessions, helping to contain them after sessions etc, and helping to manage risk. On the other hand, participants reflected on the importance for some young people of having a therapeutic space that is separate from their parents or family, particularly for older adolescents and young adults who in the process of development are trying to work through separating and individuating.

> *"Well I think it's similar to the role of parent-work in all therapy cases in that you want the parent to work alongside. You want them to support the therapy. You want them to think about their experience of their child and what their child may be going through. You want them to think about… something about the internal life of their child. I think with younger adolescents the parent-work is more important because they are very much part of the child's life still. So for younger adolescents you know that parent might be necessary to actually bring the child so in a very practical way support the therapy. If the child is you know 14 or 15 or may not be able to come by public transport especially if they come from out of borough. But I think there is also something about you know to help the parent um make connections and links about the relationship with the child and you know something about trying helping them try to explore and think about how the presenting problem developed you know what might be the meaning of it. You know when did it start and what happened in the family at the time? What happened in the relationship between the parent and the adolescent? To help the parent to think about the particular stage of adolescence and why it might be very difficult for their child at this point in time and help them think a bit about their own adolescence. Um in terms of you know might there be things that they haven't worked through that has been particularly painful for them that. You know to what extent they may project something of their or re-enact something of their adolescent experience or what might be stirred up for them… now that their child is going through adolescence." Participant 3, everyday experience*

What seemed to come across from the participant's descriptions of the role of parent-work in STPP, and what the psychotherapist might hope for from the parent, was that this was not that different from the role of parent-work in any psychotherapy case. Again, begging questions of how different STPP and its accompanying parent-work actually are from parent-work alongside open-ended child psychotherapy.

"Helping the Therapist to Maintain the Frame": The Role of Supervision in STPP

When considering the experiences of therapists working with the time-limit, it was acknowledged by the participants that a central aspect of working with STPP is the way in which the time-limit is thought about, and that perhaps this is more significant than the actual number of sessions itself. Experiences of the difficulty of working to the time-limit due to the challenge of thinking and knowing about feelings of pain, loss and separation, were also acknowledged. Linked to this, and to the potential contribution of spaces and places to think about these challenges, participants reflected on their experience of supervision.

All participants reflected on the importance of having somewhere to think about the STPP cases that they were working with, and the accompanying challenges that they were facing in this work, for example keeping the time-limit in mind. The participants seemed to feel that supervision, and particularly supervision groups had helped to keep the number of sessions in mind and work to the time-limit, to manage their own feelings about the ending and think about and contain a wish not to end, to get hold of the negative transference, to keep the STPP linked up with the parent-work being offered alongside. Furthermore, participants seemed to have valued the experience of being supervised or offering supervision in groups, as this seemed to offer the opportunity for supervisees to learn from one another as well as from their supervisor.

> ***"****I feel supervision is absolutely crucial in all work not just STPP but maybe there's something in particular in relation to STPP about the role of the supervisor in helping*

the therapist to maintain the frame. And to keep that in focus when there might be a real pull to keep it a bit in the background. Perhaps for all sorts of different reasons. I suppose thinking about my own experience of being supervised on my first STPP case. And I found that really helpful… in relation to sort of having faith in the frame… The feeling that this was good enough. And I suppose that sort of question… from Winnicott… what is the least that needs to be done? And I suppose the role of supervision generally but maybe particularly in relation STPP about keeping perhaps therapeutic zeal in check. So… helping a therapist to be realistic about what the expectations might be." Participant 6, IMPACT and everyday experience

One participant also reflected on the role their supervisor had played in helping them find their authority with regards to implementing STPP in their service in a way that would be helpful and beneficial to the service.

"I think was very helped by my supervisor in that in sort of feeling or being given the permission to be free and to be able to develop the model kind of in a way that would be helpful for us as a service. I think that's been quite important. You know if you only have to offer it to patients up to 17, we would barely be offering it at all. So that wouldn't be helpful for us." Participant 6, IMPACT and everyday experience

Participants also seemed to feel that supervision had offered a crucial place to think about how one might work with the transference in STPP, a fundamental aspect of any psychoanalytic therapy. This will be returned to in a later theme.

"I suppose in our supervision group what came up a lot was talking about to what extent do you take things up directly in the transference. And how soon you can do it… I suppose the conclusion we came more and more to in our small supervision group, that [the time-limit] didn't mean that you shouldn't take things up in the transference. That yes you have to be careful and you have to think about it and you may have to be very thoughtful about the fact that you take something very in directly in the

transference while there is not a long time to kind of work it through... And yet it seemed if you didn't do it that things would not be contained so well. Because… that is the way in which we work." Participant 3, IMPACT and everyday experience

For those participants that had participated in the IMPACT study, there seemed to be a feeling that the supervision had been very helpful and of a very high standard. In comparison, some participants seemed to experience the supervision they had or were receiving in everyday clinical practice as more case-management-focused and therefore perhaps offering less of a space to think about STPP and the challenges of working with the model.

"My supervision for IMPACT was excellent. Really good supervision… I think I had a very good supervisor and that was very helpful…. I mean it's a bit different at [service name]… everyone there has regular individual supervision but it's not the same…. Well I mean this is also being at different levels of work, I think that you know there is more about managing…cases…" Participant 2 IMPACT and everyday experience

The experience of supervision during the IMPACT study seemed to offer additional support and structure to the therapists participating, whilst also requiring them to do more work. This seemed, at least by one participant, to be experienced in a helpful way. This participant also seemed to be highlighting that some of the support present in the IMPACT study had been carried over into everyday clinical practice, by the continuation of the supervision group model, and that this provided additional support to what might ordinarily be offered in their service.

"I mean one of the big differences is the time commitment… that you made to the study so which you simply wouldn't have for all the cases you see in a general CAMHS team or even in a specialist team… The support structure around it… you know that is um different just from everyday life. I suppose what I am very glad about is the fact that certainly in a setting like I'm now in the [centre name] that the small group supervision has being continued to support people who do STPP um because you don't get that level of supervision for all your other once weekly cases that you do post-qualification

or even as a trainee. And yet for STPP that has been supported and kept going. So that is good. Yeah so more supervision, more writing up, more support structures around when you do a particular research study that must have an impact." Participant 3, IMPACT and everyday experience

This seems in contrast to the experience of another participant who shared that there had been an STPP specific supervision group for qualified staff set up in their service following the IMPACT study, however this had become a space for discussing any case due to the pressures on time and resources in the service. They also went on to share that, at the time of the interview, only child psychotherapists in training were offering STPP in their service, as qualified members of staff often had to take on more serious or risky cases, and therefore had not been able to protect clinical time for STPP cases. The relationship between service and resource pressures and STPP will be considered in more detail.

Questions

Who is "The Perfect Patient for STPP"?

All six participants reflected on their experiences of considering which patients might be suited to and be offered STPP. This included thoughts about whether certain patients and presentations might fit better with STPP, what factors might contribute to this, and the role of assessment in helping to determine this. Despite some initial hesitancy from participants, they seemed to have quite clear views about what might indicate that a patient could make use of and fit with STPP. For example, considering the nature and severity of the patient's difficulties and whether STPP would be appropriate for these:

"I think that this was a girl who was you know had some relational difficulties which caused her anxiety. Which affected her sort of quality of life but not to an extent where, err one might have to really sort of see her for longer periods or more frequently throughout the week. And so I think you know if there is such a thing as a perfect

patient for STPP I think she was pretty close to fitting that bill." Participant 5, everyday experience

Furthermore, it seemed that patients with a history of difficulty engaging in longer-term psychotherapy might be well suited to the time-limited nature of STPP, and that this would need to be addressed during the assessment.

"One young woman who was seen for STPP who had had a history of… several treatments which she had broken off after six seven months… Well I suppose that was very much the focus of the assessment with her. Thinking about her experience of that and what had happened. And I think with her my sense was very strongly that…she began with each of her previous therapists to… engage. And that after quite a struggle and periods of not attending and DNAs. But it was precisely at the point at which she started to engage. And that led to this kind of reaction… and she dropped out. So, it seemed to me that the STPP model where every session counts, where there was an ending, sort of very clearly worked with from the beginning seemed to be a really helpful model for her to really kind of foreground some of these issues which were which were there in the assessment and in her background in terms of treatment." Participant 6, everyday experience

The stage of development that the patient is at, and how STPP might fit in with this also seemed to contribute to thinking about which patients' STPP might suit, with an idea that patients' going through developmental transitions might be well suited to STPP.

"I suppose there might be thinking about the time, where they are at that stage of development…. so that might be one of the things you might include in an assessment…. It might not just be somebody who's 17. It might be somebody who's you know 14 and then the year after they're doing GCSEs… it can be children who are… going to do secondary transfer... You know that there's a huge amount of anxiety around the move. And that one might be offering it over the period of time but perhaps

also there's enough functioning going on to feel that they can get back on track. And you might then get them back on track and then they might have some adolescent experience and perhaps come back… So I suppose it's something about does the developmental stage fit with a shorter-term model." Participant 1, everyday experience

However, there also seemed to be some feeling that STPP could be pigeon-holed as a treatment for less severe presentations, and that this might not be a fair and accurate reflection of who STPP might be a helpful treatment for.

"An adolescent might be seen as a bit less disturbed and therefore STPP might be thought about and I think it's been really hard to get across an idea that this is a treatment for moderate to severe depression. And you know that continues to be hard, and I don't think that we're there yet." Participant 6, IMPACT and everyday experience

The four participants that took part in the IMPACT study were asked more directly about their experiences of patients being randomly allocated to treatment arms as part of the IMPACT study, and therefore not having the opportunity to do an assessment for STPP.

"Talking about not having an assessment. My sense with that case was well if it came through a different kind of assessment process that I would have probably said that quite a lot of family work needed to have been done before I would have seen that young person for individual psychotherapy. But we were in the IMPACT study and we had to carry it… I mean it's not as if I think it was harmful and she got something out of it but I suppose my experience of that in that sense was something about the assessment that might have had… a different outcome for the initial stages of that case at least." Participant 3, IMPACT experience

These participants reflected on the aspects of assessments that they seemed to feel were important but missing in the absence of an assessment, for example; the opportunity to assess the *"chemistry"* between the patient and therapist, and assessments supporting clinically appropriate treatment recommendations.

What Might STPP Help With?

The participants reflected on the question of what STPP might help with and shared a variety of thoughts and experiences. For example, the possibility that way that child psychotherapists think about depression may differ from other clinicians and therefore we may have a different understanding of what we are helping with when we treat depression. Furthermore, other difficulties may present themselves alongside depression, such as anxiety.

> *"…the idea that it just do[es] depression. Could it work just as well with anxiety or other things? But the model is depression... I think as child psychotherapists often we see that… our definition of depression can be a different to the psychiatric definition of depression. You know say the younger ones the kids that are acting out externalizing may also actually be quite depressed." Participant 2, everyday experience*

In addition, participants emphasised that STPP can treat and lift the symptoms of depression quite quickly, but that what might be more of a challenge is working with the underlying issues or difficulties that were being expressed or manifested as depression.

> *"I had one person who came for the whole time. She missed two sessions out of 28. Which I thought was really impressive (laughs) but I don't know how much better she got. And then I had two who walked after about 14. And I mean in all of them the depression lifted. The depression lifts quite fast I think, after about six or seven sessions. But then you sort of get into sort of what the fundamental issues might be. It takes quite a lot longer to work on really." Participant 1, IMPACT experience*

Participants also reflected on other areas that they have felt STPP has helped young people with.

> *"I guess it was something about what she was able to do was when she was able to make sense of her mum's difficulties and disturbance in a more ordinary way. I think*

she was able to separate a bit more from her. And when she was able to separate and not be so preoccupied by her… then she began to have her own social life... So I think it allowed more communication. It opened up a line of communication between sessions… I was going to say does it decrease the sort of acting out behaviour. Sometimes you know you get an increase and then a decrease… If you start becoming more aware of your depression you might then want to kind of do more things to get away from that state of mind. But once you can sort of begin to manage what the feelings are… I think it comes back down." Participant 1, IMPACT and everyday experience

As shown above, thinking about and trying to make sense of one's life experience, ways of relating to others, developing relationships, and acting out behaviours were areas that STPP was felt to help with.

How Are Time and Duration Thought About?

It is already apparent that all participants had thoughts about the time-limit in STPP. References have been made to how one might work with limited amount of time, and the challenges this poses, and also to how the psychoanalytic profession might feel about a treatment that could feel like a lot less than we would normally offer a young person. On the other hand, some of the participants felt strongly that STPP could be enough and could be helpful for some young people. This seems to imply a question about how the profession thinks about duration both in relation to the young people we work with, and also in relation to the work we are doing.

"[He] liked having somebody really show interest in him. … I think there was something about… the pace of it. He needed time to absorb things and to think and somebody that could do [this] at his pace a bit. Which is funny actually thinking of STPP as being speeded up in some ways. But within the sessions they weren't speeded up… I think

having space to just see what emerged in his mind was something he quite liked and valued. ***Int:*** *And do you think it felt short term to him? The 28 sessions.* ***Ppt 2:*** *No… I think there's many who don't want something as long and can't manage something as long. And can be helped with something briefer." Participant 2, IMPACT experience and everyday experience*

As shown above, one participant emphasised that to the young person they were working with, STPP did not feel short. Moreover, this participant seemed to be saying that STPP actually gave him an experience of someone showing interest in him and offering time and help to think about himself, at a slow enough pace to manage it. This seems to contradict the idea that STPP would reduce the space and time for thinking, because of the time-limit. Perhaps for a young person who has never experienced therapy, STPP is a good place to start.

"We find that adolescents, often, don't want to um… commit to something that they feel is endless. But there is something that they feel is more manageable maybe in their minds. They feel there is an end to it and that they can see you know the day that they come for a certain period of time and get help and then can move on. So I think it's something about the particular life stage. Also with adolescents where there might be a transition coming up… doing their GCSEs or their A-Levels and they may move schools or go off to university or at the end of University… find a job. You know that they feel that they have a certain amount of time that they can engage with the service." Participant 3, everyday experience

Perhaps this also links to the young person's developmental stage. All participants reflected on experiences that seemed to indicate that for adolescents going through periods of development, transition, and attempting to work through separation and individuation, that STPP may fit very well into this developmental trajectory. This seems connected to the data discussed above regarding a young person's age and the place, or not, of parent-work in

STPP, and also to assessments for STPP and the factors that might be considered when making a treatment recommendation.

Is STPP that Different from Ongoing Child and Adolescent Psychoanalytic Psychotherapy?

In the sub-ordinate theme "***Helping the therapist to maintain the frame": The role of supervision in STPP*** reference was made to the role of supervision helping psychotherapists think about the extent to which the transference might be worked with in STPP, given its time-limited nature. The experience drawn on indicated that one would and should not necessarily work any differently with regards to the transference in STPP, as it is a fundamental aspect of how child psychotherapists work. Furthermore, the manual was described as *"a description of how we usually work"*, and parent-work in STPP was described as *"similar to the role of parent-work in all um therapy cases"*.

> *"So when I did STPP as part of IMPACT I felt very clear that it wasn't actually very different at all to ordinary psychotherapy. Apart from keeping a… really clear idea of the frame and the time length so that you're always aware of when you're beginning and when you are ending and how far through you are. And that… makes it different. But the actual sessions didn't feel very different… Um I still maintain I don't think it is that different." Participant 2, IMPACT experience and everyday experience*

On the other hand, one participant did seem to experience STPP as different from long-term psychotherapy. They seemed to feel that it gave them licence to be more direct, which in fact lends more support to the idea that one should work in the transference as and when it emerges in STPP, and that the time-limited nature of STPP might in some way facilitate this.

> *"I think it gave me license to work in a different way to how I normally would've… I kind of did things that were quite daring in some ways. You know that I would never have thought about doing in a more long-term piece of work. I was more direct and actually the worry about being more direct in long term work is that you're going in too soon*

and what would happen to the patient. But actually, I mean it varies from patient to patient, but in this case the patient was able to take it on and use it." Participant 5, everyday experience

These reflections beg the question, is STPP that different from ongoing therapy with regard to the fundamental aspects of psychoanalytic work? The overall experiences of the psychotherapists' interviewed seemed to indicate that STPP might not be that different after all.

Additional Themes

The following two themes were deemed important and necessary for inclusion; however, they did not fit into the super-ordinate themes presented above.

Managing Pressures on Resources

Four of the six participants reflected on the reality of pressures and limitations on resources in their service, the growing waiting lists, and the ways in which STPP might help to manage these resource-based pressures.

"You know it would be lovely to work to feel that you really did have the freedom to say okay this person needs five times a week, or three times a week or whatever it is for a long time. And we can do that. This person needs twelve sessions, six sessions, 28 sessions and we can do that. And you didn't have a waiting list of 200 people, desperate. But but that's not reality. And I think that it would be a shame, a tragedy, if everything became STPP and there wasn't any room for anything more in-depth. Sometimes it feels like it's going that way. But I think STPP in itself isn't a tragedy. I think it's helpful. And effective." Participant 2, everyday experience

This excerpt represents a view held by all participants that whilst STPP cannot replace longer-term more intensive psychotherapy, it is helpful and effective, especially in the context of a

very long waiting list. On the other hand, there also seemed to be questions and concerns about what the need for a shorter-term psychoanalytic treatment might represent, for example reduced resources and therefore reduced capacity to offer longer-term treatments. If so, might *"anxieties"* about this have an impact on the way in which STPP can be received, adopted, and used by child psychotherapists?

> *"You know sort of the timing of us beginning to introduce STPP here really coincided with us really having to kind of get to grips with quite a significant reduction in the number of clinicians… [and] the resources that we have. And so therefore I think one of the anxieties was the fact that this was coming in… as a sort of consequence of having less resources and the kind of anxiety about what that… would mean for our capacity to offer longer-term treatments." Participant 6, everyday experience*

In the context of thinking about pressures on resources, all participants in the study reflected on the service within which they have experienced and used STPP. An overarching area of preoccupation seemed to be whether, and if so how, STPP fitted in with the service. For example, one participant working in a specialist medical setting in which psychoanalytic thinking and work was used in an applied way, seemed to feel that STPP had fitted well into the service and the way in which patients could access CAMHS in a more *"dip in dip out"* way, because of the fact that the CAMHS provision sits alongside medical services.

Thus, it appears that whilst STPP was experienced as helpful for managing pressures on resources; especially if it was felt to fit well into the service, there were also anxieties about what the need for shorter-term treatment to help manage resources might mean for more traditional ways of working, such as longer-term psychotherapy.

"Getting It Right"

The participants also conveyed some feeling of pressure to do STPP "right". This seemed to be linked to the fact that STPP was manualized for an RCT, so suggesting that there is a

"right" way to do it which clinicians must follow. This seemed to have implications for how free participants felt to use STPP flexibly, particularly in relation to their experiences of using STPP as part of the IMPACT study. This is clear in the description given by one participant (below).

> *"The sort of anxiety about what this thing was and were we going to be getting it right. And you know what was allowed, what wasn't allowed, that kind of kind of discourse was very very prominent. And… one of the aims of the day [a study day] was to try to dispel that and to help people to think well this is a model that's you know it's a manualized treatment, but this is now for individual clinicians and services to use in a way that's sort of going to be most helpful… I think we're also have found that in some cases in [service name] we've been quite flexible about the number of sessions. So I can think of the patient who for, various reasons wasn't able to attend from the beginning wasn't able to come for 28 sessions. So it was a 24 session treatment and we would consider we considered that as STPP…* it's that sort of thinking and the way that the frame is worked with that to me this is the kind of essence of the treatment and the time-limited nature of that.*" Participant 6, IMPACT and everyday experience*

However, this account also conveys a strong sense that despite being a manualized treatment, STPP should be used in a way which best suits the needs of the service it is being used in, rather than a strict focus on always having to be exactly 28 sessions, providing that the time-limit and frame is thought about.

Discussion

The study aimed to explore child psychotherapists' experiences of offering STPP as part of an RCT and in everyday clinical practice. The findings seem to indicate that a wide range of experiences, related to a variety of aspects of offering STPP, came to light. These findings will be summarised and discussed in relation to the literature presented earlier.

STPP in an RCT and Everyday Clinical Practice

Although there are some differences, it is striking that the findings from the analyses of both sets of data produced very similar and interwoven themes, despite being generated in different contexts. The new data collected for this study was generated in response to questions from a semi-structured interview schedule focussed on child psychotherapists' experiences of STPP. By contrast, the data utilised from the IMPACT-ME study was generated in response to questions from an interview focussed on therapists' experiences of working as part of the IMPACT study. That the themes from both analyses are so similar might suggest that the themes identified offer a helpful representation of the types of experiences that psychotherapists might have when offering STPP, regardless of context, thus giving them more weight.

It is important to acknowledge that the author worked as a research assistant on the IMPACT-ME study and conducted some of the IMPACT-ME interviews. Therefore, he was anecdotally familiar with the types of data that might have been emerging from these interviews. It is possible that this could have influenced the design of the interview schedule used, and also the analysis of both data sets, perhaps with particular themes and areas of interest more likely to be noticed or drawn out. Whilst this cannot be ruled out, the guidelines for both the TA and IPA were followed carefully to reduce the possibility of such bias. These issues are considered in more depth in the section Critical Reflections.

Perhaps unsurprisingly, a common area of experience that participants reflected on, of offering STPP both as part of an RCT and in everyday clinical practice, seemed to be the time-limit and the challenges of working with this. Some experiences seemed to suggest that STPP might not be long enough, patients might need to be offered more, and that it can be difficult to stick to the time-limit. Participants appeared to try and make sense of this in relation to the pain involved in loss and separation both for the patient and the child psychotherapist, particularly it seemed when working with depression. Participants seemed to connect this to the dilemma of whether what is offered is ever enough, and whether more could always be done (Cregeen et al, 2017). On the other hand, and to the surprise of participants from both the RCT and everyday clinical practice, there also seemed to be experiences of STPP being long enough to meaningfully help patients. Participants reflected on experiences of STPP being helpful with getting to the heart of matters, patients' (and psychotherapists') relationship to the reality of the passing of time, managing patient engagement (such as DNAs), and providing a containing structure in which projections and anxiety can be managed and thought about. In turn, this seemed to influence perceptions of the potential value of STPP, with some participants feeling strongly that they would like to continue to work with the model of STPP, and others feeling that it is important to stick to the model and not be too flexible, whilst also acknowledging that clinical need might supersede this in some situations. Questions about the importance of technique and the role of strategies to focus the work on specific areas given the time-limit also seemed to be considered, for example the use of Goal Based Measures (Emanuel et al, 2014).

Again, perhaps not surprisingly, reflections on experiences of aspects of the STPP model both in an RCT and everyday clinical practice were given. Participants spoke about the challenges of using a manual with psychoanalytic therapy, how unfamiliar and potentially restrictive this could feel, and the anxiety this could generate. In contrast, the manual was described as "descriptive not prescriptive", suggesting that it could be helpful in describing the work, whilst not limiting it. Furthermore, the manual seemed to be experienced as supportive particularly

with keeping in mind the number of sessions offered, containing both patients and psychotherapists, and providing a helpful learning tool (related to formulations around depression).

Participants also spoke about experiences of the parent-work. It appeared that participants found this an important, supportive and containing aspect of STPP, that could help engage and contain patients, particularly younger patients. It also seemed important to keep in mind that parent-work might not be appropriate or desirable for all cases, depending on the patient's age and developmental stage. Thus, it seemed that the role and place of parent-work might be case-specific and need to be thought about carefully. Parent-work also seemed to be potentially helpful for the parents themselves, from the psychotherapists' perspective, providing they were able to engage with it. Stapley et al (2017) highlighted mixed patterns of parental attendance and engagement with the parent-work offered in IMPACT, and also mixed experiences of the helpfulness of the parent-work.

Experiences of the supervision offered alongside STPP both in an RCT and everyday clinical practice were also shared. Supervision seemed to be experienced as having an important role in helping to think about the challenges of offering STPP, such as: the way in which the time-limit is thought about and subsequently worked with particularly in the face of pressure from the patient and also within the psychotherapist to offer more, technical questions such as whether and how much to work in the transference, and finding one's authority to offer STPP in a clinically relevant way for the service in which it is being offered. The group format of supervision was also reflected on as being sufficient and good enough. Interestingly, there seemed to be some differences between the experience of supervision offered within the RCT and in everyday clinical practice. It seemed more challenging to protect the space of supervision in everyday clinical practice with this becoming, perhaps inevitably, a space used for considering other cases and management issues. This seemed to be linked in the participants' minds to pressures on resources and also to the differing role of supervision in everyday work for qualified psychotherapists; less focus on clinical work and more on case

management, whereas the supervision in IMPACT was put in place to help think about the clinical work with each patient.

Emerging Questions, Revisited

A number of questions emerged both from the RCT and everyday clinical practice data, although more prominently in the latter, perhaps because there was more space for exploring such questions in these interviews. Some of these questions also seemed linked to the questions that emerged out of the literature review. These will be reflected on here, where relevant.

One question seemed to be about which patients might fit best with STPP, and a mixture of views were shared about this. There seemed to be some experience of STPP being offered more often to patients with less severe and complex presentations. This seemed to resonate with the literature presented earlier which suggested some uncertainty about whether short-term treatments such as STPP are suitable for patients with more severe presentations (Balint, Balint & Ornstein, 2013; Malan, 1963; Sifneos, 1972, Mann, 1973; Davanloo, 1980; Sherwin-White, 2017). On the other hand, it was noted that adolescents in the IMPACT study presented with *"moderate to severe depression, with self-harm, [and] suicidality*" (Goodyer et al, 2017, p.117). Furthermore, a substantial proportion of the IMPACT patients reported current suicidal ideation (61%) and more than a third of them (38%) reported lifetime suicide attempts (Goodyer et al, 2017 p.113), so challenging this idea. The relationship between the time-limit and the nature of a patient's engagement was considered. Some experiences appeared to indicate that for those who struggle with engagement in longer-term treatment, STPP might be helpful in beginning to bring relational issues to the foreground: working with the end of the relationship from the beginning. The age and developmental stage of the patient also featured, with experiences that suggested that STPP might fit well for patients at points of developmental transition, particularly the transition from primary to secondary school (and

perhaps more broadly latency to adolescence and puberty), and also from adolescence to early adulthood. Might this link to the idea that adolescence itself, in ordinary circumstances, is a time-limited process (Waddell, 2018, p. 31)?

Participants also reflected on what STPP might be helpful for, and whether it is limited to the treatment of depression as was the case in the IMPACT study. There seemed to be a general feeling that STPP could be helpful for the treatment of a variety of presentations, and also an acknowledgement that in everyday clinical practice depression comes with many comorbidities (as indicated in the literature review; Cummings et al, 2014), such as anxiety, and that STPP can be helpful for working with patients with such comorbidities. The differences between the way child psychotherapists might conceptualise depression in comparison to other mental health professions also seemed to feature. Child psychotherapists were associated with thinking about aspects of depression such as externalising and acting-out behaviours, and relational difficulties, that may not fit so neatly with diagnostic conceptualisations of depression. The participants seemed to experience STPP as potentially helpful for such difficulties, whether these are thought of as symptoms of depression or not. There were also thoughts about the helpfulness of STPP in lifting the presenting symptoms of depression, whilst not offering enough time to work through the difficulties that are underlying the symptoms.

The question of how time and duration might be thought about and understood also seemed present in the participants' experiences. It appeared that for some patients, as acknowledged by the participants, 28 sessions did not feel like a short amount of time. As reflected on earlier, it seemed that the difficulty with managing the time limit was felt as or more acutely by the participants than the patients. This calls into question why there might be a preconception within the profession of child psychotherapy that 28 sessions is thought about as short, and therefore perhaps why the word 'short' appears in the name STPP. Participants gave the impression that STPP helped patients with the reality that time passes and is not infinite (as stated by Money-Kyrle, 1971). However, perhaps there is a difficulty within the profession of

tolerating the reality of time passing, its finite nature, and of the inevitably disappointing reality of only managing to do so much. Perhaps this contributed to the difficulty some participants had with sticking to the time-limit/ending. Child psychotherapists might well argue that it is the role of supervision to help manage these difficulties and conflicts in the work of STPP (as the participants seemed to emphasise this), however the supervision is also offered by child psychotherapists, who may be subject to these preconceptions. The difficult reality of only being able to do so much seems linked to Winnicott's idea, referenced by one of the participants, that one should be asking *"how little need be done?"* (1962, p.166), and also to the idea of an ending that is good enough (Lanyado, 1999). In turn, might this influence child psychotherapists' perception of lengths of time, possibly leading to the length of STPP feeling or seeming shorter than it actually is? While there is likely to be a great deal of individual variation in how people manage this existential question, might this be an important contributing factor to the resistance STPP could, and sometimes does, face?

Furthermore, participants seemed to be left questioning whether STPP is really that different from open-ended psychotherapy and appeared to feel that, whilst the main difference was having to keep in mind the time-limit from the beginning and bring this into sessions, in many ways it is not substantially different. For participants offering STPP in both an RCT and everyday clinical practice, this related to experiences working with the manual, and also to fundamental aspects of psychoanalytic psychotherapy such as parent-work, supervision, working with breaks in the therapy and working with the transference. Together these experiences seemed to suggest that psychotherapists experienced offering STPP as more similar to open-ended psychotherapy than they had expected to. The question of whether one has to work differently in short-term treatments, by modifying technique, emerged in the literature review. For example, the therapist taking a more active position (for example: Rank & Ferenczi, 1925; Alexander & French, 1946; Marmor, 1979), challenging resistances more directly (Freud, 1937), or focussing on specific events, associations, memories and affects (Malan, 1963). The participants did reflect on the need to keep in mind and talk about the

number of remaining sessions, and so perhaps this an example of working in a more active way. This is interesting in relation to Bion's (1967) idea about the need to leave memory and desire out of the consulting room. Of course, this is not interpreted as meaning that the therapist will literally have no memory of the patient but is an expression of the analytic attitude that conveys the therapist's commitment not to impose their own presuppositions on the patient. Is this possible when having to hold in mind the number of sessions and duration of treatment? Furthermore, the experience that the time-limit of STPP can engage patients who have previously been resistant to engaging in therapy, seems related to Freud's (1937) writings that an end-date can help analyses that have otherwise become stuck or "interminable". However, as stated above, participants seemed to experience the way they worked in STPP as not that different from open-ended psychotherapy. The question of difference between STPP and open-ended psychotherapy will be discussed further in Critical Reflections.

The relationship between STPP and the pressures on NHS resources also featured in the participants' experiences in both groups. STPP seemed to be thought of as having a potentially important role in helping to manage these pressures, whilst still offering a treatment that is true to core elements of psychoanalysis; as was the case with Mann's (1973) short-term therapy to help manage waiting times. On the other hand, the very need for a time-limited treatment in order to help manage these resource pressures seemed to provoke anxiety about the longevity of more traditional longer-term psychoanalytic treatments that are offered to some patients currently, even within the NHS (this point will be developed in Critical Reflections). Perhaps linked to this, there was a view that STPP might fit best in services and settings where psychoanalytic work is more applied and less traditional.

Participants' experiences related to the impact of offering STPP as part of an RCT were reflected on, both in the IMPACT-ME data, and the current study, as four of the six participants interviewed for the present study had also participated in IMPACT. Perhaps most significantly, participants reflected on the challenges of offering STPP to patients who had been randomised

to, rather than assessed and recommended for the treatment. There seemed to be shared experiences that a lack of assessment could lead to difficulties with engagement, perhaps due to the lack of opportunity to explore whether STPP was an appropriate treatment recommendation for the patient, and for the patient to have a taster of psychotherapy and therefore make an informed choice about entering into STPP. This also emerged in the literature review (Malan, 1963, 1976; Marmor, 1979) and might indicate that assessments have an important role in helping to find the most appropriate treatment for patients, which would probably not come as a surprise to most psychological practitioners, let alone child psychotherapists (Butcher, 1997).

The anxiety that offering STPP as part of a large RCT seemed to generate also featured. This appeared to be focussed around anxieties about doing STPP 'right'. This seemed related to the highly regulated nature of the RCT, the manual, and perhaps the knowledge for IMPACT participants that sessions were audio-recorded and then rated for fidelity (Goodyer et al, 2011). By implication this introduces the possibility of doing STPP 'wrong'. Interestingly, these anxieties were still present in the accounts of psychotherapists offering STPP in everyday clinical practice, perhaps suggesting a hangover of such anxieties from the RCT. As noted previously, Osborne (2011) identified the theme "Doing it Right" in her doctoral research exploring therapists' experience of an aspect of CAT. Might this suggest that regardless of whether a therapy has its origins in an RCT, therapists might always have some degree of anxiety about whether they are doing or getting it right? Of course, this is also a piece of research. Therefore, it is possible and perhaps likely that this theme emerged here because participants felt anxious about both portraying their experience of offering STPP in a "right" way and what the author would think about how they portrayed these, and also about participating in the current study in a "right" way i.e. giving the author what he was looking for when he asked questions in the interviews.

Whilst it is not possible to be conclusive about whether the findings of this study offer support for the possibility that STPP might offer as good, or better, treatment outcomes than longer-

term treatments (given the qualitative nature of the study), the experiences shared here do suggest that psychotherapists who have used STPP as well as the longer-term treatments that are part of their routine practice do regard it as being potentially helpful for certain patients. Thus, perhaps one should not expect worse outcomes from STPP simply because it is shorter. This also seems linked to the question of what, if anything, might be lost when treatment length is limited. One thing that seemed to be felt to be lost was the opportunity to work through the issues and conflicts that might be underlying the presenting symptoms. One might consider whether this is what the patient wants, and whether for some patients, symptom alleviation is the primary aim. However, the participants who reflected on this seemed to do so with some regret that there was not an opportunity to help patients work through these deeper issues and conflicts, seemingly because of the time-limit.

Critical Reflections

Thus far, the findings of the study have been discussed mostly in relation to what the participants reported their experiences to be. At this point it is helpful to consider how these experiences might be understood and interpreted more critically.

Participants in this study shared a range of experiences which seem to suggest that, to their surprise, STPP and the more traditional open-ended approach might not be so different after all. This related to aspects of the work such as technique (e.g. working in the transference), assessment, which patients STPP might be able to help, potential treatment outcomes, and model-based structures such as supervision and parent-work. Why might the participants have expected STPP to be both different and not as helpful as they seemed to find it to be (that is, why were their preconceptions so powerful?), and why might their experiences of offering STPP have changed these preconceptions?

A possible way of understanding this was previously offered; a difficulty within the child psychotherapy profession with managing the reality of the passing of time and the possibility

that one may never be able to offer/do enough. Another approach to understanding more about this might be to go back to a question posed in the literature review: are psychoanalysis, psychoanalytic psychotherapy, psychodynamic psychotherapy, STPP and so on, actually distinct and different treatment models, as so often asserted? And, in turn, why is there a need to assert this distinction?

Might it be the case that short-term treatments challenge and threaten (at least in perception rather than apparent lived experience, as shown in the findings) some of the supposed core psychoanalytic traditions? These traditions form a central part of the training of child and adolescent psychoanalytic psychotherapists. For example, trainees must meet the clinical requirements which include having the experience of a three-times-weekly case from each of the three age groups (under-five, latency, and adolescence), all lasting a minimum of one year, and one lasting two years, with accompanying weekly individual supervision. Might this leave child psychotherapists feeling that new developments, such as STPP, threaten their identity and existence; particularly if STPP's success might mean the decline of intensive, longer-term, open-ended work within the NHS, where the pressure to deliver more for less continues to grow?

To develop this further, might this link back to the criticism and sense of being under attack, that psychoanalysis is reported to have experienced since its beginnings (Lothane, 2001)? If so, this might have created a legacy of defensiveness and reluctance in psychoanalysis and subsequently child psychotherapy, such that developments to the established ways of working feel threatening. In turn this may contribute to a feeling of a need to resist such developments and think about them as different, distinct, and fundamentally unwanted. This might speak to the reluctance that some participants alluded to regarding STPP and working with the time limit. For example, that STPP was not long enough and that more would be needed in order to do the job properly. Of course, this may have been based on clinical experience with patients; however, might this clinical experience be influenced by a predisposition to feeling threatened and in need of protecting a professional identity built around the traditions of

psychoanalysis? Moreover, linked to the previous explanation above, might there be a preconception that the work offered will never be enough if it is not traditional psychoanalysis? In the Additional Theme, “Managing Pressures on Resources”, there seemed to be some anxiety about the need for shorter-term treatments and what this means for the place of longer-term work. Perhaps this is an example of the feeling of threat to identity and existence, and then in response a reluctance and resistance to change.

It is interesting, then, that overall, the participants seemed to experience STPP as a valuable treatment option, and as more psychoanalytic than they expected. In the manual, STPP is described as being true to core psychoanalytic principles (Cregeen et al, 2017). Thus, it could be argued that in many ways STPP is traditionally psychoanalytic, and therefore it seems odd that it was not expected to be so. Perhaps this helps make sense of why participants seemed to be more open to STPP as a treatment option, once they had gained experience of offering it; the lived experience that STPP really is not that different from open-ended child psychotherapy. However, how else might this favourable view of STPP be understood? Could it also be connected to an underlying anxiety that if cuts to resources might mean a reduction in the capacity to offer longer-term, open-ended, more traditional psychotherapy, and fundamental worries about the existence of child psychotherapy, STPP might have to be the best alternative, and therefore that the discipline might need to embrace it? With such anxieties at play, might the participants have felt some need to identify and focus on the psychoanalytic components of STPP (transference, parent-work, supervision and assessment etc) so as to remain connected to the traditions of psychoanalysis and psychoanalytic psychotherapy, even within a time-limited therapy?

The need for a critical reflection on the author’s position in relation to the profession of child psychotherapy, and his experience of STPP, is also necessary. It seems possible that the author’s interest in exploring child psychotherapists’ experiences of offering STPP, which developed as previously stated during work as an RA on the IMPACT-ME study, could have been driven by a motivation to try and prove something of the value of psychoanalytic child

psychotherapy, given that he went on to train and now work as a child psychotherapist. If so, this might have made it more difficult for the author to hold a critically reflective stance when developing the interview schedule, conducting the interviews, analysing the data, and writing the analysis up. Moreover, given that it is likely that the author holds similar passions for psychoanalysis and child psychotherapy to those held by the participants, might he also be subject to the potential resistance and reluctance that some of them seemed to experience in relation to STPP? Additionally, given that the author knew a number of the participants and had been supervised by three of them during the course of his training, might he have been influenced by the pre-established hierarchy in these relationships, making it more difficult to question and interpret their responses in the interviews and during data analysis, particularly if he might be inclined to agree with their views? Finally, given that the doctoral supervisor is also a child psychotherapist, and edited the STPP treatment manual (Cregeen et al, 2017), might this call into question how objective the dialogue regarding the data analysis and emerging themes was? If so, these factors might have made the author more likely to identify themes that continue to serve the traditions of psychoanalytic child psychotherapy, search for answers within the data that fitted a preconceived idea of what could be found, and to not explore or interrogate the responses given by the participants at a deeper level.

Whilst it is important to consider these potential limitations and biases, rigorous methodology for both the thematic analysis and the interpretative phenomenological analysis (as documented in the methodology section) were employed in order to try and minimize their potential impact. For example, as highlighted in the section on reflexivity: the use of reflective note-taking on the transcripts and in a diary, the internal reflection employed by the author throughout the process, and the dialogue between the author and the doctoral supervisor when outlining the emerging themes. Furthermore, the findings are suggestive of experiences that also do not fit the aforementioned preconceptions, which lends support to their being an openness within this work to discovering new ways to understand the experience of offering STPP.

Limitations and Strengths

In addition to the potential for subjective bias, accounted for by employment of rigorous methodology (documented above), the findings presented here are only an exploration of a small sample of child psychotherapists' experiences of offering STPP, and to a fairly limited patient population of adolescents and young adults. Therefore it is not possible to draw firm conclusions about what it might be like to offer STPP, or to generalise the experiences of the participants of this study to other child psychotherapists offering STPP, or what the experiences of child psychotherapists might be if they were to offer STPP to younger children.

However, given the dearth of research exploring the experiences of psychotherapists of offering any modality of therapy, the current study could offer an important and potentially stimulating contribution to this field of research. Furthermore, to the author's current knowledge this is the only study that combines qualitative data exploring child psychotherapists' experiences of offering a specific type of time-limited therapy, by combining data from an RCT and freshly collected data. This appears to be a novel method of exploring such a question.

Conclusions and Implications

As noted, psychoanalysis and psychoanalytic psychotherapy have a long history of time-limited treatment going all the way back to Freud (1937). This study explored child psychotherapists' experiences of one such treatment: STPP.

It would appear that the child psychotherapists interviewed as part of an RCT and in the current study experienced STPP as a potentially helpful and valuable treatment option for children and adolescents and young adults with a range of mental health difficulties. Furthermore, there seemed to be some surprise at this being their experience, with a sense that STPP is more similar to open-ended psychotherapy than they had been expecting. This seemed to relate to key aspects of technique (working in the transference), and the model (parent-work,

supervision and assessments). STPP was also felt to be helpful for aspects of work such as engagement, connecting patients to the reality of the passing of time, and particularly for young people at points of developmental transition. Participants' experiences also seemed to suggest that whilst it is important to work to the model (as per the manual), it might also be for each team of child psychotherapists to think about how STPP fits best within their service, and meets the needs of both the patients they are working with and also the service and the resources available.

However, it is complex to attempt to draw out implications for the profession of child psychotherapy, from the experiences documented here, as one has to be cautious about the way in which these experiences are understood. It seems possible that the participants' perceptions and experiences of STPP might have been influenced by a number of less conscious preconceptions and conflicts. These might include: difficulties with managing the passing of time and tolerating the reality of only being able to do so much, which STPP faces them with; worry about what the presence of STPP might mean for the identity and existence of child psychotherapy and its traditions; and perhaps because of this a need to embrace and promote STPP and its psychoanalytic components and roots. This might have been further contributed to by the author's position as having a previous personal and professional connection to STPP, as well as to the profession of child and adolescent psychoanalytic psychotherapy. In combination these factors could have rendered it more likely that STPP was experienced as a helpful, valuable, and psychoanalytic. Rigorous methodology was of course employed in order to try and manage these potential biases.

Thus, the small sample of child psychotherapists interviewed here appeared to experience STPP as a potentially helpful, and at its core psychoanalytic, treatment option. This could lend support to the use of STPP by child psychotherapy teams within mental health services in the NHS. It is for these teams, and child psychotherapists themselves, to begin to think about and examine their preconceptions about short-term treatment options and continue to do this thinking, in the context of responding to the cuts to services within the NHS.

References

Abbass, A. A., Rabung, S., Leichsenring, F., Refseth, J. S., & Midgley, N. (2013). Psychodynamic psychotherapy for children and adolescents: A meta-analysis of short-term psychodynamic models. *Journal of the American Academy of Child & Adolescent Psychiatry*, *52*(8), 863-875.

Alexander, F. (1925). A metapsychological description of the process of cure. *International Journal of Psychoanalysis, 6*, 13-34.

Alexander, F., & French, T. M. (1946). Psychoanalytic Therapy; principles and application. New York: Ronald Press.

Balint, M., Balint, E., & Ornstein, P. H. (2013). *Focal Psychotherapy: An Example of Applied Psychoanalysis*. London: Routledge.

Baruch, G., & Fearon, P. (2002). The evaluation of mental health outcome at a community-based psychodynamic psychotherapy service for young people: A 12-month follow-up based on self-report data. *Psychology and Psychotherapy: Theory, Research and Practice*, *75*(3), 261-278.

Bateman, A., & Fonagy, P. (2001). Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalization: an 18-month follow-up. *American Journal of Psychiatry*, *158*(1), 36-42.

Bengtsson, J., Nordin, S., & Carlbring, P. (2015). Therapists' experiences of conducting cognitive behavioural therapy online vis-à-vis face-to-face. *Cognitive behaviour therapy*, *44*(6), 470-479.

Bion, W. (1967). Notes on memory and desire. *Classics in Psychoanalytic Technique*, 259-260.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101.

Butcher, J. N. (1997). Introduction to the special section on assessment in psychological treatment: A necessary step for effective intervention. *Psychological Assessment*, *9*(4), 331.

Calvert, R., & Kellett, S. (2014). Cognitive analytic therapy: A review of the outcome evidence base for treatment. *Psychology and Psychotherapy: Theory, Research and Practice*, *87*(3), 253-277.

Cregeen, S., Hughes, C., Midgley, N., Rhode, M., Rustin, R. ed. J Catty. (2017). Short-term Psychoanalytic Psychotherapy for Adolescents with Depression: A Treatment Manual. London: Karnac.

Cummings, C. M., Caporino, N. E., & Kendall, P. C. (2014). Comorbidity of anxiety and depression in children and adolescents: 20 years after. *Psychological Bulletin*, *140*(3), 816.

Davanloo, H. (1980). *Short Term Dynamic Psychotherapy.* New York: Aronson.

Driessen, E., Cuijpers, P., de Maat, S. C., Abbass, A. A., de Jonghe, F., & Dekker, J. J. (2010). The efficacy of short-term psychodynamic psychotherapy for depression: a meta-analysis. *Clinical Psychology Review*, *30*(1), 25-36.

Emanuel, R., Catty, J., Anscombe, E., Cantle, A., & Muller, H. (2014). Implementing an aim-based outcome measure in a psychoanalytic child psychotherapy service: Insights, experiences and evidence. *Clinical child psychology and psychiatry*, *19*(2), 169-183.

Fairburn, C. G., Jones, R., Peveler, R. C., Hope, R. A., & O'Connor, M. (1993). Psychotherapy and bulimia nervosa: Longer-term effects of interpersonal psychotherapy, behaviour therapy, and cognitive behaviour therapy. *Archives of General Psychiatry*, *50*(6), 419-428.

Fonagy, P., & Target, M. (1994). The efficacy of psychoanalysis for children with disruptive disorders. *Journal of the American Academy of Child & Adolescent Psychiatry*, *33*(1), 45-55.

Freud, S. (1937). Analysis Terminable and Interminable. In *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XXIII (1937-1939): Moses and Monotheism, An Outline of Psycho-Analysis and Other Works* (pp. 209-254).

Gill, MM. (1982). Analysis of transference. Volume I. Theory and technique. *Psychological Issues, 52*, 1-193.

Goodyer, I. M., Tsancheva, S., Byford, S., Dubicka, B., Hill, J., Kelvin, R., ... & Wilkinson, P. (2011). Improving mood with psychoanalytic and cognitive therapies (IMPACT): a pragmatic effectiveness superiority trial to investigate whether specialised psychological treatment reduces the risk for relapse in adolescents with moderate to severe unipolar depression: study protocol for a randomised controlled trial. *Trials*, *12*(1), 175.

Goodyer, I. M., Reynolds, S., Barrett, B., Byford, S., Dubicka, B., Hill, J., ... & Senior, R. (2017). Cognitive behavioural therapy and short-term psychoanalytical psychotherapy versus a brief psychosocial intervention in adolescents with unipolar major depressive disorder (IMPACT): a multicentre, pragmatic, observer-blind, randomised controlled superiority trial. *The Lancet Psychiatry*, *4*(2), 109-119.

Göttken, T., & von Klitzing, K. (2011). “I hate nursery school because I’m not alone!” Brief Psychoanalytic Therapy for children with emotional symptoms and affective disorders (PaCT). *Kinderanalyse, 19*, 189 –214.

Göttken, T., White, L. O., Klein, A. M., & von Klitzing, K. (2014). Short-term psychoanalytic child therapy for anxious children: A pilot study. *Psychotherapy*, *51*(1), 148.

Holmes, J. (1994). Brief dynamic psychotherapy. *Advances in Psychiatric Treatment*, *1*(1), 9-15.

Horner, A. J. (1994). Treating the Neurotic Patient in Brief Psychotherapy. Jason Aronson, Incorporated.

Howard, K. I., Kopta, S. M., Krause, M. S., & Orlinsky, D. E. (1986). The dose–effect relationship in psychotherapy. *American Psychologist*, *41*(2), 159.

Klein, M. (1932a). Die Psychoanalyse des Kindes. Munich/Basle: Fischer.

Klerman, G.L., Weissman, M.M., & Rounsaville, B.J. (1984). *Interpersonal Psychotherapy of Depression*. New York: Basic Books.

Lanyado, M. (1999). Holding and letting go: Some thoughts about the process of ending therapy. *Journal of Child Psychotherapy*, *25*(3), 357-378.

Larkin, M., & Thompson, A. R. (2012). Interpretative phenomenological analysis in mental health and psychotherapy research. *Qualitative Research Methods in Mental Health and Psychotherapy*, 101-116.

Lothane, Z. (2001). A Response to Grunbaums 'A Century of Psychoanalysis Critical Retrospect and Prospect (and other texts): Requiem or Reveille'. In *International Forum of Psychoanalysis* (Vol. 10, No. 2, pp. 113-132).

Malan, D. H. (1963). *A Study of Brief Psychotherapy*, New York: Plenum.

Malan, D. H. (1976). *The Frontier of Brief Psychotherapy: An Example of the Convergence of Research and Clinical Practice*. New York: Plenum.

Malan, D. H. (1979). *Individual Psychotherapy and the Science of Psychoanalysis*. London: Butterworths.

Mann, J. (1973). *Time Limited Psychotherapy*. Cambridge: Harvard University Press

Marmor, J. (1979). Short-term dynamic psychotherapy. *The American Journal of Psychiatry*. *136*(2), 149–155.

Menninger, K. (1958). *Theory of Psychoanalytic Technique.* Basic Books.

Midgley, N., Ansaldo, F., Parkinson, S., Holmes, J., Stapley, E., & Target, M. (2011b). Experience of therapy interview (Young Person, Parent and Therapist Versions). Unpublished manuscript, Anna Freud Centre, London.

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

Midgley, N., Ansaldo, F., & Target, M. (2014). The meaningful assessment of therapy outcomes: Incorporating a qualitative study into a randomized controlled trial evaluating the treatment of adolescent depression. *Psychotherapy*, *51*(1), 128–37.

Midgley, N., Holmes, J., Parkinson, S., Stapley, E., Eatough, V., & Target, M. (2014). “Just like talking to someone about like shit in your life and stuff, and they help you”: hopes and expectations for therapy among depressed adolescents. *Psychotherapy Research, 26*(1), 11-21.

Midgley, N., Isaacs, D., Weitkamp, K. & Target, M. (2016). The experience of adolescents participating in a randomised clinical trial in the field of mental health: A qualitative study. *Trials*, *17*(1), 364.

Midgley, N., Parkinson, S., Holmes, J., Stapley, E., Eatough, V., & Target, M. (2015). Beyond a diagnosis: The experience of depression among clinically-referred adolescents. *Journal of Adolescence, 44*, 269–279.

Midgley, N., Parkinson, S., Holmes, J., Stapley, E., Eatough, V. & Target, M. (2016). 'Did I bring it on myself?' How adolescents referred to mental health services make sense of their own depression. *European Child and Adolescent Psychiatry*, *26*(1), 25-34.

Money-Kyrle, R. (1971). The aim of psychoanalysis. *International Journal of Psychoanalysis*, *52*, 103-106.

Osborne, J. (2011). *Clients' and therapists' experience of sequential diagrammatic reformulations in cognitive analytic therapy* (Doctoral dissertation, University of London).

Psychoanalytic or Psychodynamic? (2019, November 24). Retrieved from https://www.bpc.org.uk/about-psychotherapy/what-pp.

Parkinson, S., Eatough, V., Holmes, J., Stapley, E. & Midgley, N. (2016). Framework Analysis: A worked example of a study exploring young people's experiences of depression, *Qualitative Research in Psychology, 13*(2), 109-129.

Rank, O. (1924). The trauma of birth in its importance for psychoanalytic therapy. *Psychoanalytic Review*, *11*(3), 241-245.

Rank, O., & Ferenczi, S. (1925). *The Development of Psychoanalysis*. New York: Nervous and Mental Disease Publishing Co.

Ryle, A., Poynton, A. M., & Brockman, B. J. (1990). *Cognitive-Analytic Therapy: Active Participation in Change: A New Integration in Brief Psychotherapy*. Hoboken, NJ: John Wiley & Sons.

Searle, L., Lyon, L., Young, L., Wiseman, M., & Foster-Davis, B. (2011). The young people's consultation service: An evaluation of a consultation model of very brief psychotherapy. *British Journal of Psychotherapy*, *27*(1), 56-78.

Sherwin-White, S. (2017). Melanie Klein Revisited. London: Routledge.

Sifneos, P. E. (1972). *Short-term Psychotherapy and Emotional Crisis*. Cambridge: Harvard University Press.

Smith, J.A., Flower, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: Sage.

Stapley, E., Midgley, N., & Target, M. (2015). The experience of being the parent of an adolescent with a diagnosis of depression. *Journal of Child and Family Studies*, *25*(2), 618-630.

Stapley, E., Target, M. and Midgley, N. (2017). The journey through and beyond mental health services in the UK: A typology of parents' ways of managing the crisis of their teenage child's depression. *Journal of Clinical Psychology*, *73*(10), 1429-1441.

Thompson, C. M. (1988). Sándor Ferenczi, 1873–1933. *Contemporary Psychoanalysis*, *24*(2), 182-195.

Trowell, J., Joffe, I., Campbell, J., Clemente, C., Almqvist, F., Soininen, M., ... & Anastasopoulos, D. (2007). Childhood depression: a place for psychotherapy. *European child & adolescent psychiatry*, *16*(3), 157-167.

Waddell, M. (2018). *On Adolescence*. London: Routledge.

Weissman, M. M., Markowitz, J. C., & Klerman, G. L. (2007). *Clinician's Quick Guide to Interpersonal Psychotherapy*. New York: Oxford University Press.

Winnicott, D. W. (1962). *The aims of psycho-analytic treatment*. In The Maturational Processes and the Facilitating Environment: Studies in the Theory of Emotional Development, pp.160-170. London: Routledge.

.

Appendices

Appendix A: Participant Information Sheet

Participant Information Sheet

The Tavistock and Portman NHS
NHS Foundation Trust

Study Title: An exploration of psychotherapists' experiences of offering Short-Term Psychoanalytic Psychotherapy (STPP) in everyday clinical practice and a randomised controlled trial (RCT).

Part 1 tells you the purpose of this study and what will happen to you if you take part.

Part 2 gives you more detailed information about the conduct of the

Part 1

We would like to invite you to take part in an exploration of therapists' experiences of offering Short-Term Psychoanalytic Psychotherapy (STPP) in everyday clinical practice, compared to a randomised controlled trial (RCT). This would involve you taking part in an audiotaped interview lasting approximately 45 minutes to one hour, with the main researcher in the study. This interview will be semi-structured, and will explore your experiences of delivering STPP, in the service within which you work. You may have already participated in similar interviews, as part of the IMPACT and IMPACT-ME studies. The current study will be using qualitative data collected for IMPACT-ME, regarding therapist's experience of taking part in IMPACT, and also of delivering STPP. Therefore, if you have taken part in IMPACT-ME, and choose to participate in this study, your data from both studies will be used and compared, to allow us to explore whether there are similarities and differences between the experiences of therapists that offer STPP in an RCT study, and as part of their everyday clinical practice.

Before you decide whether to participate, you need to understand why the research is being done and what it would involve. Please take time to read the following information carefully; talk to others about the study if you wish.

Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

---

1. What is the purpose of the study?

The purpose of this study is to find out about your experience of offering STPP in everyday clinical practice, in order to learn more about how therapists experience offering this relatively new treatment option. Experiences of therapists offering STPP as part of a randomised controlled trial will also be explored, and comparisons will be drawn between the two sets of interviews, to see what can be learned about STPP.

2. Why have I been invited?

You have been invited because you are a therapist who is currently working at the Tavistock and Portman Clinic, and offering STPP as part of your clinical practice. You may also have taken part in the IMPACT depression study as a therapist offering STPP, and therefore may have taken part in an interview about your experiences of offering STPP in IMPACT. If so, this will allow the current study the opportunity to directly explore similarities and differences in therapists' experiences of offering STPP between an RCT and everyday clinical practice.

3. Do I have to take part?

Your participation is entirely voluntary and it is up to you to decide whether or not to take part. We will describe what we are aiming to find out in this study and go through this information sheet with you. We will then ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason.

4. What type of study is this?

This is known as a qualitative study that uses the method of face-to-face interviews. As STPP is a relatively new treatment option, little is known about therapists' experiences of delivering it. In order to learn more about this, we need to interview therapists who have delivered STPP. Recording and analysing these interviews should provide useful information from them about their experiences.

5. What will happen to me if I take part?

If you agree to participate, the researcher will ask you to sign a consent form, and arrange an interview either at the time of signing the consent form or at a more convenient time. During the interview the researcher will ask questions related to your experience of delivering STPP. He/she will record the conversation using an audio tape recorder. The

purpose of the recording is to allow the researcher to capture all the information discussed during the interview, which is important for them to analyse later. The interview will take between 45 minutes and an hour.

6. What will I have to do?

You will be asked to answer the questions based on your personal experience during the interview. However, you can refuse to answer any questions which you feel uncomfortable about answering and you can stop the interview at any time.

7. What are the possible disadvantages and risks of taking part?

During the interview, sometimes, you might be asked questions about certain topics or experiences which are sensitive or may upset you. You can refuse to answer any questions which you feel uncomfortable with, or you can stop the interview anytime.

8. What happens when the research study stops?

You will be kept up to date with the progress of the study, and informed of any publications linked to the findings of the study.

9. What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be looked into. The detailed information on this is given in Part 2.

10. Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be kept confidential. When writing about the findings of the study, all participants will be assigned a pseudonym, or referred to as therapist 1, therapist 2 etc. This will ensure anonymity.

11. Is the purpose of this study educational?

Yes. The data from this research will be used for a professional doctorate in Child and Adolescent Psychoanalytic Psychotherapy.

Part 2

12. What will happen if I don't want to carry on with the study?

You can withdraw from the study without giving a reason and at any time.

13. What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions (see details below). If you remain unhappy and wish to complain formally, you can do this by contacting the Tavistock Research Ethics Committee (details below).

14. Will my taking part in this study be kept confidential?

The recorded interview will be transcribed by the main researcher. Only the interviewer and the project supervisor, Dr Jocelyn Catty, will have access to the audiotape. All information will be coded and anonymised. Once the transcript has been completed and checked by the interviewer for accuracy, the audio recording will be erased by the interviewer.

The information we have collected as paper copies will be stored in a locked filing cabinet, while the electronic data can only be accessed with a secure password. Only the researcher and supervisor will have access to the data.

The data we collect will be used only for the purpose of this research; if data were to be used for future studies, further Research Ethics Committee approval would be sought. The transcripts will be kept for five years according to the Medical Research Council guidelines.

Although the study sample will small and therefore this limits the extent to which data can be kept anonymous, all possible steps will be taken to ensure that all information collected about you during the course of the research will be kept strictly confidential, and anonymised.

15. What will happen to the results of the research study?

The hope is that the results of this study will be published in medical/psychological journals. You will not be identified in any report, publications or presentation without seeking your full consent. Direct quotes from the interviews may be used in reports and publications; however, the quotes will be anonymised to ensure that you cannot be identified.

16. Who is organising and funding the research?

The Tavistock and Portman Clinic, and the University of Essex will be overseeing the research, which is being conducted as an integral part of a Professional Doctorate in Child & Adolescent Psychoanalytic Psychotherapy.

17. Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your safety, rights, well-being and dignity. This study has been reviewed and given favourable opinion by the Tavistock Research Ethics Committee.

18. Further information and contact details.

General Information about research

You can visit the following web site to obtain more general information about research:

INVOLVE – Promotes public involvement in the NHS: http://www.invo.org.uk

Specific information about this research project

Danny Isaacs

Child and Adolescent Psychotherapist in Doctoral Training

Adolescent and Young Adult Service

Tavistock and Portman Clinic

120 Belsize Lane

London

NW3 5BA

Tel: 020 938 2326

Email: disaacs@tavi-port.org.uk

Who you should approach if unhappy with the conduct of the study

Dr Jocelyn Catty MA (Oxon) DPhil

Research Lead, Child Psychotherapy Doctoral Training (M80)

Child & Adolescent Psychotherapist (ACP)

Child and Family Department
Tavistock and Portman NHS Foundation Trust
120 Belsize Lane
London NW3 5BA

Tel: 020 8938 2511

Email: JCatty@tavi-port.nhs.uk

OR

Tavistock Research Ethics Committee (TREC)

Tavistock and Portman NHS Foundation Trust
120 Belsize Lane
London NW3 5BA

Tel: 020 8938 2511

OR

Simon Carrington,

Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk)

Appendix B: Consent Form

The Tavistock and Portman NHS
NHS Foundation Trust

Consent Form

Full Title of Project: An exploration of psychotherapists' experiences of offering Short-Term Psychoanalytic Psychotherapy (STPP) in everyday clinical practice and a randomised controlled trial (RCT).

Name of Principal Investigator: Danny Isaacs

	Please initial box
1. I confirm that I have read and understand the participant information sheet dated …….. version …….. for the above study and have had the opportunity to ask questions which have been answered fully.	☐
2. I understand that my participation is voluntary, and I am free to withdraw at any time, without giving a reason.	☐
3. I understand that by giving consent to take part, I am agreeing to be interviewed and that this interview will be audio recorded.	☐
4. I give consent for the data collected regarding to my experiences of offering STPP, to be used in articles written for publication.	☐
5. I give consent to take part in the study.	☐

Name of Participant	Signature	Date
Prinicipal Investigator /Person taking consent	Signature	Date

1 copy for participant/1 copy for principal investigator

Appendix C: Interview Schedule

As recommended in guidelines for qualitative research interviewing (e.g. Smith et al., 2009), the interview would be semi-structured, with the interviewer having in mind some key areas to be explored, but flexibly and led by the therapist.

The key areas to be explored would be:

1. **The context within which the therapist has been using STPP**

Possible prompts:

Where?

How long have been using the model?

Number of STPP cases therapist has had?

Is STPP integrated into the service – if not how did they come to be using it?

Always have an STPP case on-going?

2. **Experience of offering STPP**

Possible prompts:

Differences/similarities to usual way of working

Implications of using a Manual

Implications of having a pre-determined number of sessions

Time limit and its impact

Supervision/Support

Parent-work alongside the case

Difficulties/challenges of using STPP

Strengths and limitations of the model

Assessment and how patients referred for STPP

3. **Reflections on experience of using STPP**

Possible prompts:

Did therapist also offer STPP as part of the IMPACT study?

What, if anything, was different in using STPP as part of a randomised controlled trial, compared to in everyday clinical practice?/How does the experience of using STPP in everyday clinical practice compare to an IMPACT?

What have they learned from using STPP?

If seen more than one case, any thoughts about who it works for and who it may not work for?

Is it a model of treatment that they will/hope to continue to offer?

If it is not an established treatment option in the service they work in, do they hope to support its wider introduction? And how?

Appendix D: List of Search Terms for IMPACT-ME Transcripts

Short-Term Psychoanalytic Psychotherapy

Short-Term Psychodynamic Psychotherapy

STPP

Short term

Time limit

Brief

28

Psychotherapy

Manual

Protocol

Parent work

Supervis* (Supervision/Supervisor)

Session

Assessment

Random*

Experience

Transference

Negative

Calendar

Strength

Weakness

Audio

Recorder

Dictaphone

Appendix E: Example of Annotated Transcript from the Thematic Analysis

I: yeah and if you were starting therapy again with *(name of adolescent)*... is there anything that you think you would do differently at the time...

P: *(pause)* I suppose... erm... I suppose I would have been less anxious and I think that would have helped me handle her... I think I was quite anxious in beginning the piece of work and... I think you know if I perhaps had had you know more... trust in the work giving her the containment that she needed and was most asking for... I think while giving it to her I didn't believe that that's what I was doing erm if I could just have had more belief in the structure of the work... and the boundaries that I was giving her being the container that she wanted... then perhaps a more relaxed me would have been still more helpful for her erm but I mean that's you know that's more on a person level I think erm... at a practical level I can't think of anything else there...

Commented [DI1]: Time limit/structure of STPP – therapist needing to have more belief in the helpfuless of this.

I: yeah no that's great that's really helpful... and with hindsight now do you feel that STPP was a suitable treatment for *(name of adolescent)*...

P: yes I do...

I: yeah...

P: yes, yes and interestingly... *(name of parent worker)* told me that *(45.00 minutes elapsed)* her parents felt it was-it was the right option of the 3...

I: oh really...

P: yeah...

I: okay...

P: yeah...

I: and why do you think sort of with hindsight now that yeah STPP was the right treatment for *(name of adolescent)*...

P: erm... I suppose because of the kind of depression that it was that had involved such a lot of erm projection of the negative parts of herself erm it gave us the opportunity to think about that... erm... through the relationship that we developed in the room...

I: okay...

P: and that how she would... erm... project a lot of erm... negative feelings into me...

I: hmm...

P: and-and-and experience me as very... erm... judging her-disinterested heartless just malicious or whatever...

I: yeah...

P: erm and we had the, we had the chance to actually think about and understand... what that was about where it came from why she, why she experienced me like that...

Commented [DI2]: Negative Transference – Importance for patient of being able to explore and experience the negative transference and have it worked through

I: okay...

P: erm... and-and then live to see the next session and the next session...

I: yeah...

P: erm and that these things could be survived between us... in-in the live relationship that we had... erm... I think that you know it's-it's probably the only modality that offers that...

I: yeah...

P: erm I think that erm... one... treatments that might have addressed the symptoms of her depression in terms of thinking about her-her thought patterns probably would have helped in a very temporary sense but wouldn't have been... erm... really... exploring the origins of-of her difficulties which-which-which were very much related to... erm... her parents and her early years...

I: yeah...

P: erm... and her-her experience of-of-of-of her mother being a very preoccupied mum... which I mean which I haven't been into she was preoccupied for several reasons... erm... but certainly you know she needed to... I suppose rework... that-that relationship... erm which she had the chance to do...

I: okay... and... alongside the therapy so you've talked about her sort of academic success in her *(47.30 minutes elapsed)* GCSEs... being helpful for her... and then also about the relationship with mum sort of becoming closer... erm and were there any other sort of things outside of the therapy that were helpful for *(name of adolescent)* or that have been unhelpful for her do you think...

P: outside of the therapy...

I: hmm...

P: erm... *(pause)*... well I mean I wouldn't say this was completely outside of the therapy but I think that *(name of parent worker)* work with the parents did help the parents to think about the relationship between the 2 girls their 2 daughters... and to sort of mediate a bit...

Commented [DI3]: Parent Work – how PW helped parents to manage relationship between patient and their sister

.....

I: erm how do you feel about that in relation to working with *(name of adolescent)*...

P: erm... well I think nothing more specifically stands out with-with *(name of adolescent)* erm... *(sighs)*... I think at the outset one... you know... for an assessor... one could... wish a particular treatment arm might be the outcome for a particular patient...

Commented [DI4]: Randomisation/Assessment – a wish for a particular patient to get a particular treatment – link to how this might be less likely as no assessment and randomised?

I: yeah...

P: erm... I think it was fine for *(name of adolescent)*...

I: yeah...

P: I think it worked quite well... erm... yeah I haven't, I really haven't found out much about that I haven't really talked about it with *(name of parent worker)* either...

I: yeah, yeah no that's-that's helpful just to hear about what it's been like particularly for *(name of adolescent)*...

P: hmmm... what in... can you give me any what in particular...

I: erm... well I suppose what the aim of this session is because I know you've had an interview before so we've sort of got a sense of-of broadly how you sort of feel about the research so I suppose it's just seeing what your experience of doing a research study alongside therapy is like with this particular sort of client I suppose... and I think you've answered that really well so far anyway...

P: well I think-I think perhaps one point is worth making not relating particularly to *(name of adolescent)* erm... is that one needs and-and I haven't at-at all stages been able to do this because *(52.30 minutes elapsed)* I've always felt that erm... it-it is its own structure and one has to adhere to it and therefore somehow not think outside the IMPACT box but actually having been reminded... you know more than once by-by the IMPACT supervisor... erm who has been most helpful erm... one needs to be able to feel free enough to think about drawing in other CAMHS resources...

I: uh-huh...

P: alongside the IMPACT that it is... and should be able to combine with... say anti-depressants...

I: hmm...

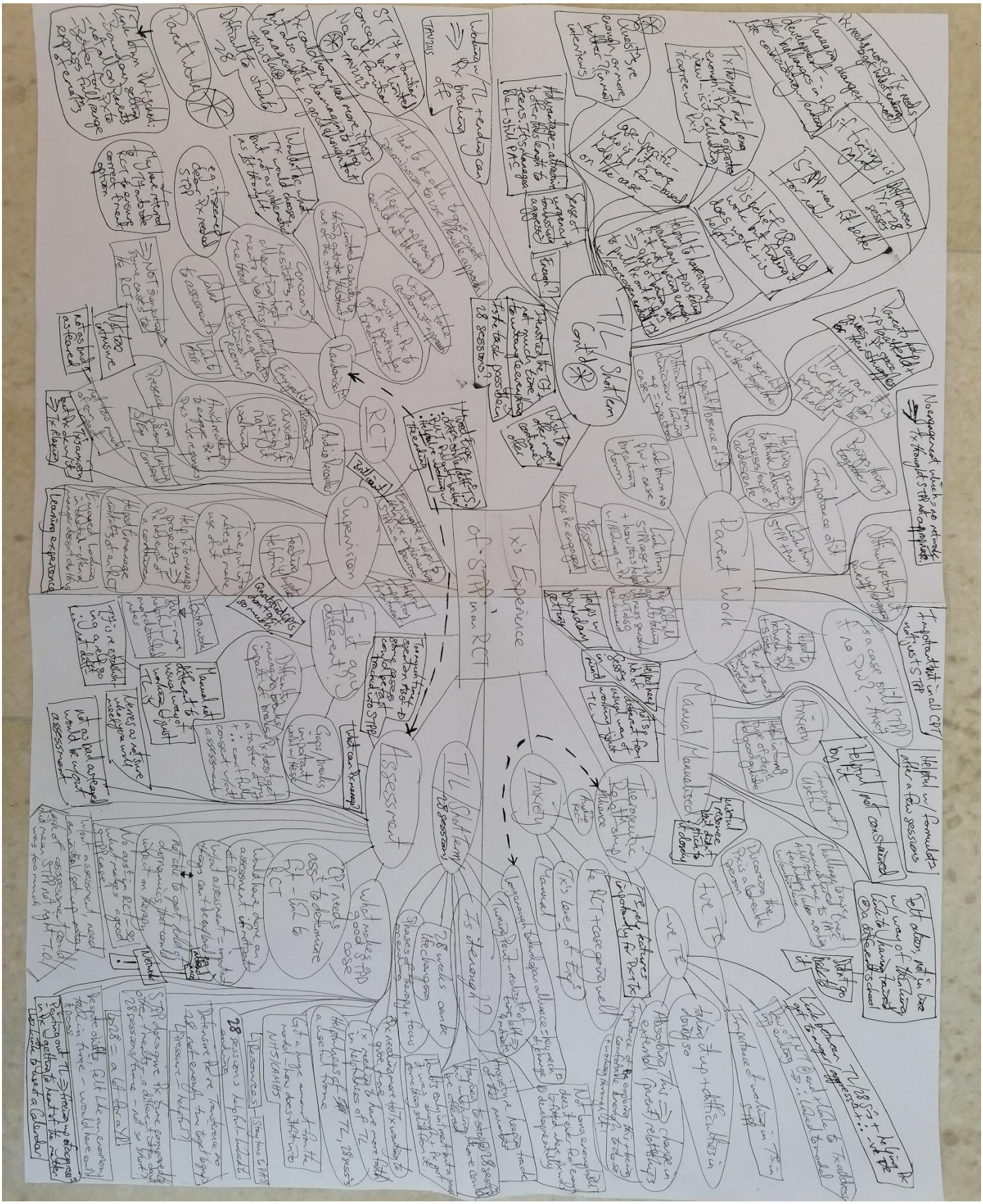
P: erm... I think that I... all too easily have sort of thought you know well... what I'm the clinician offering this treatment and this treatment's got to cut it and that's you know that's it... erm... and... I think I have I haven't erm... particularly felt... I suppose linked up enough with other IMPACT clinicians in order to be able to keep you know cross thinking alive...

I: yeah...

P: erm which perhaps is something to do with this clinic and I think you know we-there haven't been that many of us and... you know perhaps we haven't actually been erm... in regular communication enough erm... but that it isn't a standalone treatment it is you know able to make use of-of other treatments if and when appropriate...

Commented [DI5]: Experience of offering STPP as part of a research study – a feeling of it limiting ones capacity to think outside of the treatment being offered due to the study structure i.e. not linking up with other professionals AND
Supervision – helping to manage the above!

Appendix F: Thematic Analysis Mind Map



Appendix G: Example of an Annotated Transcript from the Interpretative Phenomenological Analysis

Ppt 1: [00:15:15] I mean you know there's questions about whether there would still be sort of profoundly long pieces of work about whether you've got a mother with very impoverished sort of I don't know how much of an impoverished sort of experience she had actually, given that she was actually quite articulate and thoughtful and doing something.

Commented [DI6]: 41. OfC: should complex/serious cases have longer term/more profound pieces of work around them?

Int: [00:15:33] And is there's something important there then in the idea that umm STPP. Um because of the time limit. The limited number of sessions is could potentially be I mean a piece of work in its own right but a sort of a precursor to something else.

Ppt 1: [00:15:51] Definitely definitely. I mean I think both really. You know it's. You know sometimes it might reveal really fundamental problems which you might think need a huge amount of work. But also this might be a point in time where. They're not really wanting to. You know they want to sort of get back on the road to functioning and being aware of what that might be. And it might get them on the road to functioning and they might then to revisit it later with a gap. I would say. But also there's something about you know sometimes a depression where particularly with depression it's you know people get frozen or stuck. They can't sort of move anywhere. So with this girl I saw recently she she couldn't get out of her home. She wasn't able to sort of move despite a wish to so maybe it allowed her to kind of escape and move on from something. I think that was probably be the difference. Yeah trying to think. I mean.

Commented [DI7]: 42. OfC: wanting to strongly agree with the idea that the interviewer had – because he really believed in it, or because it was suggested??

Commented [DI8]: 43. OfC: the idea that STPP might reveal underlying problems that need more work, but might also be enough and all the Px wants at that point in time – back on the road to functioning..

Ppt 1: [00:17:08] I mean I was just thinking about another girl actually. Sorry. I thought I was thinking about this other girl that said she hadn't told her mom that she was coming for treatment and she had had an overdose that she was 16. And in a way the question was about what would you tell her mum. And then she managed to tell her mum. Who then was horrified that she would go into psychotherapy and was dismissive of it. But there was something important in that she was then able to talk to her mum about it. About what it was what she had done to herself and about how what a state she was in.

Commented [DI9]: 44. OfC: STPP helping adols to become un-stuck –

EC: seems to be saying something about the value of STPP and how helpful it can be/how helpful he has found it for Pxs?

This is continued in the example below... re communication

Int: [00:17:48] With the overdose?

Ppt 1: [00:17:49] Yeah. So I think it allowed more communication. It opened up a line of communication between sessions. Yeah. Yeah. Yeah. It's allowed her to sort of say that she was doing something which was also getting in the way of having using her mum in a more ordinary way. Even if it was limited but more ordinary. Yeah. I don't know I was going to say does it decrease the sort of acting out behavior. Sometimes you know you get an increase and then a decrease. Yeah so sometimes you sort of would get a kind of peek. You know it gets really difficult. And then then people start making sense of things.

Int: [00:18:37] And in terms of acting out behaviors what sort of things are you thinking about.

Ppt 1: [00:18:40] I'm just thinking that this one used to sort of stay out really late at night and get completely pissed. Go off with boys you know in a slightly risky way. Umm not really thinking about who she was going off with. So putting herself in a really a vulnerable position. Or you know taking quite a lot of drugs. And alcohol. So generally after putting themselves at risk being a bit unsafe, actually.

Commented [DI10]: 45. OfC: STPP as aiding communication, and then having an impact of acting out behaviours – increase then decsrease

EC: Ppt doesn't differentiate between STPP and other CPTs – perhaps this lack of differentiation suggests that this is more a universal PAC PT phenomena and therefore STPP isn't that different??

Int: [00:19:11] And something about the process of the of STPP umm. So you said that it can. Maybe there's a peak. Of that sort of behaviour but then there seems to be a decrease.

Ppt 1: [00:19:22] Yeah. Because I think coming in you know to start to think about themselves or put them in touch with something like anybody there's a bit of a flight from it. So you get the acting out behaviors umm as a sort of response to getting in touch with

something. So if you start becoming more aware of your depression you might then want to kind of do more things to get away from that state of mind. But once you can sort of begin to manage what the feelings are then you see I think it comes back down.

Int: [00:19:58] And do you think that that is different in STPP to sort of ongoing psychoanalytic therapy.

Ppt 1: [00:20:06] Not necessarily. No. No I don't think that it's actually. I mean I would think. Some types of peak with which they have come in. Maybe you know it's a high point in terms of level of acting out. And I think that. I don't know. I mean the [service name pt 1] I think and the [service name pt 2] would probably know more. But whether. It may be in the very past and maybe it's not in this department we might have thought very we might have been more hesitant about offering people psychotherapy when they're very suicidal.

Int: [00:20:48] In the past?

Ppt 1: [00:20:48] Yeah I wonder.

Int: [00:20:50] Wha what would be the reason behind that?

Ppt 1: [00:20:52] Well that we arent picking up too much and actually we're gonna you know that they need their defenses and we'll push them over. So that's sort of speculative thought. Sometimes it's hard to talk to to get colleagues to know that you're talking about somebody who is can be quite moderate to severe you know that isn't mild that they can think that they just need inpatient. I don't know whether I'd agree right. Not entirely sure inpatients always good things for these people.

Int: [00:21:32] So would you be more inclined than is what you mean you'd be more inclined to get them into into therapy.

Ppt 1: [00:21:37] Yeah yeah. With a lot of support around them. So that might be with you very much with the parents engaged. Possibly sort of their risk being monitored psychiatrically within that kind of crisis team. I don't know whether. The problem is you know you might be putting them into a group of very very risky already.

Int: [00:22:13] With inpatient?

Ppt 1: [00:22:14] Yeah. Yeah. And what does that mean. It's not a group normal.

Int: [00:22:22] And you said then about the support like if if a young person like that was going to be in therapy then the support around them would be very important. Yeah and one of the things that's um well at least in the impact study one of the things that seemed to be important about STPP was the parent work alongside it. I wondered what your experiences are of how you know what that's like in real practice and how it functions how important it is. Yeah all those sorts of things.

Ppt 1: [00:22:47] Depends on the age. So umm depends on the cases. We had one case we didn't have a parent who was going to engage at all. And actually she she was an older adolescent and did well. So in actual fact I was just thinking three cases that I can recall even more easily that. Only one did ha was there much parent work really you know which was sort of once every month the other two was there was two meetings for one over the whole course. So it's not seven. And the other one was there was one meeting at the start because mother didn't want to engage and the child was 17. Umm so in those cases I don't know. I mean I think there were a point where. They were making moves to be separate and away from their family. So at that point perhaps it felt more.. less important to engage them.

Commented [DI11]: 46. Related to comment above – interviewer asks for some clarification around the acting out behaviours and Ppt explains this: acting out against the thinking and becoming more aware of the feelings, then learning that these might be manageable and the acting out decreases.

Commented [DI12]: 47. EC: the process described above are not different in STPP compared to ongoing CPT

Commented [DI13]: 48. This whole section is about risk and whether risky cases should be seen for psychotherapy – im unclear whether this is related to STPP although it comes off the back of a question about STPP so probs is related, but may also be a description of this dilemma in relation to ongoing/normal CPT??

A good section to use when thinking about the differences between STPP in EDP and CPT in EDP

Commented [DI14]: 49. OfC: the importance of considering each case when thinking about parent work (and possibly any factor of STPP or any other treatment).

Commented [DI15]: 50. OfC: parent may not engage

Commented [DI16]: 51. OfC: but may not matter if Adol is older
EC: Px did well – suggests this didn't matter

Commented [DI17]: 52. OfC: easy to recall the detail of the cases in relation to PW

Commented [DI18]: 53. OfC: difficulties in setting up/engaging parents in PW

Commented [DI19]: 54. EC: offering understanding and reflection that there may be a point when adol is trying to separate that it is less important to engage parents

Int: [00:23:55] Engage the parents?

Ppt 1: [00:23:56] Yeah. Having said that the one I was saying that sort of walked away if we'd been able to engage the parents in something I think the child would have stayed. And actually also just thinking about my one which stayed the whole 28 in the impact study they had fortnightly parents work with a psychiatrist.

Int: [00:24:17] So there might be something important and helpful about the parent work in terms of helping particularly young people to engage and really stick with and be in STPP?

Ppt 1: [00:24:27] I think it depends where they're at. Umm developmentally. So I wouldn't say definitely either way. So I think you have to think about their their developmental stage. It Might be. It's always a tricky one. How much work to offer parents when you put an adolescent in treatment. Sometimes I think they can feel like it's a real abuse of the you know the boundary of oh the parents being too close and they don't want them too close. And that might feel developmentally appropriate. So you could almost sabotage it.

Int: [00:25:10] Right. So it's actually a really finely balanced thing for each young person and actually having STPP.

Ppt 1: [00:25:17] Yeah I mean you know I suppose our bottom line would be how much can they support the child coming. But what does that look like isn't the same. And you know if the child is spending most of their time outside the home and the difficulties are sort of located there. It may feel. How much is that going to be relevant. I suppose when they're risky you might want to feel like really you need to engage the parents because they need to be part of a package that is checking on the risk of the young person.

Int: [00:25:57] Yeah, ok. So It's really you know with the parent work because in if I've understood it right in impact you know that was a big that was an important part of the treatment package with STPP that there would be. Well it was sort of presented that way. And parents didn't engage as much but um

Ppt 1: [00:26:13] I think it depended. It depended across clinics. Is my feeling. I mean in our clinic it was the two psychiatrists who did it. Most of the parent work.

Int: [00:26:29] Perhaps then it also depends on who which professionals are offering the work.

Ppt 1: [00:26:34] Absolutely and what that sort of their idea of parent work what might look like. I mean we know it's very varied whatever. So whenever you get questions about what is the parent work from somebody who's not a child psychotherapist and you say it's very varied they go well what does that mean. Is it not a standardized way. And there might be an expectation you know we might say well if you've got a child in intensive therapy we'd hope for a fortnightly minimum possibly weekly if you can. But it's not absolutely a given. It might be something else. So when you've got somebody in STPP it might be even less. And it depends actually.

Int: [00:27:19] And actually in impacts was it that there was it was seven sessions. So across the.

Ppt 1: [00:27:25] So it would be monthly.

Int: [00:27:27] That would be monthly. Yeah

Commented [DI20]: 55. OfC: engaging some parents in PW might help the Px stay in STPP
EC: the case that he had that stayed for the whole treatment had fortnightly parent work – so making an implicit link between these

Commented [DI21]: 56. OfC: thinking about what developmental stage a patient is at in relation to PW (but STPP more broadly?)

EC: cautious not to say either way whether PW helps YP engage or not – depends on the case

EC: Adols can feel it is an abuse of boundaries when Parents are too close – this might be developmentally appropriate

Commented [DI22]: 57. OfC: most important thing to consider is how much the parents can support the child attending, but this varies from case to case
EC: conveys a sense that appropriate parental involvement/engagement for each case is important – and that this would vary from case to case

Commented [DI23]: 58. OfC: PW less appropriate if child is making steps to separate/less relevant

Commented [DI24]: 59. OfC: the need to try and provide a safe structure around the therapy – involving the parents if it is a risky case
EC: the safety of the patients is paramount

Commented [DI25]: 60. OfC: the role of PW in the impact study
EC: how PW was carried out in Impact was clinic, and professional/clinician dependent

Commented [DI26]: 61. OfC: what is PW and how do we explain what it is? Especially when a range of clinicians might be offering it

EC: some protectiveness about PW and the profession – its not done our way or the right way by other disciplines

In impact it was standardized in the number of sessions but this doesn't mitigate for differences in the way it is offered/conducted

Ppt 1: [00:27:28] Yeah that's why it was seven and 28. Yeah that's right that's why the 28 was set as the figure. Because you could divide it by seven (laughter).

Int: [00:27:39] So was the parent wo the number of parent work sessions set first?

Ppt 1: [00:27:43] I dont know. I think that's what Margaret Rustin said I remember her saying that instead she said why 28. Yeah well it divides by seven so you can offer once a month. So maybe they were thinking how can we offer one monthly appointments. For parent work because we can't expect them to attend as much. I think people mess about. Sometimes parents were seen much more often, really.

Int: [00:28:05] Right. Yeah It's interesting. Yeah and you mentioned then also about sort of an idea of there being a standardized way of doing parent work but also made me think about the fact that in impact there was a manual. And of course there still is a manual. But I wondered what your experience is comparing impact to wor working with STPP now in terms of the manual.

Ppt 1: [00:28:25] The manual. Well the manual is descriptive and it's not prescriptive. So I think what was interesting is that you think about the different phases you know beginning middle and end. I have to say to be honest I haven't looked at it recently.

Int: [00:28:41] But do you think it's necessary to sort of keep.

Ppt 1: [00:28:43] No. Because it it's a description of our work. It's a description of how we work usually.

Int: [00:28:48] Is it?

Ppt 1: [00:28:48] Yeah. So It's not a description of something that we don't do. You know it's describing our models of working, really. There might be technical issues you might need to think about in relation to short term work that people might thought about more. You know which might be like keeping the number of sessions in mind, when to talk about you know when t when you might say something about the sessions and that might be related to you know what comes up in the therapy. But it also might be something you introduce from outside. Um.

Int: [00:29:29] But tha that's some of the differences then of STPP to sort of normal ongoing therapy.

Ppt 1: [00:29:36] Yeah. Yeah. Because you wouldnt have a number. Yeah. And sometimes people might be very clear about when the end date possibly is. You know even at the start.

Int: [00:29:48] Yeah.

Ppt 1: [00:29:51] I mean quite often nowadays people say you know when they ask people about treatment they'll say to parents well we'd really expect a minimum of a year. But often people don't say open ended. People aren't used to the idea of that, certainly adolescents aren't. That can be quite a frightening thought. Well it depends on their adolescent of course you know.

Int: [00:30:16] But for some as if it goes on forever.

Ppt 1: [00:30:18] Well sometimes they might want that. You know to go on forever. No it's going to be time limited so it can be horrible. But sometimes it's very you know if you say well we're going to meet for the year. And also you know we were I think twenty eight

Commented [DI27]: 62. OfC: how was it decided that it would be 7 PW sessions that would be offered, and that would work out as monthly

EC: some laughter and joking around during dicusssion that the monethly parent work was what determined the number of STPP sessions at 28 – random/haphazard/not scientific/how can we offer monthly sessions etc?? *****

Commented [DI28]: 63. OfC: the manual describes it doesn't prescribe

EC: haven't looked at it recently – suggesting that he doesn't seem to feel it is all that necessary to look at it regularly??

Commented [DI29]: 64. OfC: its important for him to say clearly that the manual is descriptive of how we usually work – doesn't need to be looked at regularly

Commented [DI30]: 65. OfC: descriptive of "our" models of working – also the sense of belonging

Commented [DI31]: 66. OfC: the differences that one needs to keep in mind with short term work

EC: these are technical things that need to be thought about – need to keep thinking and keep these things in mind

Commented [DI32]: 67. OfC: differences between STPP and normal ongoing therapy

Commented [DI33]: 68. OfC: how people talk about length of treatments
EC: adols can be frightened by treatments that are described as open ended

Commented [DI34]: 69. OoC: what the Px wants in terms of treatment length
EC: it can be horrible for some adols, depending on the adol for it to be time limited

sessions you could sort of work out with holidays it could often be about an academic year. If you're sort of starting in mid-September. You know with the breaks that come in.

Int: [00:30:43] So for some adolescents there's something quite helpful about//

Ppt 1: [00:30:48] Yeah because they've done the year and they've ended and that's fine. Yeah they're ready to go. Actually. Also I mean I think you know for us sometimes is if you get 17 year olds who are about to go to university that's all they can do. At that point in time. You can't do any more.

Int: [00:31:05] So is there something then in terms of who in you know everyday practice patients that are not necessarily that it's more suitable for but for the young people that might be more likely to engage with it is it do you find that it tends to be slightly older adolescents or is it not as simple as that.

Ppt 1: [00:31:25] I think it's an easier sell to my colleagues for the older adolescents. I think they still find it hard to believe. The younger ones that we should offer shorter lengths of treatment.

Int: [00:31:36] Right. And colleagues by colleagues who do you mean.

Ppt 1: [00:31:40] Other child psychotherapists.

Int: [00:31:41] Other child psychotherapists. Right.

Ppt 1: [00:31:43] Yeah I think they often find it hard. And maybe we don't really push it because we find it hard to.

Int: [00:31:50] Mm hmm. As you said before the endings and the time limit. Yeah.

Ppt 1: [00:31:57] And despite the kind of pressures on services lots of child psychotherapists tend to see people for longer.

Commented [DI35]: 70. OoC: the length/time/number of sessions in STPP can be helpful for adols / fits into developmental trajectory

EC: done the year and ready to go

Commented [DI36]: 71. OoC: developmental trajectory – all that can be done for some/cant do more e.g. going to uni

EC: making the best of the situation/doing the most you can

Commented [DI37]: 72. OoC: "selling" STPP to colleagues, bringing them on board with it, encouraging them to use it etc – in the context of offering it to older adols who have limited time anyway – good fit between the adols needs and the difficulties with demonstrating to colleagues the place of STPP

EC: still some disbelief that shorter treatment should be offered, particularly to younger adols

Commented [DI38]: 73. Other colleagues are CPTS – not another discipline!

Commented [DI39]: 74. OoC: not sticking to/getting on board with STPP/shorter treatments because it is hard – see people for longer

EC: not sure where to place himself – uses "they" and "we" – is he one of the ones that finds it hard or not?

Appendix H: IPA Initial Themes Table

	Participant and Corresponding Comment Number from Coding on Interview Transcript					
Emerging Themes	**1**	**2**	**3**	**4**	**5**	**6**
The Service in which STPP is used: context, how it compares to other services, structure of it, how Patients come into the service, Therapists experience/view of the service, place of STPP in the service/MDT differences in view re STPP - who refers to STPP?/how does the service think about the length?/history of treatment in the service	1, 2, 8, 9, 4, 6, 7, 3, 5, 10, 15	3, 4, 5, 6, 7, 8, 11, 12, 21, 86, 106	1, 8, 9, 11, 13	1, 3, 4, 5, 6**, 7, 10, 11, 26	3, 4, 5, 6, 7, 9, 10, 11, 46, 47**	1, 2, 3, 4, 36, 40
Resources: Linked to 'The Service…' / on what grounds are treatment decisions made?	23, 87, 88, 89, 90, 91	21, 50, 51, 71, 75**, 76, 82, 99	10, 59, 60			5, 6, 15, 19, 20, 21, 33, 40
Randomization / Allocation / Assessment / Suitability / How to understand which cases are seen for/offered STPP / The Fit / Patient Choice / Individual Differences / Patient presentation	4, 11, 14, 16, 17, 18, 19, 21, 22, 39, 41, 69, 75, 77, 78, 79, 80, 81, 83, 84, 85, 92, 132, 134, 137, 138, 153-154	15, 22-27, 30, 31, 46, 64, 96	17-22, 51	11, 12, 13, 14, 15, 16, 22, 23, 35, 54	8, 9, 12, 13, 14, 15, 16**, 19, 40,	7, 9-13, 17, 18, 19, 27, 36-39** (case egs)

RCT Vs EDP (including reflections on IMPACT results)	13, 19, 20, 48, 60**, 61, 118, 119, 120**, 130, 131, 132, 135, 136, 139**, 140, 141	15, 16, 27, 88, 89, 90, 91, 37, 38, 48, 52, 53, 59, 60, 62**, 95	22, 34, 44, 52, 47	14, 15, 17, 28, 30, 32, 39, 52, 53, 55, 56, 57, 58**, 62		8, 26, 33, 46, 51, 59, 60, 62**
Factors Effecting Therapist engagement: Desire/Reluctance to offer STPP (and how to understand this) / who offers e.g. Qual Vs Trainee / clinician experience / taking authority	24, 25, 27, 29, 74	10, 39, 41, 59	1, 2, 3, 4, 7, 12	2, 28	1, 2, 5, 14, 23, 26, 61	16, 17**, 19, 41, 50
Patient experience / Factors effecting Patient engagement/attendance	31, 33, 76, 102, 103, 106-109					28
Aspects of STPP: Parent Work	38, 49-59, 61+62**	77-86, 98	3, 5, 34, 35, 44, 48, 49	17, 18, 19	62-72	45-49
Aspects of STPP: Manual/Model/Frame (put together but some ppts - the manual symbolises the model)	20, 63-65	7, 16, 17, 18, 19, 20, 42	5, 6, 38-43, 51, 57, 63**	29, 30	45	25, 26, 30, 31, 52
Aspects of STPP: Supervision/Thinking Spaces	115-118, 121-123	45, 47, 48, 59-61	23-36 (32**)	38, 39, 58	33, 34	22, 33, 34, 35, 42, 43, 44, 50
Aspects of STPP: Working with the Time	35, 43, 98,	32, 63,	29, 58, 61, 62	31, 33, 34, 35,	27, 29, 30, 36,	51-56**

Limit/Ending /Is it enough?/CPTs difficulties with endings/Loss and Separation / helpfulness of the TL	100, 110-113, 128, 152, 153	50, 51, 54, 55, 56**, 57, 65, 70, 74		37, 42, 43, 44, 45, 46, 47, 48	35, 37, 40, 41, 42, 48, 49, 51, 52, 67	(reality of time)
Aspects of STPP: Structure and/or Flexibility? - arguments for both being helpful	110	10		8, 9	20, 21, 22, 24, 25, 30, 31, 32, 39	14, 29, 30, 50, 52
Aspects of STPP: Passion for/Belief, or lack of, in the model / Good enough?	72-74, 142, 145**, 146**, 147**, 148-151	49, 50, 65, 66, 67, 69, 70	57, 62	24		29, 57, 58
Aspects of STPP: How do we measure STPP/Ask the right questions/GBM	141, 143, 144	92, 93			22, 24, 74	
Aspects of STPP: What makes an STPP case an STPP case?	28, 45, 47, 48**, 66**, 67, 77, 125, 145**	14, 15				
Is STPP still Psychoanalytic Psychotherapy? Differences or lack of between STPP and Ongoing Child Psychotherapy / Psychoanalytic Identity/ development of psychoanalytic skills	75, 123-127	37, 40, 43, 57, 58, 100, 101, 104		4, 25, 27**, 58	49, 50, 53, 55** (different), 56, 57	24, 32
Is STPP still Psychoanalytic Psychotherapy? - STPP Vs Ongoing CPT (above) - Transference			29, 30+31**	31, 46	27, 28, 49**, 58, 59, 60, 73	
Psychoanalytic treatment -	30		58			

CPT/Psychoanalysis as stuck in its ways/idealized						
Psychoanalytic treatment - Px fit with this way of working	32, 34, 35, 36, 37, 43, 44, 45, 46, 104, 133					
Where does the Ppt position themselves? - Talking as if not from own experience / Relation to interviewer / experience of the interview	40	8, 70			23, 26, 61	
What does/can STPP help with or treat (symptoms/underlying issues?/developments) / Is it just for depression?? / sleeper effect	26, 43, 54, 56, 66-72, 79-85, 92-96, 101	29	46, 48	11	66, 73	
Case Examples	70, 86, 97		48 (PW), 50 (Px)	20 + 21		
How do we think about time/time limit/development stage/adol development/age		11, 12, 13, 33, 34, 35, 36, 72, 73, 97, 98	14, 15, 16, 35, 37, 57	35, 37, 40, 49, 50, 51	35-37, 51, 52, 53, 74	Linked to the PW codes and age
Positives of STPP				40, 41, 46		
Challenges of STPP						
Implications for/How to think about the development of STPP and what might stop it				59, 60, 61, 62		11, 13, 22, 23, 36, 37

** indicates important data

Appendix I: Final IPA Themes Table (following supervision discussions)

Final Themes		Participant and Comment Number from Coding on Interview Transcript					
Superordinate Theme	**Subordinate Theme**	**1**	**2**	**3**	**4**	**5**	**6**
Reflections on Experience of the Model	**Ending from the Beginning: Working with the Time-Limit**	35, 43, 98, 100, 110-113, 128, 152, 153	32, 63, 50, 51, 54, 55, 56**, 57, 65, 70, 74	29, 58, 61, 62	31, 33, 34, 35, 37, 42, 43, 44, 45, 46, 47, 48	27, 29, 30, 36, 35, 37, 40, 41, 42, 48, 49, 51, 52, 67	51-56** (reality of time)
	Descriptive Not Prescriptive: Working with the Manual	20, 63-65	7, 16, 17, 18, 19, 20, 42	5, 6, 38-43, 51, 57, 63**	29, 30	45	25, 26, 30, 31, 52
	Working Alongside: The Role of Parent-work	38, 49-59, 61+62**	77-86, 98	3, 5, 34, 35, 44, 48, 49	17, 18, 19	62-72	45-49
	"Helping the Therapist to Maintain the Frame": The Role of Supervision in STPP	115-118, 121-123	45, 47, 48, 59-61	23-36 (32**)	38, 39, 58	33, 34	22, 33, 34, 35, 42, 43, 44, 50
Questions	**Who is "The Perfect Patient for STPP"?**	4, 11, 14, 16, 17, 18, 19, 21, 22, 39, 41, 69, 75, 77, 78, 79, 80, 81, 83, 84, 85, 92, 132, 134, 137, 138,	15, 22-27, 30, 31, 46, 64, 96	17-22, 51	11, 12, 13, 14, 15, 16, 22, 23, 35, 54	8, 9, 12, 13, 14, 15, 16**, 19, 40,	7, 9-13, 17, 18, 19, 27, 36-39** (case egs)

		153-154					
	What Might STPP Help With?	26, 43, 54, 56, 66-72, 79-85, 92-96, 101	29	46, 48	11	66, 73	
	How Are Time and Duration Thought About?		11, 12, 13, 33, 34, 35, 36, 72, 73, 97, 98	14, 15, 16, 35, 37, 57	35, 37, 40, 49, 50, 51	35-37, 51, 52, 53, 74	
	Is STPP that Different from Ongoing Child and Adolescent Psychoanalytic Psychotherapy?	75, 123-127	37, 40, 43, 57, 58, 100, 101, 104	29, 30+31**	4, 25, 27**, 58 31, 46	49, 50, 53, 55**, 56, 57 27, 28, 49**, 58, 59, 60, 73	24, 32
Additional Themes	**Managing Pressures on Resources**	1, 2, 8, 9, 4, 6, 7, 3, 5, 10, 15 23, 87, 88, 89, 90, 91	3, 4, 5, 6, 7, 8, 11, 12, 21, 86, 106 21, 50, 51, 71, 75**, 76, 82, 99	1, 8, 9, 11, 13 10, 59, 60	1, 3, 4, 5, 6**, 7, 10, 11, 26	3, 4, 5, 6, 7, 9, 10, 11, 46, 47**	1, 2, 3, 4, 36, 40 5, 6, 15, 19, 20, 21, 33, 40
	Getting it Right	120, 139	88	32, 47	28, 56, 57	26	51, 52, 53

** indicates important data

Appendix J: Ethical Approval Letter

The Tavistock and Portman NHS
NHS Foundation Trust

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

Tel: 020 8938 2699

https://tavistockandportman.nhs.uk/

Danny Isaacs

By Email

23 April 2018

Re: Trust Research Ethics Application

Title: *An exploration of therapists' experiences of delivering Short-Term Psychoanalytic Psychotherapy (STPP), in everyday clinical practice compared to a randomised control trial (RCT).*

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

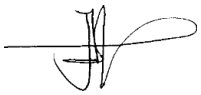
If you have any further questions or require any clarification do not hesitate to contact me.

I am copying this communication to your supervisor.

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

Yours sincerely,

Best regards,



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

cc. Catrin Bradley, Course Lead
Jocelyn Catty and Brinley Yare, Research Tutors

Framing the Clinical Research Portfolio

The clinical research portfolio submitted for the qualification of Professional Doctorate in Child and Adolescent Psychoanalytic Psychotherapy, consists of a clinical qualifying paper named; “In-dependence: A young woman’s struggle with dependency”, and a qualitative thesis entitled; An exploration of child and adolescent psychotherapists’ experiences of offering Short Term Psychoanalytic Psychotherapy (STPP).

These two pieces of work, though independent of one another, will be considered here. I will begin with the context for and motivations behind both, reflections on the methodology used for both and the implications for the findings of each, and the ways in which the themes of both pieces of work intertwine. The importance of research, including these pieces of research, for the child psychotherapy profession will then be considered. Finally, I will reflect on my experiences of completing the doctorate.

Context and Methodology

Doctoral Thesis

Whilst working as a research assistant on the IMPACT-ME study; the qualitative sub-study of the IMPACT study (a multi-site RCT investigating three psychological treatments for adolescent depression), I was introduced to STPP; one of the treatment arms of the study. Briefly, STPP is a manualized 28-session psychoanalytic psychotherapy, with monthly parallel parent work.

The aim of the IMPACT-ME study was to explore the experiences of the participants in IMPACT. This included interviewing the young people receiving the therapies, the parents of these young people; who throughout the study had completed questionnaires as part of data collection, and the therapists offering each type of treatment. I was planning at the time to train as a child psychotherapist, and whilst I was only just beginning my journey into the

world of psychoanalysis, STPP seemed to be somewhat at odds with my experience and understanding of psychoanalytic treatment, because of its time-limited nature. This fascinated me, and I felt intrigued to know more about it.

Through the therapist interviews I had done as part of IMPACT-ME I had begun to hear anecdotes about psychotherapists' experiences of STPP. There seemed to be some excitement about STPP, and the possibility of having an evidence-based psychoanalytic psychotherapy available for child psychotherapists working within the NHS. This seemed particularly important in the context of cuts to NHS budgets and the reductions in services that had followed the 2008 recession. On the other hand, there also seemed to be hesitation and concern about the idea of a manualised time-limited psychoanalytic psychotherapy, and the potential implications for longer term, open-ended psychotherapy if STPP were found to be a helpful and effective therapy. Furthermore, ideas about the role of the manual, assessment, and the impact of offering STPP as part of an RCT had emerged. These anecdotes continued to spark my curiosity, and only served to make me more interested in exploring psychotherapists' experiences of offering STPP.

I worked on IMPACT-ME for a year, and then left to begin the child psychotherapy training. During this year the IMPACT-ME research team worked on a number of different projects using the IMPACT-ME data (leading to a number of publications), however they had not begun to explore psychotherapists' experiences of offering STPP, or the other IMPACT treatment options. I was already aware that I would be completing a piece of research for my clinical doctorate, and therefore I began to think about this as a potential idea for my thesis. Once underway with the child psychotherapy training and having begun the process of writing a proposal for my doctorate, with the support of the research seminar leaders', I settled on this idea.

I had decided that it would be interesting to explore psychotherapists' experiences of offering STPP both within an RCT, and also in their usual day to day clinical work. This stemmed from the aforementioned anecdotal themes that seemed important to psychotherapists.

Therefore, I applied for permission to use data from IMPACT-ME, and this was granted. I also planned to interview six psychotherapists offering STPP as part of their usual clinical work. Having established where the data would come from, I then explored which type of qualitative analysis I would use for both data sets, and with the help of my supervisor decided that Thematic Analysis would be appropriate for the IMPACT-ME data, and Interpretative Phenomenological Analysis for the newly collected data.

Clinical Qualifying Paper

The main clinical assessment during the child psychotherapy training is the qualifying paper, which trainees write at the end of their final year. This paper is written about one of their three intensive (three times per week) cases. These cases come from each of the three age groups: under five, latency (5-11), and adolescent. For each intensive case trainees receive weekly individual supervision from an experienced child psychotherapist. Trainees write up and then present detailed notes of the moment-by-moment happenings of a session with the patient, called process notes.

Whilst I had good experiences of intensive work and supervision across all three cases, I discovered that my area of clinical interest was in work with adolescents. Therefore, I chose to write my qualifying paper about my adolescent case.

The qualifying paper took the form of a single case study. The required me to read through all of the process notes I had written and presented in supervision a number of times, and to then begin to gather up the main themes that seemed to be emerging from the notes. As these themes emerged, I then began to gather quotes from the session material that seemed to be pertinent to the emerging themes. Alongside this, I already had in mind some of the important themes from the work with this young woman, given that I had seen her for two and half years, two years of which had been three-times weekly. I then gathered these themes and the relevant material and began to write the paper. This was a challenging

process as there was an enormous amount of data, and it was important to find the material from the process notes that most vividly captured the themes I wanted to write about. This process took two months, and whilst at times I found it quite overwhelming, it was also interesting to read back through the notes, as it brought powerfully back to my mind the journey of the therapy.

I wanted to give a sense of the course of the therapy, as well as the main themes that emerged, partly because these were inherently connected, therefore I wrote the paper both chronologically and thematically. The central focus of the paper formed around the experience of this young woman's experience of dependency, and her journey through the therapy of becoming, and allowing herself to be, dependent, and so actually then becoming more genuinely independent. One conflict for this young woman was that such genuine independence (which she so craved) required her to be in-dependence of the therapy and of me as her therapist; something that due to her life experiences was frightening for her.

Comparisons and Reflections on Methodology

As can be seen, both my doctoral thesis and the clinical qualifying paper were qualitative in nature. The thesis was a more formal piece of qualitative research, with two different types of qualitative analysis applied to each data set along the guidelines set out by two different research groups. Whereas, the analysis of the data for the qualifying paper, whilst thematic in nature and comprehensive in depth, was not so formally carried out.

Nonetheless, both pieces of work offer implications for the reader and potentially for the psychoanalytic profession, and possibly even for the wider mental health research community. The doctoral thesis suggests that STPP can be a helpful and appropriate psychoanalytic treatment option for young people with a range of mental health difficulties. Furthermore, it seems to suggest that STPP was not experienced as being that different a treatment to open-ended psychoanalytic psychotherapy. The qualifying paper offers ways of

understanding how anxieties about dependency might influence the way in which a young person engages in and responds to intensive psychoanalytic psychotherapy.

However, it could be argued that both pieces of work are to differing extents, subjective. The sample of psychotherapists sharing aspects of their experiences of STPP was in total 28 (26 psychotherapists from the IMPACT data, and six participants from whom new data was collected; however, four of these had participated in and been interviewed for IMPACT). Given the relatively small sample, the findings of the study cannot be generalized to all child psychotherapists, as it cannot conclusively be said that all psychotherapists would experience STPP in the same ways as the participants in the study. Therefore, there are likely to be important aspects of experience that are not represented in the study. The qualifying paper represents the experience of one child psychotherapist in doctoral training, and one female patient, aged 23 at the beginning of the therapy, with a particular set of life experiences that she brought with her to therapy. So again, the themes drawn out in the qualifying paper about dependence and independence cannot be generalised to other patients or psychotherapists.

However, it is important to also state that in neither piece of work have I claimed to offer generalizable results or firm conclusions, but rather potential ways of thinking about and understanding psychotherapists' experiences of offering STPP, and intensive psychotherapy with a 23 year old young woman, that might be of value to other child psychotherapists, mental health professionals, and perhaps service commissioners when thinking about which treatments a mental health service might offer. Furthermore, it would be remiss to not mention that to my knowledge there are no other studies exploring the experience of therapists' of offering a particular type of therapy (from a broad perspective rather than focussing on aspects of the therapy; see literature review and discussion), let alone of child psychotherapists offering a time-limited manualized psychoanalytic therapy. Therefore, the thesis may well offer something novel and potentially helpful to the profession.

It also seems important to consider the place of findings from qualitative research in the context of hierarchies of empirical evidence in health research. From the teaching I received on the doctorate, and from my prior research experience, I learned that quantitative research methods; more specifically meta-analyses and randomised controlled trials (RCTs), are usually privileged as the most robust and reliable types of methodology. In comparison, qualitative research and clinical case studies in particular, find themselves at the bottom of the hierarchy. However, as I learnt from my experience working on IMPACT-ME, there has been an increase in the number of studies using both quantitative and qualitative methodologies, known as mixed methods. Mixed methods offer both the internal validity of an RCT with the external validity of qualitative exploration and analysis. Furthermore, through my experiences working on IMPACT-ME and also through the research teaching I have received over the course of the doctorate, I have also held in mind the need to consider the research question being asked, when considering what methodology might most appropriately attempt to answer that question. For example, quantitative methodology would not have appropriate to explore the question of psychotherapists experiences of offering STPP.

Finally, it seems pertinent to hold in mind that the research methodology used might also depend on who is asking the question. As a child psychotherapist interested in the detail, subtly and nuance of the clinical encounter with my work with one patient, a clinical case study was the most appropriate methodology. Clinical case studies are established and well used within the psychoanalytic profession as a way of sharing experience of clinical encounters.

An Interesting Parallel

The two pieces of work discussed here have an interesting parallel, whilst at the same time seem to be in opposition to one another. The qualifying paper explores an intensive (three-

times weekly), open-ended psychoanalytic psychotherapy with a 23-year-old young woman, who was still working through the process of moving through adolescence and into young adulthood. The doctoral thesis explores the experiences of child psychotherapists' when offering a time-limited and once-weekly psychoanalytic psychotherapy to, predominantly, adolescents. Thus, both types of psychotherapy were carried out with adolescents, however with different lengths and frequency of sessions. In fact, it strikes me that the qualifying paper represents the kind of more traditional psychoanalytic work that some participants in the doctoral study were concerned might lose its place as a consequence of the introduction of STPP. But perhaps the question ought to be, is there room for both?

I hope that both pieces of work show the value of both types of psychoanalytic psychotherapy. In addition, I hope that the work done here offers some insight into the way we might think about and make decisions about for whom these different types of psychoanalytic psychotherapy might be most appropriate

For example, the patient discussed in the qualifying paper had a thorough assessment and the treatment recommendation was for intensive psychotherapy. This was related to her history of relational trauma, subsequent difficulties in relationships, and also her developmental stage; she was at least somewhat more ready to engage in a more intense relationship. Simultaneously, the psychotherapists interviewed for the doctoral thesis seemed to share experiences that for some patients STPP was also the treatment of choice. Their experiences seemed to suggest that STPP could be helpful for patients with a variety of difficulties, that it could be suitable for patients with more severe difficulties, and that it might be particularly helpful for those patients who either have struggled to engage in a therapeutic relationship, and/or are going through some kind of developmental transition. Moreover, it seemed that a thorough assessment was crucial in order to determine the suitability of STPP for that patient, and to give the patient a chance to make an informed decision about engaging in treatment.

So, perhaps the answer to the question might be that hopefully there can be room for both, depending on the needs of each individual patient.

The Importance of Research for Child Psychotherapy

As I learned during the research teaching that I received on the training, the evidence base for psychoanalytic child psychotherapy, whilst slowly beginning to grow, is small. I had also become more aware of this during my work on IMPACT-ME, and so came to the doctorate with a passionate view that it was important for child psychotherapists, and trainees to engage with research and try to contribute to the growth of the evidence base. Anecdotally, there is at times an 'anti-research' position within the profession of child psychotherapy. I have experienced this with peers, and also now in my role doing some teaching of research methods to first year trainees. This seems to be driven, in part, by a feeling that research (particularly quantitative) does not 'fit' with the way we think or work, and that it is too crude to pick up on the subtleties and nuances of what we do with patients in the consulting room. This, at times, seems to lead to a disengagement with research. However, this to me seems problematic. After all, we are the ones in the position to best understand how to develop research questions and projects that are most suited to exploring, and potentially measuring what we do in the most suitable and appropriate way.

As such, despite the challenges of completing the doctorate, which I will come on to consider, I continue to passionately believe that integrating a professional doctorate into the clinical training is crucial for the profession of child psychotherapy. This is in order to give us the skills and understanding to have discussions with colleagues from other disciplines regarding research, and evidence-bases for treatments from an informed and critical perspective. Therefore, I feel that it is a positive step forward for the profession that the doctorate is now becoming integrated into the clinical training.

This, hopefully, will also have implications for the evidence-base for psychoanalytic child psychotherapy with more research being done to show the potential role of this way of working in child and adolescent mental health services. This, again hopefully, could contribute to the number of mental health diagnoses and difficulties for which child psychotherapy is listed as a treatment in the NICE guidelines. For example, the IMPACT study contributed to psychoanalytic child psychotherapy being considered as a recommended treatment for adolescent depression in the NICE guidelines. In turn, this could contribute to the continuation of child psychotherapy being commissioned in NHS trusts across the country, given that commissioners make these decisions using tools such as NICE guidelines. Given the context of the 2008 recession, and the period of austerity that the country has endured since then, and may well continue to endure, finding ways to meaningfully show the value of what we do, in ways that fit the criteria of those who make decisions about service provision seems crucial to me. My experience of doing the doctorate suggests to me that it could help to make small steps in this direction, particularly when one considers that each cohort has between 15 and 20 trainees, all of whom have the opportunity to produce a small, but meaningful piece of research. From the point of view of my research, I hope that it will offer a perspective on the potential helpfulness of STPP for some, not all, patients, with a range of mental health difficulties. I also hope it will contribute to the ways in which we as child psychotherapists think about time, treatment duration, and the place of core aspects of psychoanalytic work, such as the transference, in shorter term work.

Reflections on My Experience of the Doctorate

The prospect of training as a child psychotherapist, and at the same time completing a professional doctorate was something that excited me greatly. Having come into the clinical training from a research background I felt clear that I wanted to continue to use and develop

my research skills and knowledge, whilst also learning how to be a child psychotherapist. I was also excited about the prospect of continuing some of the work I had been doing on the IMPACT-ME study, as I had thoroughly enjoyed my time working on that project.

My cohort was the first group for whom the doctorate was integrated into the training, with the aim of completing both the training and the doctorate within the four years that the clinical training has historically taken. This brought with it a prestige; however, it also quickly became apparent just how challenging completing both a clinical training and a professional doctorate alongside one another would be. This was especially the case as we were the first group to attempt to do so, and so inevitably at times it felt like we were guinea pigs and that the course team were also learning as to how to balance the demands of all aspects of the training. For example, trainee child psychotherapists have to meet clinical training requirements which involve seeing a certain number of cases from the variety of age ranges, whilst also gaining other experiences of parent work, group work, family work, amongst many other things. Most of these pieces of work are longer-term and ongoing. Therefore, as a trainee your weekly timetable is quite clearly set and defined for many months in advance, and as such it is difficult to fit in additional work or take time away from the clinic you are based in, in order to work on other things such as the doctorate.

Thus, it was a significant challenge finding the time to consistently work on the doctorate and stay on top of the workload. In the clinical psychology training, this is managed by giving trainees a day per week for the whole of the training, in order to work on their doctorate. However, in child psychotherapy this would not be possible as it would make it very difficult for trainees to meet the clinical requirements. Just practically, if one has an intensive case, you must be in that clinic three different days during the week to see the patient. Add to this the reality that trainees often see two, or sometimes even all three, intensive cases at the same time. Coupled with the day out of clinic for Wednesday seminars and workshops; which is a full day, and all other ongoing clinical work, it soon becomes clear that taking a day per week is unrealistic.

In order to manage this, we were given half a day per week to take as research time during the third and fourth year of the training. However, as explained above, it was not realistic to take this on a weekly basis, and so we were supported to gather this time up and take it in chunks. I was fortunate enough to have a very supportive tutor and supervisors, who encouraged me to take this time. However, in reality it meant taking a week each half term and adding extra weeks onto the beginning or end of breaks over Christmas and/or Easter.

This did make it possible to work on the doctorate, and also for myself, was a better way of managing my time, as I prefer to work on things in blocks rather than a little bit at a time. However, this did mean that often I did not get a proper break from work of some kind, and at different points, particularly over the final two years, felt close to burn out.

Alongside the challenges of fitting in the necessary work on the doctorate, aspects of the work itself also proved challenging. I enjoyed the process of recruiting and interviewing the psychotherapists, and of managing the data I had collected; including transcribing and reading the transcripts. However, carrying out both the thematic analysis and IPA was time consuming, and at times quite confusing; particularly for the IPA as I had a lot of data. However, with the support of my supervisor I was able, with a number of months of work, to gather up the salient themes emerging from the data. When it came to writing up the findings up, I thoroughly enjoyed this.

Despite these challenges, my passion for the project I was working on remained, and I felt determined that I would get it done. We were also granted a 4-month extension to the original deadline, without which it would have been very difficult for me to complete the doctorate on time. As such, I have felt supported, and I am very grateful to my doctoral supervisor, my tutor, and my service supervisors for consistently encouraging me to complete the doctorate. I also feel I have learned a huge amount about research in general, but more specifically qualitative research. As stated above, my hope was that continuing work in research would develop my emerging skill set, and I feel that this has been the case.

It has certainly been a great challenge to complete this piece of work, and to a standard that I feel happy with. However, with the aforementioned support I have been given, I feel that I have done so. I now feel I can look back on the experience of my clinical training and recognise that whilst it has pushed the limits of what I thought I was able to manage on a personal and professional level, I feel pleased with what I have done.