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From Less to More: The clinician's experience of the transition from non-intensive to intensive psychoanalytic psychotherapy with looked-after and adopted children. A thematic analysis.

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A thesis submitted for the degree of Professional Doctorate

in

Child and Adolescent Psychoanalytic Psychotherapy

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Contents

Abstract

The aim of this study is to explore the clinician's experience of the transition from non-intensive (once-weekly) to intensive (three-times-weekly) psychoanalytic psychotherapy with looked-after and adopted children (referred to as LAAC) in the NHS Child and Adolescent Mental Health Services (referred to as CAMHS). The study aims to understand more about the processes involved in this transition when it takes place with children who have experienced early and often traumatic discontinuity, as well as the possible impact upon the therapy of this transition. The literature review reveals that the subject of transitions across session frequencies with LAAC has not yet been studied, despite its prevalence and significance as a clinical practice, confirming this to be a new and valid piece of research. The data for this study was collected through semi-structured interviews and analysed using Reflexive Thematic Analysis. The results offer insight into the complexity and challenges involved in this transition, raising questions about the process and arguing for greater understanding of the meaning for each patient of this change in session frequency. The findings conclude that moving LAAC patients out of once-weekly psychotherapy and into intensive treatment is a vastly more complex undertaking than is often acknowledged; attention is drawn to the difference between a successfully managed transition and an unsettling disruption, cautioning that change to the care plan requires significant preparation and understanding of the patient's object relationship so that the risk of enacting early, traumatic discontinuities may be minimised. This study suggests that increasing session frequency may not always enable hoped-for developments and that, for some children, once-weekly frequency may be preferable. The findings indicate areas for further research while highlighting the need for greater understanding of this practice to enhance clinical judgement when considering this move and its possible implications for the therapy.

Introduction

This chapter offers context and rationale for the study while outlining the key features of the thesis. It also considers the impact of the unique circumstances of the Covid-19 pandemic in which the study took place.

Context

The child psychotherapy training requires the trainee child psychotherapist to have three training cases. These entail seeing patients of each developmental stage – under-five, latency and adolescent – for intensive psychoanalytic psychotherapy, lasting for a minimum of one year. In contemporary CAMHS practice, intensive treatment comprises three-times-weekly sessions and is the most intensive frequency offered in NHS work with children. It represents the highest value resource offered by a CAMHS team and, for reasons of staff shortages, is now only offered by child psychotherapy trainees whose training demands this depth of clinical experience. In the current climate of budget cuts, when CAMHS teams are understaffed and having to manage long waiting lists, the allocation of this high-value resource to one patient represents a significant commitment on the part of the team. Intensive treatment is usually offered in cases of extreme and severe disturbance, often where previous interventions have failed to bring about change or improvement; children who are offered intensive psychotherapy may have even already received other high value resources such as in-patient care and are likely to have received psychiatric assessment. Intensive psychotherapy is likely to be offered to LAAC who currently constitute the greater part of the CAMHS child psychotherapist's caseload (Robinson et al., 2017).

Establishing a once-weekly psychotherapy case requires a so-called 'working up' process that demands considerable investment of time and relationship-building to secure family and network commitment in order to support the regular weekly time, not to mention the cooperation and consent of the child. Training cases for trainee child psychotherapists are often drawn from the once-weekly caseload, in which there is already a committed relationship between family and service to supporting treatment. When assessing the possibility of moving a LAAC patient into intensive psychotherapy from once-weekly psychotherapy, there is a need for careful understanding of the child's relationship to

change; the common LAAC history of disrupted attachment and discontinuity of care means that change itself can feel fraught with danger. This study seeks to understand more about the processes and factors that might influence the extent to which moving into intensive treatment is felt to be either a successful transition or a traumatising discontinuity through exploration of the impact of this change upon the therapy.

Rationale

My interest in researching this subject derived from my own experience of moving into intensive work with an adopted boy who had been attending once-weekly sessions for one year. Upon reflection, the move felt rushed and driven by my wish to begin an intensive case; it felt hard to know how to talk with the patient about why we would soon be meeting three times a week or to anticipate the impact this would have upon the therapy. In the first intensive session, I felt I had become a new and frightening figure and felt alarmed to witness the destruction of every document from the once-weekly sessions. I realised that, rather than a transition from lower to higher frequency, this move felt like the destruction of the familiar once-weekly relationship, casting the patient into dangerous waters. I had been unprepared for the impact on the therapy of this move and sought to understand it more deeply.

Literature Review

My search for literature on this transition revealed a dearth of papers on this not uncommon aspect of the child psychotherapy training and of child psychotherapy more generally. In the absence of papers that discuss the transition from lower into higher frequency psychotherapy, the literature review considers instead papers that explore the question of frequency from both quantitative and qualitative perspectives.

Method

The study was designed to explore in-depth a singular clinical experience. Data from the interviews of five participants was analysed using Reflexive TA to mine for codes and themes through a psychoanalytic lens. The small sample size and richness of detail gathered

through the semi-structured interview schedule allowed for the exploration of complexity and nuance.

Key Findings

The findings conclude that changing the careplan of LAAC patients by increasing the session frequency risks repeating early and traumatic experiences of upheaval and unpredictability. The heightened sensitivity to transition of the LAAC population may usefully be thought of as providing a microscope through which to explore the implication and impact of transitions more generally; while this study focused upon the particular experience of the transition from less to more with LAAC, the findings offer transferable insight into this transition across the wider patient population, including the need for careful orchestration of people and thinking around the case to "create a bridge" (Sorensen, 2000) between frequencies. The findings also highlight feelings of guilt around undeclared training needs that demand changes to established care plans of vulnerable children, even in those cases where the outcome may be beneficial.

Circumstances

The interviews for this study of transitions took place during the first lockdown of the Covid-19 pandemic. The data gathered, analysed and codified into themes belongs to this time of profound disruption and loss whose influence cannot be overstated.

Chapter 2

Literature Review

2.a). Literature Search

This chapter aims to offer context to the present study through discussion of the literature pertaining to the research question. Initial searches confirm that the clinical experience of the transition from once-weekly to intensive psychoanalytic psychotherapy has not been studied as a phenomenon in its own right. This is surprising given that it takes place in every intensive psychotherapy due to this treatment being recommended in CAMHS only after an assessment period at once-weekly frequency. In the absence of papers devoted to the transition into intensive psychotherapy from lower intensity sessions, I chose to create a review of literature that explored key component concepts of the research question (*Appendix G: mind map of concepts for literature searches): frequency, qualities of frequency and ideas about the frame. A systematic search of the following key terms was carried out on PsychInfo and PEP Archive to ensure maximum access to papers on psychology and psychoanalysis:

1. *Frequency: High AND Frequen*: Low AND Frequen*: Frequen* AND Psychoanaly*: Frequen* AND Psychotherapy:*

The above searches were combined and the abstracts of results were hand read for relevance to ideas about the meaning and centrality of frequency in psychoanalysis.

2. *Move OR transition AND Intensive psychotherapy: Frequency* AND Increase**:

Results from this combined search were diffuse prompting the use of limiters of age (6-12 years old) and publication (Journal of Child Psychotherapy). These results yielded papers that were hand read for relevance to the concept of moving between frequencies in treatment, which none did.

3. *Convert OR conversion*:

Bibliographical references were pursued from the previous combined searches using the "snowballing" technique and the term "conversion" was found to denote the transition from psychotherapy into psychoanalysis.

4. *Intensive AND psychotherapy: Non-intensive AND psychotherapy: once-weekly AND psychotherapy*:

The limiter of age (6-12 years old) filtered these results into selection of papers that were manually read for relevance to the transition articulated in the research question, but nowhere was this transition mentioned. Papers were selected that capture the qualitative experience of intensive and once-weekly psychotherapy as context for understanding the possible rationale for considering transition between the two frequencies.

Following these searches, the related theoretical concepts were searched:

Rhythm: Object constancy: Object permanence: Temporality: Frame AND psychoanalytic: change* OR disrupt* OR alter*

Ideas about frequency emerged as a central preoccupation in discussions about adult psychoanalysis and became the starting point for this literature review. Moving on from considerations of frequency in the abstract, I decided to explore the possibilities and potential limitations of once-weekly psychoanalytic psychotherapy with children as compared with those of intensive psychoanalytic psychotherapy. This discussion will draw from papers that explore both once-weekly psychotherapy with LAAC as well as those that describe intensive psychotherapy with LAAC, offering insight of the qualitative experiences of psychotherapy with LAAC at these different frequencies in the hope of getting closer to understanding the possible experience of movement between the two. From discussion of ideas about frequency and examples of working at different frequencies, this literature review will move into an exploration of the qualitative experience of frequency through close discussion of papers on key psychoanalytic concepts of rhythmicity, object constancy

and temporality. Lastly, this section will review a selection of papers that discuss psychoanalytic ideas about the frame and the possible meaning of disruption to this.

The psychoanalytic concepts key to this study are outlined by way of theoretical background to the literature discussion and the wider study. Underpinning the theoretical framework is Klein's model of an internal world of objects in dynamic relation to the self and an "object relationship" that is understood to carry the blueprint for later patterns of relating. This object relationship establishes itself through the process of internalising earliest experiences of contact with the primary carer and is described by Klein in 'Envy and Gratitude' (1957): "if the undisturbed enjoyment in being fed is frequently experienced, the introjection of the good breast comes about with relative security…in this way a good object is established which loves and protects the self and is loved and protected by the self" (p.188). Psychoanalysis invites the transference of this object relationship onto the analyst-patient relationship, allowing aspects of the internalised primary object to be projected onto the figure of the analyst and modified through interpretation. Developing Klein's ideas about introjection, Bion proposed the model of containment, in which the infant's earliest, inchoate terror of annihilation is received by the primary carer, whose "alpha function" (Bion, 1962) or thinking transforms it into something more digestible that can be returned to the infant in its modified, thinkable form. Through repeated experience of this containment, the infant can be understood to internalise the containing function of the primary object. Bion's model of containment forms the frame of reference for child psychoanalytic psychotherapy through which the child psychotherapist attempts to receive and metabolise the undigested emotional communication of the patient, transforming it through alpha function before offering it in modified form as interpretation to the patient. Key to this study is the concept of object constancy, in which the internalised primary object is imbued with earliest experiences of containment and reliable, attuned caregiving. Object constancy can be understood to form the basis of trust and lies at the heart of other qualities such as causality and temporality (Shulman, 2019), concepts that will be explored further in this literature review. Experiences of unreliable early care, neglect and discontinuity, such as those commonly suffered by LAAC, can contribute to a poor sense of object constancy which can, in turn, create a heightened vulnerability to feelings of

instability and sensitivity to change. This has the potential to make the proposition of changing the careplan of a LAAC patient a challenging and potentially fraught undertaking.

2.b).Literature Review Findings:

1. Frequency of sessions.

    i. Early psychoanalysis: ideas about session frequency.
    ii. Developments: distinctions between psychoanalysis and psychotherapy.
    iii. Conversion from psychotherapy to psychoanalysis.
    iv. Psychoanalytic child psychotherapy and current CAMHS practice.

2. Rhythm – a qualitative exploration of frequency through discussion of three key papers:

i. Rhythmicity: 'On temporal shapes: the relation between primary rhythmical experience and the quality of mental links' by Suzanne Maiello, (2001)
ii. Object constancy: 'Time past, time present, time future: reflections on the development of the sense of duration as a foundation for a durable object, going on being and sense of self' by Graham Shulman (2019)
iii. Temporality: 'The development of the concept of time in fostered and adopted children' by Hamish Canham (1999)

3. Psychoanalytic ideas about the frame.

2.b.1.i). Early Psychoanalysis: ideas about session frequency

The literature on session frequency shows it to be a question central to the identity of psychoanalysis. Freud (1913,) confirmed working with adult patients "every day except on Sundays and public holidays – that is, as a rule, six days a week" (p.127) noting that "even short interruptions have a slightly obscuring effect on the work" (p.127) and the phenomenon of a "Monday crust" (1913, p.127) after the Sunday break. The idea of high frequency analysis was based upon the discovery of the transference (Freud, 1905) – the projection of early objects onto the figure of the analyst – and the belief that high frequency contact allowed this to develop most effectively. The early days of child analysis continue this high frequency gold standard and Klein's (1961) *Narrative of a Child Analysis* is an account of ten-year-old Richard's five-times-weekly sessions during his and Klein's war-time evacuation to rural Scotland. Since this time, debate about session frequency has continued, testing the boundaries of what can be termed "classical psycho-analysis" and what this means for the psychoanalyst, whose training has been built upon a training analysis of four or five weekly sessions according to the post-war training model agreed by the different schools within the International Psychoanalytical Association. Practicalities of time and money currently mitigate against this, leading to what some have termed as a crisis of identity for psychoanalysts, trained to work at five-times-weekly frequency and analysed, themselves, at this frequency. In her 2018 paper 'How Many Times?' Polden cites a survey conducted in 2014 by the British Psychoanalytic Council that confirmed that most psychoanalysts now work at a once-weekly frequency. Polden quotes Merton Gill's reflection in 1984 that "what is considered the necessary frequency is gradually dropping" (p.586) and requests urgent discussion to identify updated definitions of clinical practice that make possible analytic work at depth. Polden (2018) questions whether beliefs about high frequency work risk taking on the mantle of the overvalued idea, (Britton and Steiner, 1994), an article of faith that offers conviction in the face of uncertainty.

2.b.1.ii) Developments: distinctions between psychoanalysis and psychotherapy

An ongoing and lively discussion was found across papers about the extent to which frequency can define modality, in particular the role of frequency in differentiating between psychoanalysis and psychoanalytic psychotherapy. Kernberg (1990) differentiates the objectives between these modalities in terms of psychoanalysis aiming to achieve fundamental change in personality structure and to make the unconscious conscious while psychoanalytic psychotherapy aims to bring about an improvement in symptoms through partially reorganising aspects of the personality. Quoting from his earlier 1984 paper, Kernberg identifies the defining features of psychoanalysis and psychoanalytic psychotherapy as "interpretation, transference analysis and technical neutrality" (Kernberg, 1984). Kernberg disputes that frequency of sessions should define psychoanalysis and proposes a twice-weekly frequency as the minimum required for a psychoanalytic psychotherapy to explore transference developments. According to Kernberg, once-weekly sessions would entail too much time devoted to updating the therapist on events in the patient's life outside therapy, precluding good enough integration of external progress with the developments in the transference. Gill (1984) however, rejects Kernberg's assertion, proposing that transference analysis can take place at any frequency and cautioning against an overvaluing of high frequency work per se on the grounds that different frequencies may suit the needs of different patients.

2.b.1.iii) Conversion from psychotherapy to psychoanalysis

While searching for literature on clinical transitions, the term "conversion" emerged as a term used specifically for the transition from psychotherapy into psychoanalysis. Sherick and Chopra (2014) acknowledge surprise that scant attention has been paid to converting child psychotherapy to child analysis given its prevalence and cite their own fruitless PEP archive searches as evidence of this neglect, although they cite some literature on this experience with adults. Sherick and Chopra acknowledge that the evaluation of such a conversion requires detailed attention to the situation of child, family and psychotherapy as the move from psychotherapy to analysis will have an impact upon everyone involved in the child's life. Sherick and Chopra identify the possibility that the child will experience the

analyst as a “new object” (p.466) available to carry a deeper transference as well as to facilitate outstanding developmental experiences (Hurry, A., 1998). Sherick and Chopra eschew exploration of this experience from the perspective of the analyst, discussing instead generalised assumptions about the narcissistic appeal of working at higher frequency and increased satisfaction at having more time and space to interpret. Their clinical illustration of conversion from child psychotherapy to child analysis reads as a rather idealised account of improved access to the child’s internal world via play and dreams as well as increased thematic connection. Their illustration notes a shift away from defences of denial of conflict towards a feeling of greater safety to explore feelings of aggression. They also mention that higher frequency sessions render analytic breaks more impactful, but leave the reader to hypothesise what kind of impact these breaks had upon behaviour and state of mind. Frustratingly, their paper offers no discussion of the rational for moving into higher frequency work with children already in low frequency psychoanalytic psychotherapy and expresses no concern that the possibility that changing frequency could be problematic. Overall, this paper presents an unhelpfully sanitised version of the clinical transition addressed by this study.

In her 1989 paper on conversion from psychotherapy to psychoanalysis with adults, Bassen cites a 1976 survey of its members by the American Psychoanalytic Association which confirmed that 12% of psychoanalytic cases had converted from psychotherapy with the same clinician. Bassen proposes that the recommendation for higher frequency work may be understood as an enactment on the part of the analyst, who may have training needs to fulfil or who may be in receipt of countertransference projections of longing for more. She suggests that the “common clinical experience” of “intensified affect, ideation and transference” (p.80) may follow a recommendation to increase session frequency but resists detailed exploration of the transition itself into higher frequency contact. Also eschewing detail on the clinical experience of transitioning into higher frequency sessions with adult patients, Skolnikoff (1990) joins Bassen in considering the analyst’s vulnerability to seduction in the new, higher frequency contact – “grandiose fantasies of what we might accomplish” (p.113) - while cautioning that higher frequency of sessions does not guarantee deeper analytic work.

2.c.1.iv). Psychoanalytic child psychotherapy and current CAMHS practice.

Child psychotherapy in CAMHS is psychoanalytic. As thresholds rise for CAMHS referrals, so do the severity and complexity of disturbance and trauma seen in young patients. It is, perhaps, not surprising to learn that LAAC comprise the greater part of the current CAMHS caseload of child psychotherapists (Robinson et al., 2017). Child psychotherapy is a profound and ambitious undertaking that attempts to understand where development has been stymied by defensive maladaptations and tries to create a safe enough relational environment for these to be given up in favour of more trusting ways of relating. It is often seen as the last hope for children whose difficulties prevent them from engaging with other kinds of help and clinicians are usually working to address very early deficits and distortions in personality development (Waddell, 1998) caused by neglect, abuse or addiction. The literature evidences a historic leaning in favour of intensive psychotherapy over once-weekly psychotherapy for such cases, identifying as its central task the structural change achieved through enabling separation of self from object (Harris, 1971); intensive psychotherapy is likely to confer greater dependence upon the figure of the therapist while providing a regular rhythm of contact through which to explore the impact of separations from the therapist. Empirical studies of the efficacy of intensive psychotherapy for children are few, perhaps surprisingly for such a high value resource; one important example is the study by Fonagy et al (1996), which evidences better outcomes for children treated intensively to those children treated with non-intensive psychotherapy.

Rationale for intensive psychotherapy:

Assessment process:

The rationale for offering the high value resource of intensive psychotherapy in contemporary CAMHS is usually established through a rigorous process of assessment, which aims to gain an initial understanding of the child's object relations and to understand their state of mind (Rustin, 2004). Green (2009) suggests a measure of 'age-appropriateness' through which to evaluate the child's difficulties. Additionally, the child's response to feeling understood and their wish for understanding indicates their likely capacity to make use of psychoanalytic psychotherapy. Wittenberg (1982) proposes that

assessment should aim to answer three questions: “a) who has the pain, b) what is the attitude to the emotional pain, c) what is the attitude to getting help.”

The frame of the assessment mimics the consistency of the psychotherapy setting, typically a minimum of three once-weekly sessions at a fixed, regular time and day each week. The frame of several weekly sessions allows the clinician some insight into a child’s response to separations, in particular the defence systems that are employed to manage the time in between sessions, as well as an opportunity for the clinician to track any changes or developments across the sessions. Parallel to this process of information gathering about the child’s internal world, a clear picture of the stability of the home environment must be acquired and a parent figure identified who would be able to support the child’s psychotherapy by reliably bringing them to sessions (Rustin, 2004), providing the necessary holding during breaks in therapy and supporting the ebb and flow between development and regression as it takes place during treatment. The weekly assessment sessions with the child are usually preceded by an initial meeting with parents/carers where concerns can be shared and a developmental history gathered. At the end, a feedback meeting with parents/carers will usually be arranged to discuss findings from the assessment which the clinician builds into a meaningful formulation of the child’s functioning. On the basis of this formulation, recommendations for treatment (whether individual, parent-child or family psychotherapy) can be explored by therapist and parents/carers. The formulation will also guide decision making about the frequency of sessions and the likely duration of treatment. Where a treatment plan is agreed for individual psychotherapy, whether once weekly or intensive, regular parent sessions are recommended to support the treatment through exploration of the parental contribution to the child’s presenting difficulties (Green, 2009).

When is intensive psychotherapy indicated?

It is clear from the above discussion of assessment that a multiplicity of factors may come into play in the decision to offer intensive psychotherapy. However, perhaps surprisingly, there appears to be currently no standardised procedure employed for assessment of indicators for intensive psychotherapy, despite the existence of meaningful measures to assess personality functioning from a psychoanalytic perspective, such as the Shedler-

Western Assessment Procedure (SWAP), which could (if adapted for children) provide a comprehensive description of indicators for intensive work. Despite this, there is general agreement that key indicators for intensive work may include high levels of confusion between self and object, often manifested in perverse behaviours or severe and chronic developmental distortion or delay. Similarly, high levels of anxiety between sessions or a difficulty in holding on to contact between sessions suggest that intensive work may be needed to sustain the meaningful contact needed for the therapist to take on and work through the transference of early, disappointing parental figures. Intensive work is also indicated for children with histories of highly disrupted attachment who may struggle with lower frequency treatment to make a good enough attachment to the therapist for therapeutic contact to be sustained. Poor ego strength and extreme rigidity of defences are also often indicators for intensive psychotherapy which is likely to offer more secure holding of underlying phantasies and anxieties, enabling the possibility for rigid defences to be given up with lower risk of fragmentation or disintegration (Green, 2009).

Intensive psychotherapy

Allnut (2016) illustrates Harris' ideas about structural change in her description of intensive psychotherapy with two-year-old Joseph. Allnut proposes that Joseph's absence of internal space, understood here as the failure to "internalise the inner spaces of another's mind" (p.29), leaves his personality structured upon the surface. Allnutt describes the process whereby intensive psychotherapy allows Joseph to experience and introject the early attunement and containment that he lacked as an infant. This appears to enable some yielding of his rigid defences and allow for some exploration of interiority, first of the room and then the inside of his own mouth with his finger. Through this exploratory process, Allnutt traces Joseph's progression towards clearer delineation of self and other, inside and outside and greater capacity to transition across from one to the other without collapsing or losing his sense of self. Similarly, Jackson (2004) describes intensive psychotherapy enabling structural change for five-year-old Yasmin, whose extreme defences may be understood to have helped her to survive her first months in an orphanage. Like Allnutt's Joseph, Yasmin lacks internal apparatus to distinguish self from other and, instead, relies upon defences of "adhesive identification" (Meltzer, 1975) in search of the sameness that protects her from unbearable separateness and ensuing fragmentation. Jackson describes Yasmin's gradual

development, through the patient-therapist relationship, of the earliest building blocks of selfhood, through the experience of containment first and then through the emergence of a space to play. Jackson, like Allnutt, acknowledges the clinician's challenge to be creative in going beyond the limitations of language to make and sustain emotional contact

Once-weekly psychotherapy

Despite Harris' reservations about the limitations of once-weekly work, the *Journal of Child Psychotherapy* is replete with impressive papers that testify to transformative once-weekly psychotherapy with severely deprived and traumatised LAAC; Kenrick (2000) attests to the development of reflective capacities through the once-weekly psychotherapy of five-year-old Kris while he moves through temporary foster placements. Kenrick's paper describes how once-weekly psychotherapy is sufficient to contain Kris' terror of his own "crocodile rage" (p.400) and his belief that this drives people to abandon him, supporting him to internalise some containing capacity of his own and leaving him better able to express anger at his helplessness and hope for his future. Once-weekly treatment was also sufficient to enable Kris to develop and maintain a dialogue within himself that could help him process his multiple and apparently random his life moves, helping him to make better use of the care offered to him and to build more trusting relationships. Similarly, Edwards describes once-weekly psychotherapy being sufficient to allow six-year-old Gary to make necessary developmental progress; according to Edwards, Gary's enactments of throwing himself head first onto the floor communicated early and traumatic experiences of feeling emotionally dropped Edwards acknowledges the need for more active physical holding as well as verbal containment in the face of Gary's descent into mindless violence both towards himself and towards the toys in the room, differentiating between a more communicative aggression that could be contained by words and destructiveness that needed to be physically stopped to prevent damage. Edwards describes once-weekly sessions enabling Gary to develop internal links that allowed him to begin to connect with his own feelings of love and aggression. While neither of these papers offers a rationale for the choice of once-weekly as opposed to intensive psychotherapy, they both testify to the transformative potential of once-weekly work. Rustin (2001) offers an account of once-weekly psychotherapy with two boys whose development had been derailed by early trauma, identifying as her task the grasping of their psychic pain and then creating a safe enough setting in which they might

be able to risk change. Rustin raises ideas about technical adaptations when working with severe and complex trauma, referencing questions of temperature and distance (Meltzer, 1976) and reflecting upon the need for talking quietly and allowing time and space for new thoughts to be digested. The concept of an optimum temperature and distance when working with highly disturbed children, like LAAC, invites consideration of the possibility that higher frequency contact may, in some very extreme cases, feel too hot and that the lower temperature of once-weekly sessions might feel more manageable, allowing for therapeutic work to take place and in challenge to the orthodoxy that intensive treatment is best. This is the conclusion reached by Miller (1992) in her account of the near breakdown of intensive psychotherapy of Yvonne, a highly traumatised seven-year-old girl whose early deprivation and sexual abuse left her deeply confused and dependent upon defences of erotisation to protect her against terror and disintegration. While the severity of Yvonne's confusion prompted CAMHS clinicians to recommend intensive psychotherapy, Miller reflects that for most of the intensive sessions, Yvonne seemed to experience her as a terrifying mother figure from whom Yvonne needed to defend herself. In this case, the combination of extreme defensive rigidity coupled with instability and upheaval in Yvonne's living situation, seemed to mitigate against Yvonne being able to tolerate the intensity of three-times-weekly contact with her therapist and led, eventually, to the realisation on the part of the therapist that a lower frequency contact might be preferable. Miller comments upon Yvonne's initial feelings of rage and rejection at the frequency of sessions being reduced but reflects upon the gradual emergence of a capacity for separateness with the boundaries offered by the new once-weekly session. Miller's is the only paper to offer a rationale for the positive choice to change from higher to lower frequency sessions and is the only paper of this selection that addresses this change in frequency. Miller's reflections suggest that changes in frequency – whether from low to high, or high to low – carry meaning for the patient and can be understood in terms of their object relationship.

2.c.2. Rhythm: a qualitative exploration of frequency

The second part of this literature review will consider papers that explore the qualitative dimension of frequency – rhythm – in an attempt to come closer to the felt experience of changing frequency as framed in the research question. Central to this section of the

literature review is the psychoanalytic concept of object constancy: the reliable and constant quality of the primary object internalised (Klein, 1957) through the earliest consistent and sufficiently attuned moments of meeting (Sander, 2002) with the primary carer. This positive internalisation of reliability and consistency forms the basis for object constancy, of which the central qualities of rhythmicity and temporality allow for the development of trust and meaning. This section will discuss three key papers on rhythmicity, object constancy and temporality to mine some of the psychoanalytic thinking most pertinent to the exploration of possible meaning and impact of discontinuities in rhythm.

2.c.2.i). Rhythmicity

Maiello (2001) locates the earliest experience of rhythmic contact at the heart of the relationship between self and other. In bringing together the fundamental concepts of together-apart, presence and absence, loss, within time, Maiello identifies that the repeated oscillation between these experiences creates a rhythm. Rhythm is, Maiello asserts, an essential feature of being alive that starts in utero to the sound of the maternal heartbeat. By the time it comes to be born, the full-term infant has developed as an organic being to the regular pulse of the mother creating conditions for the expectation of rhythmic contact in the outside world, perhaps a preconception (Bion, 1962) of attuned feeding and care in response to the rhythm of bodily and emotional needs. Maiello acknowledges her debt to Alvarez, to whom the book containing this chapter is dedicated, in particular Alvarez's idea that "internalized objects maintain a dynamic form, a shape in time" (p.179). These are the titular temporal shapes that the infant experiences in its earliest encounter of comings and goings with the primary carer. When these comings and goings take place with enough regularity, the infant has an experience of "reliable temporal shapes" that it can internalise, forming the basis of trust and enabling a capacity to bear small discontinuities and non-rhythmic absences through the development of flexible mental links (Bion, 1967). In other words, development of sufficient object constancy to be able to tolerate changes in rhythm.

Maiello illustrates these complex ideas with observational material from two infants, David and Leo, both born prematurely. The loss of the life-sustaining rhythmic environment of the womb before they were ready to tolerate post-natal life appeared initially to be

catastrophic for both infants however there were significant differences in the development of each. Maiello describes Leo managing to overcome his early trauma enough to express interest in his environment and appetite to take in food and contact. Between feeds, Leo was observed making rhythmic sucking gestures and breathing more regularly. His reaching for the breast after leaving his incubator and his exploratory search for contact with his environment, carer, toys suggested that Leo had, despite his early trauma, sustained and realised his earliest preconception of a rhythmic relationship. By contrast, the description of David conveys a "breakdown of the capacity to wait" (p.188) for this rhythmical interpersonal relationship, evinced in sound communications lacking intention or seeking response and a slower, more hesitant reaching for contact outside the incubator. Further material from the psychotherapy of five-year-old Rosetta illustrates the contrast between rhythmicity as the pulsing link between temporal shapes and repetitive stereotypies that eliminate variation, contact and growth. The reliability of psychotherapy seemed to expose Rosetta to "interpersonal rhythmic experiences" (p.192) that, over time, helped her to internalise the trust needed to tolerate discontinuity and move towards being separate. Maiello concludes that it is this internalised and flexible link with a rhythmic temporal shape that lies at the very heart of being able to be a separate person in a relationship with another.

2.c.2.ii.) Object Constancy

Shulman's 2019 paper was selected for its consideration of the impact upon development of rhythmic discontinuity, inviting further exploration of the possible meaning and impact of change in session frequency. Shulman, like Maiello, starts by acknowledging the work of Anne Alvarez, presenting his paper as a response to Alvarez's question as formulated in his abstract: "How does a sense of a durable object get built up?" (p.1). Shulman offers observational material from the intensive psychotherapy of one-year-old Findlay, whose traumatic discontinuities of early care appear to have left him without a sense of a durable internal object; Findlay shows no emotional engagement with the task of bringing pen to paper, apparently unable to link the pen with making marks on the paper and unable to

engage with his foster carer's demonstrations of this activity. Shulman identifies a sense of absence in Findlay: his expression, like the paper, is blank. Shulman describes a qualitative difference in Findlay's engagement with this task once he has the sustained attention of his foster carer and the observer; after the intermittent random dots on the page, Findlay becomes able to draw a line, suggestive, Shulman proposes, of his feeling more connection via the close attention of his object. Shulman links the "'moment of meeting' of pen and paper" (p.325) with the moment of meeting between Findlay and his object, as experienced through the newly acquired sustained attention of his carer, proposing that the increase in Findlay's own focus and attention imbues the whole experience with causality and emotional meaning. Shulman links this development of causality with a sense of "past, present, future at a micro-level of experience" (p.326) that he suggests speaks to an incipient sense of duration within time of self and object. Shulman references the thinking of Sander (2002) with regard to, as Shulman cites, "'moments of meeting'" (p.327) between infant and mother that take place to the rhythm of the infant's bodily needs and generate a sense of internal coherence and a sense of duration. Over time, this rhythmic meeting of needs can be understood to form the basis of trust and temporality.

Shulman links Sander's ideas with those of Maiello discussed above, before introducing the ideas of Rey (2004) about the unconscious meaning of earliest rhythmic introjects, starting with the maternal heartbeat, and the catastrophic nature of disruption to this rhythm. Shulman links Rey's ideas about rhythmic introjects and the meaning of regularity or discontinuities with the psychoanalytic setting, suggesting that the regular rhythm of sessions may evoke the earliest rhythm of 'moments of meeting'. This is the closest articulation, in all the literature reviewed so far, of the research question's central focus and the possible meaning and impact of change to the regular rhythm of session frequency.

The next part of this paper considers contributions of neuroscience, developmental research as well as psychoanalysis towards understanding the impact of discontinuities and disruptions upon development, including ideas about dysregulated and desynchronised relationships to time. Shulman also references the ideas of Canham (1999) on distortions of temporality in LAAC, discussed in greater detail below.

2.c.2.iii.) Temporality:

The search for literature on the experience of changing session frequency led to the broader field of time and temporality, central concepts in psychoanalysis which aims to distinguish the past from the present. From discussion of the previous two papers, it will be clear that a sense of temporality – the capacity for separating past from present while making meaning between the two – is a developmental achievement that is relational in its basis and develops out of infant's internalisation of reliably, rhythmic early care. A key paper on the disorders of temporality widely acknowledged to be common to LAAC is Canham's often-quoted 1999 paper; in exploring the impact upon personality development of rhythmic discontinuities in early care, Canham's paper offers further scope for consideration of the possible impact and implication of a change to session frequency. Canham notes among his LAAC patients a distorted capacity for perceiving time as if they inhabit a continuous present in which past, present and future cannot be differentiated. Crucially, Canham differentiates chronological time from causality and sequentiality, linking the figure of Father Time with an idea of a third (Britton, 1989) that can triangulate and regulate contact between the mother-baby dyad. To the ideas around reliable rhythmic contact already discussed above, Canham notes that early experiences of chaos or neglect can leave LAAC without a securely internalised sense of a responsive object and, confusingly, leave earliest unmet needs to persist and impinge upon later developmental stages. Compounding an already distorted perception of time, the familiar LAAC experience of interminable waiting for adoptive or foster homes can often contrast with a confusing sense of time speeding up when placed suddenly in an appropriate placement, perhaps to push through a transition before pain can be registered in the network. Through discussion of case material from the two-year-long intensive psychotherapy of eleven-year-old Toby, Canham traces an evolution in Toby's capacity to experience himself in time, noting that the regularity of the rhythm of sessions enabled the introjection of a more reliable internal object.

2.c.3. Psychoanalytic ideas about the frame.

The psychoanalytic frame is the broad term given to the setting of an analysis. Along with consistency of place and adherence to principles of psychoanalytic work, the frame is commonly understood to refer to the session times and frequency of an analysis.
A hand-read selection of the papers yielded by this search revealed no detail on the experience of change to the analytic frame although some papers that explored the meaning of the frame are here discussed in their relevance to the research question. For LaFarge (2014) the frame, once established in its reliability, can come to evoke and represent the earliest experiences of contact with primary carer and the fantasies this elicits. LaFarge suggests that the regular frame of the analytic sessions may protect phantasies of an "ideally attuned containing mother" (p.315) which can break down with disruption to the regularity of rhythms (in the form of changing session times or analytic breaks). Similarly, Bleger (1967) proposes that each patient comes into treatment with their own "frame" (p.511), a matrix of defensive structures that have held aspects of the personality in what feels like a familiar sense of self. Bleger proposes that the reliability of the agreed analytic frame can allow the patient's unique frame to be projected onto the analysis in such a way that enables primitive phantasies of fusion, protecting the patient from having to experience the analyst as separate. Changes to the frame in the form of analytic breaks or holidays may represent a threat to these phantasies of fusion, as illustrated by Bleger's clinical material from the analysis of Mr Z; in the quoted vignette, Bleger illustrates the extent to which the consistency of the frame had come to protect the organisation of the patient's defensive structures and, in so doing, perpetuate his omnipotence. Only when there was a significant interruption to the regular rhythm of Mr Z's weekly sessions (in the form of the first holiday break) did a crack open in this organisation, causing a collapse of his omnipotence and revealing an unanalysed "ghost world" (p.515) of the unbearable aspects of himself and his vulnerability. Bleger's ideas are developed further in LaFarge's (2014) paper where she proposes that the analytic frame represents a "symbiotic link" (p.312) between patient and analyst that can be understood as "an unspoken shared belief about the rhythm and continuity of our time together" (p.313). Disruptions to the frame are therefore a challenge to this shared, unspoken belief and can expose, as illustrated in LaFarge's clinical material, a "terrifying, disorganizing chasm" (p.313) in which the symbiotic link that binds patient to analyst is destroyed. As well as describing her patient's response to the analytic break, LaFarge reflects upon the significant

impact upon herself of the disrupted frame, describing “an unprecedented disturbance in my own experience of time” (p.312).

2.d) Conclusion to Literature Review

The searches detailed in this literature review reveal a paucity of literature on the clinical experience of the transition from once-weekly to intensive psychoanalytic psychotherapy. The literature attests to the central importance of rhythmic regularity to personality development and proposes a link between the earliest rhythm of need-meeting and the regularity of psychoanalytic sessions. Given this insight, the present study argues for greater understanding of the practice of changing the care plan to move patients into intensive work from once-weekly sessions.

Chapter 3

Methodology

3.a) Aim:

This research project is a small-scale in-depth piece of qualitative research, aiming to understand more about the clinician's experience of a singular clinical phenomenon: the move from once-weekly to three times weekly psychoanalytic psychotherapy when working with LAAC.

3.b) Ethics

Ethical approval was sought through detailed outline of the aims, rationale and methodology for this project. On the basis of this application, ethical approval was given for the project by the Tavistock's Research Ethics Committee (TREC) panel (*Appendix A)

3.c) Methodology:

3.c.i) Design:

This is a small scale, qualitative study that aims to understand a singular, clinical phenomenon – the transition from once-weekly to intensive work with LAAC - through the experience of the clinician. In order to conduct this study, a sample of five trainee child psychotherapists was recruited and participants were interviewed using a schedule of semi-structured interview questions. The data collected was analysed using Reflexive Thematic Analysis (Reflexive TA), (Braun & Clarke, 2021), a method of qualitative analysis appropriate for the in-depth and detailed exploration of nuanced and emotionally complex experiences. It was chosen of all the qualitative methodologies for its straightforward process as well as theoretical freedom which is "compatible with both essentialist and constructionist

paradigms" (Braun and Clarke, 2006, p. 78). As a method rather than a methodology with its own theoretical framework, Reflexive TA has the flexibility to become "infused with theoretical assumptions when enacted in a particular study" (Braun & Clarke, 2021, p.41); Reflexive TA was particularly chosen as it suited the psychoanalytic nature of this study, offering the possibility to mine data for either latent or manifest content and the freedom to interpret unconscious meaning within codes and themes (Braun & Clarke, 2006) through a psychoanalytic lens. Given my dual role as architect and engineer of this study, Reflexive TA allowed me to explicitly position myself within a constructionist paradigm in acknowledgement of my central role in generating meaning, "Themes cannot exist separately from the researcher" (Braun & Clarke, 2021, p.42). During the interview process, I was aware that the interviewee was likely to be receiving unconscious communications about expectations based upon my own experience of this clinical transition and I was sensitive to the potential influence this could have upon the interview. Between the stages of initial coding and finalising themes, I was aware that my own experience would have some influence upon the salience of quotes and details that stood out for me and the thinking around which they coalesced into themes and, eventually, into the structure of the report. The option of other qualitative methodologies was considered, such as Interpretative Phenomenological Analysis (IPA) which would also have lent itself to the small sample size of this study. While IPA is an appropriate methodology for the in-depth exploration of an experience or phenomenon, its emphasis upon the particular rather than wider patterns across data mitigated against using it for this study, where the aim was to explore what could be understood about a particular clinical experience common to the five clinicians interviewed in this study.

3.c.ii) Participant Sample Group:

A sample of five participants who were all trainee child psychotherapists was recruited through dissemination across networks of trainee child psychotherapists and at the Fostering and Adoption workshop at the Tavistock training of approved advertisements (Appendix A*) for the research project. Five trainee child psychotherapists, all of whom were training at the Tavistock and known to me came forward to participate. Inclusion criteria required participants to have experience of the transition into intensive work from once-weekly sessions with a looked-after or adopted child with a cut off for transitions that

had taken place more than three years prior to interview. Of the five participants interviewed, four spoke about a case that had already ended while one spoke about an ongoing case. All five of the participants were white women of European and non-European origin and different ethnic and cultural backgrounds. While limitations of the study are discussed further in chapter 6, it is important to note the sameness of colour, gender and class common to the participants and researcher which may have contributed to unconscious shared assumptions that may limit the potential scope of exploration. Two participants had nearly qualified at the time of interview, while two participants were in the third year of training at the time of interview. One participant was in the second year of training at the time of interview. It was unspecified as to whether the case under discussion was the participants' first, second or third intensive training case. The five participants who responded to the project adverts were all given a participant information sheet (*Appendix B) detailing the project's aim and the structure of the interviews. They were informed about the project's provision for data protection as well as about the proposed results of the study. Consent (*Appendix C) was given by all participants on the basis of this information and a debrief form (*Appendix D) was sent to each participant.

3.c.iii) Data Collection

Data was collected through interview with participants. As this is a qualitative piece of research, the interviews were semi-structured to ensure that each participant was asked the same questions while also allowing space for exploratory and free-associative reconstruction of the clinical experience in question. Due to Covid-19, approval was sought and granted from TREC to conduct interviews over the telephone. Participants agreed a convenient time with the researcher. Interviews lasted between 60-70 minutes, depending on the participant's responsive expansiveness. Interviews were recorded digitally and an identifying number given to each interview. Interviews were transcribed at the earliest opportunity and anonymised to protect the identity of clinicians, patients, clinical teams or places mentioned in the interviews. Once transcribed anonymously, recorded interviews were stored on encrypted disk and removed from the original recording device. The interview schedule can be found in the appendices (*Appendix E).

3.c.iv). Data Analysis:

The data was analysed using Reflexive Thematic Analysis (reflexive TA). In keeping with the six-step process of reflexive TA (Braun & Clarke, 2006) the data gathered at interview was read several times as a familiarisation exercise. During this stage, familiarisation notes were added in the margins. At the coding stage, individual interviews were read at a micro level to identify possible codes, which were noted, with quotes, within a grid of columns titled "Possible Codes" and "Field Notes" in a separate document for each interview. At this stage of the coding, each interview yielded a multiplicity of codes which required some stepping back from the close reading of individual interviews to a more distanced position from which to identify patterns of codes across the whole data set. From this distance, it was possible to identify which of the possible codes could qualify as initial codes. A new document was created for each interview of initial codes from which a spreadsheet of most frequently recurring initial codes was created. From this, it was possible to group initial codes into potential themes. The choices made as to how initial codes might be grouped into potential themes were informed by recurrence of codes as well as by the researcher's own response to salient details, in keeping with Braun and Clarke's (2021) acknowledgement that coding is "an inherently subjective process" (p.42). Several attempts were made to refine these potential themes, including listing them across a series of columns on a large A3 card (*Appendix H) in addition to returning to the original data set to identify quotes that might sit more squarely within potential themes than those selected at the coding stage. This reviewing and refining process produced a large quantity of themes which then functioned as new codes that were eventually gathered into final themes. At this step of the process, the potential for themes to be grouped variously required the researcher to relinquish an idealised fantasy about right and wrong in favour of embracing subjectivity:

> "Themes cannot exist separately from the researcher – they are generated by the researcher through data engagement mediated by all that they bring to this process (eg. their research values, skills, experience and training)." (Braun and Clarke, 2021, p. 42)

The potential themes were then tested for robustness in relation to the research question before being identified as final themes. These final themes and final codes were then written up as a report which is discussed in the following chapters.

Chapter 4

Results

4. a) Introduction to results

This research study aims to understand more about the clinician's experience of moving patients who are looked-after or adopted from non-intensive to intensive psychoanalytic psychotherapy. As clarified earlier, this research took place within NHS CAMHS services and the clinicians interviewed were all trainee child psychotherapists in the process of completing the four-year full time NHS child psychotherapy training. The data from the five interviews collected were analysed using Reflexive Thematic Analysis which generated four main themes from eleven codes. The researcher identified these eleven codes from the data based upon high frequency recurring words and concepts, as well as the concepts explored in the literature review and interrogated by the research question. The four main themes have been identified across a matrix of possible themes suggested by the codes and the researcher acknowledges the alternative possible groupings of codes into themes that would also have been meaningful.

4.b) Themes

1. The challenge of coming together
    A) Rejecting and being rejected
    B) Claiming and being claimed vs being taken
    C) Helpful vs unhelpful coming together with supervisor
2. Making sense
    A) Anxieties around understanding and knowing
    B) Profound questions and process questions
    C) Is intensive psychotherapy a cruel trick?
3. Survival
    A) Dread
    B) Surviving once-weekly sessions

C) Surviving intensive work

4. Change
    A) Transition: Development or discontinuity

4.b) 1) Theme 1: The challenge of coming together:

Given the trauma of ruptured contact between baby and birth mother that is shared by all participant's patients, it is understandable that the very question of contact itself – how a dyad comes together – runs through the entire data set. There are three dyads alive in each of the interviews:

1. The original dyad of birth-mother and baby.
2. The secondary dyad of therapist and patient.
3. The tertiary dyad of trainee and supervisor.

Every interviewee spoke to the complex and painful challenge of attempting to come together in the therapist-patient dyad and, for some, this was repeated in the trainee-supervisor dyad. Due to the protean nature of this triad of dyads, the interplay between them will be more amply explored in the discussion section. Participant D described a bewildering experience of first contact between therapist and patient in which the early struggle of mother and baby felt live:

> "I was as shellshocked as she was in terms of what do we do together? We were in the room. We were both having an experience of coming together for the first time. Imagine mother and child coming together for the first time, tentatively trying to find their way together." (Participant D)

For this participant, the complexity of managing contact with their traumatised patient came to define the entire treatment: "I started to think about the work as being about can we just be together?"

4.b) 1. A) Rejecting and being rejected

Because all the patients were looked-after or adopted, they had all experienced a primary trauma of separation from birth mother. Participant A and C's patients were both removed at birth while the patients of Participants B and F were removed from the care of birth mother after six months or more due to neglect. Interview D did not specify the time at which the primary trauma of separation occurred. Each of the interviews spoke to a powerful experience of rejection in the therapist-patient dyad with either the therapist or the patient doing the rejecting, or sometimes both. The researcher proposes that the primary trauma of being separated from birth mother was experienced as a felt rejection.

Therapist as rejecting object:

Before the transition to intensive work, all participants spoke of a struggle to claim their patients. During the once-weekly sessions, some participants acknowledged feeling that they were the ones rejecting their patients; Participant C reflected upon feeling that "initially, I was a bit rejecting," noting that the patient "could evoke something quite rejecting or shutting down" in the therapist, a "cold steeliness that sometimes I felt she pushed into me as someone who was really sort of unreceptive and uncaring." For this participant, rejecting the patient also involved rejecting her from her mind once the session was over: "she was not one of the patients who for a long time was present in my mind outside of the sessions". Participant C described feeling helped by intensive supervision to identify these feelings of rejection as a communication from the patient:

> "I really needed my supervisor to point it out in a very concrete way. It was very hard for me to believe that she liked me and wanted something from me…It was interesting….with my under five [case] who I was seeing at the same time, was so easy for me to get in touch with something maternal in me. But didn't come with her in that way that you would expect it to come, and I really needed help to connect to it in her and in me." (Participant C)

For other participants, the move into intensive work made the therapists feel more rejecting towards their patients; for Participant B, intensive work heightened feelings of hatred for the patient, stirring a wish to get rid of them:

> "It was that [sic] the intensive work provoked….it provoked hate, really. This is a child that provokes a lot of hate. Her old school got rid of her. We were really shocked how they managed to do that. The school she's in now is really tempted through the intensive work…they were really not managing at one point. There's a wish to drop her. Intensive work did allow that to come through. We had to work with it together." (Participant B)

Moving into intensive work took other therapist-patient dyads into a different kind of rejecting scenario, with some participants describing countertransference responses of detachment and shutting down. For Participant E, moving to intensive work elicited a somatic reaction that prevented the lively contact that had characterised once-weekly work:

> "I would feel this heavy drowsy feeling as if I was zoning out, detaching from him…I was so cut off it felt like I was watching from behind a screen…an internal battle to stay with him while feeling completely shut down." (Participant E)

<u>Patient rejecting therapist</u>

Participants also shared experiences of feeling rejected by their patients. In once-weekly work, several interviewees reflected upon feeling shut out during sessions. Participant A remembered feeling shut out from the patient's play: "I was an onlooker, not involved at all". Participant C recalled once-weekly sessions in which the patient kept the therapist on the outside:

> "I wasn't really invited in…she would stay busy with her back to me. She could just ignore me for entire sessions". (Participant C)

Rejection was the starting point for Participant D, who felt powerfully rejected before even meeting the patient:

> "She refused to come to the first meeting. She didn't want to come after having such a long wait: 'I've waited so long now I don't know if I really want to do it' (therapy). Really what she was saying was 'I don't know if I want to do it with you.' I sensed a real sense of rejection right from this first meeting." (Participant D)

Participant D described an intensification of feeling rejected by the patient after moving into intensive work:

> "She became more and more shut down in terms of not speaking with me" and "the way she settled into the treatment; she used it in a way to block me out, reject me."

Participant D's description conveys the patient's immediate need to communicate to the therapist a painful experience of feeling unwanted and rejected that the therapist was tasked to survive. Participant D hypothesised that intensive work allowed this therapeutic dyad to work at the earliest development stage of infant observation, describing feeling "in counter transference the kicking and screaming of the child who needs to be picked up and attended to." The intensive work was, according to this participant, "becoming a space where she could bring younger aspects of herself, and she could have a rest and be with someone who was interested. Even though she found the interest intrusive and frightening, she learned to tolerate being with me. And I could be someone interested in her and care for her. And survive the rejection."

4.b) 1. B). Claiming, being claimed vs being taken

Given the shared primary trauma of being separated from birth mother, it is perhaps unsurprising that claiming and being claimed emerged as a significant preoccupation across the data set. Moving into intensive work allowed some participants to achieve what appears to be a mutual claiming. Participant C described noticing that this claiming process began with the idea of moving into intensive work:

> "What's really interesting, when I started thinking about her as an intensive, it felt a bit like I was making more of a claim for her in my mind and she could make more of a claim for me in hers." (Participant C)

After starting intensive sessions, Participant C perceived the patient to "feel like she could own the place a bit more….was able to express her own claiming of what could be hers". This claiming took the form of territory marking:

> "She used a sharpie to draw a cross under the sofa to claim it as her own. It would have been easy to tell her off but I took it up as her permanently leaving her mark on the room – making a claim for something that felt like hers." (Participant C)

For Participant A, moving into intensive work appeared to allow the patient to feel wanted by the therapist:

> "We've increased her sessions and said 'I do want you. You are a wanted baby'".

Reflecting on the increased loving feelings that grew from the move into intensive work, Participant A shared that increased frequency had allowed the patient to feel "connected to me in a more loving way. Had more loving feelings towards me. Recognised that…maybe she felt more wanted by me. Whereas once a week didn't even touch the surface. She even used to say 'whatever'…she seemed to feel more owned by me. Maybe felt I was taking ownership of her."

In contrast with this more consensual experience of mutual claiming, other participants described the move into intensive psychotherapy eliciting feelings of being taken by force or trapped. Some participants described being aware that their patients felt trapped by the intensity and Participant D described talking to the patient about this:

> "When I began intensive supervision we had to look at was she consenting or not…when I tried to talk to her about why she was coming. She said she felt she had to. And I didn't buy that – didn't think that was right. I would talk to her about being forced into something, how that felt quite abusive. Although I didn't use that language at the time. But I wanted to offer a sense that she wasn't being trapped by me." (Participant D)

Participant E remembered the intensive work evoking trapped feelings that the patient was able to communicate within the setting of the room:

> "I remember one session where he got a ball of string, covered the whole room in like a spider web of string, like a matrix, lasers – I wasn't allowed to cross. Trapping me. Something about him feeling very trapped and abused. This was once we moved into intensive." (Participant E)

Some participants described how they (the therapists) could sometimes feel trapped within the intensive work. Participant D reflected upon a growing sense of entrapment as the intensive work continued:

> "The more the work went on, the more blocked out I'd feel, the more persecuted she was feeling...it was really difficult. I felt like I was suffocating." (Participant D)

Participant D linked the trappedness to feelings of "stuckness" in the therapy and a powerlessness to speak or think:

> "It felt important to experience something with her and pay careful attention to …. Did her head come a bit towards me? Did we meet eyes? Oh we're looking at each other! I might get a 'Shut up! Don't look at me!' A lot of the time it felt that I was really a prisoner." (Participant D)

For this participant, feeling trapped brought feelings of despair:

> "It was very difficult to feel hopeful about the work. Difficult to feel it was helping her in any way… It was hell. Really, really hell." (Participant D)

Participant D used this experience to learn more about claustrophobic phenomena:

> "I became interested in *The Claustrum* [by Donald Meltzer] at that stage…and trying to understand the stuckness I was experiencing with her."

<u>4.b) 1. C) Helpful vs unhelpful coming together with supervisor:</u>

Notably, those participants who felt able to claim their patients also described the supervisor-trainee relationship as a helpful coming together of minds, although the interview did not include questions about supervision. Participant C acknowledged this:

> "What was really helpful in supervision was she helped me notice what we were getting into and I shifted my position into more.. helped me be more receptive and empathetic to the communications, which was quite hard to do". (Participant C)

Participant C noted the positive effect of a change in supervisory emphasis when moving from service supervision into intensive supervision, which focussed more upon "the love and the loss, much more than anger and destruction and envy, which were paths that I was going down and could so easily have stayed down if I hadn't gone into supervision. And I think that's what really changed the course of the work and helped her really make quite substantial changes in the way she was relating to me and able to express her need and longing and loss."

Participant A described feeling "pretty well linked together [with supervisor] to try and make sense of this situation" and references a pair able to come together to think – "we were thinking about this in supervision" – and talk – "I feel as if she [the patient] could easily just come home with me. I talked about this with my supervisor, who said that's dangerous talk. I said of course not, but there's something more human between us. More natural kind of reverie". The supervisory relationship receives less mention in those cases where the move into intensive psychotherapy elicited a less positive experience of mutual claiming, leaving open questions about a more ambivalent coming together that may have exposed the trainee to disappointment and confusion; intensive supervision is mentioned three times by Participant D and not once by Participant B.

4.b) 2: Theme 2: Making sense

4.b) 2.A) Anxieties around understanding and knowing

The attempt to make sense of bewildering behaviour was a common preoccupation for all participants. For some participants, the struggle to make sense of their patients' communications was greater during once-weekly work. Participant C reflected upon this struggle as a kind of blindness:

> "I felt really shocked at my own…how blind I was to her communications."

For Participant A, the struggle to make sense came from an absence of thinking space in once-weekly work caused by chaos:

> "My work was about keeping her in the room and keeping her and I [sic] safe, ducking from flying toys. I could say, 'Can we stop that now? I don't want to be hurt', but it was meaningless to her." (Participant A)

Participant A was able to reflect upon the move to intensive work opening up a thinking space:

> "I just remember a feeling of 'Oh you're giving me space to think! When we moved into more frequent sessions, I could collect my thoughts and even have a thought."

By contrast, Participant B experienced the move to intensive work as shutting down a thinking space wherein to make sense of the patient's communications:

> "There wasn't enough space in my mind to even think. It was 'How can I get through each session?' I was on survival mode. And the capacity to think or reflect was really limited if not at all." (Participant B)

Similarly, the struggle to think was compounded by moving into intensive work for Participant D:

> "It was very difficult to think. I was filled with so much rage, I'd feel it in a very bodily way, as I explained. Feel it in my arms, in my legs, I'd have to really breathe and let that go through me." (Participant D)

After moving into intensive work, Participant E described feeling exposed to powerful somatic countertransference feelings of illness or intoxication that hampered attempts to make sense of what was happening in the session:

> "The big change was what I began to feel in my body. How much of a struggle to make sense of what was going on. Feeling terribly guilty about the intensity of this feeling: I can't stay with this boy! I'm being drugged! A virus is happening to me! I just couldn't make sense of it at all. It took such a long time for me to try and make sense of that projections. Felt like it was of me. Was so hard to untangle." (Participant E)

Participant E identified that the struggle to understand these feelings to be projections was because they shut down a thinking function:

> "So much violence, and disturbance in the room, and I was having an internal battle to stay with him while feeling completely shut down. I was very worried that my mind was being damaged. I didn't have a thinking mind. I couldn't help him. It felt very, very deadly." (Participant E)

Difficulties with communication compounded the problem of reaching a shared understanding within some of the therapist-patient dyads. Participant D reflected upon an ongoing struggle to talk with the patient that left important questions unexplored, including the move into intensive work itself:

> "There was a lot of work happening with the carer to think about move to intensive work but was very difficult to talk with her [the patient] about it as she would lock me out." (Participant D)

Participant D reflected that, after moving into intensive psychotherapy, these difficulties in talking led to enactments of shutting out the therapist:

> "One time she ran out of the room, I couldn't find her anywhere. She was hiding in another therapy room. When I finally found her and asked her to come out, she ran out of the room and barricaded me out. In an extremely clear way she was letting me know about the stress of being close and needing to have respect for this in terms of what I could do to her. But we couldn't talk about it, so things were being acted out." (Participant D)

For this dyad, talking became possible in weekly review meetings after intensive psychotherapy had ended.

4.b) 2. B) Questions about more:

The move into intensive psychotherapy created questions for both patient and therapist. Participant B recalled being asked questions by the patient that were stirred by the move into intensive work:

> "Where does all this 'more' come from suddenly? Who was getting it before?"

For this therapist-patient dyad, the availability of "more" appeared to stir early anxieties of deprivation. For some participants, the process of moving into intensive work left them with unanswered questions. Some described feeling that their own inexperience left them unqualified to understand the criteria behind the decision to move a patient into intensive psychotherapy; Participant B describes delegating this understanding to the service supervisor:

> "I was in my first year. I didn't really know when a child is appropriate to go into intensive so was very much directed by my supervisor who felt that what she was bringing needed to be explored more." (Participant B)

Reflecting upon the move into intensive work, Participant B questioned the meaning of "more" for her patient:

> "My naivety at the time, that offering more means more: when I don't know if that necessarily is true. Offering more can be much more complicated for these children."

Participant C shared questions about whether the need for intensive work can be schematised in terms of aggressive behaviours or, indeed, whether it is ever possible to identify whether moving into intensive psychotherapy is the most helpful recommendation:

> "Am I taking the child who really needs it? Or is it the children who really act out and kick and hit and scream who really need something intensive. So I wasn't sure if I wasn't also just getting a nice case for myself if there's such a thing? But in myself I didn't feel it was an easy case – I felt emotionally extremely drained every time I saw her and hopeless and quite incompetent really and unsure of whether intensive could help her shift." (Participant C)

Participants questioned the interplay of competing needs behind the decision to change the care plan from once-weekly to intensive treatment, in particular the relation of the child's need to the bigger picture of an intensive case. Participant E reflected that the child who needs intensive psychotherapy must wait not only for a therapist to become available but also for a training supervisor to take on the case:

> "Part of the difficulty is finding a supervisor. That might be part of the reason why it didn't move to intensive initially: when could it be supervised? Rather than the child's need. Trying to remember was that the deciding factor: availability of supervisor?" (Participant E)

Some participants reflected upon a process of joined up thinking with their service that supported their case being moved into intensive work. Participant A conveyed a sense that the decision to move into intensive treatment had been based upon a team-wide acknowledgement of the complexity of the undertaking accompanied by a due diligence that identified the child's need and capacity to make use of intensive psychotherapy as well as the trainee's capacity to offer this within the team's resources:

> "It felt like really big, well thought through decisions to make and I learn so much from her. So much…that it really did feel like if this was something I could offer… intensive work – that she was the child who could make use of it and we have done enough careful, considered thinking to be able to offer this." (Participant A)

Other participants expressed doubts about the rigour and care behind the decision to move their case from once-weekly to intensive psychotherapy. Participant D reflected that the patient seemed to sense an absence of due care in the decision to change the frame:

> "Going into intensive work, for the duration, she had an understanding of perhaps something being …not very well thought out." (Participant D)

Some participants questioned the validity of moving into intensive work. Participant B expressed disappointment that the impact of this move failed to bring the hoped-for improvement in the patient's anxiety:

> "Made me realise how complicated this all is. In terms of the impact, I think I was completely disappointed. I had a lot of people saying it would really contain her. But I don't really know what that means now. I couldn't contain her at all." (Participant B)

Reflecting upon the impact of changing the care plan, Participant B's question – "Would it have been different if we had gone straight into intensive work?" – invites exploration of the

impact of change upon the course of the therapy and how far this unsettled the hoped-for improvement. For other participants, the move into intensive psychotherapy left them with questions about whether their work could even be described as "child psychotherapy". For Participant D, the move into intensive work raised questions about the nature of the therapeutic intervention:

> "What is therapeutic contact? Did I really have a patient? What was going on here?"

Participant B reflected upon feeling uncertain as to whether therapeutic work was taking place in the enactment of chaos that followed moving into intensive work:

> "Should this be happening? She is using the space to show more disturbance. But on the other hand, this is out of control and people were complaining. Doesn't look good in terms of therapy. She would press the alarm all the time. I was conflicted: is this actual work? Is this part of the patient she needs to show me? What it's like to be in absolute terror a lot of the time? Feeling really scared or am I …I felt very guilty: is this something I've done?" (Participant B)

<u>4.b) 2.c). Is intensive psychotherapy a cruel trick?</u>

The words "trick" and "tricky" had striking prevalence across the data set, in relation to the research question about the move from once-weekly to intensive psychotherapy. Some participants expressed discomfort with the training need for an intensive case. Participant C described feeling this discomfort before making the offer of intensive work:

> "And in that very uncomfortable way as a trainee I had training needs, we started looking for a latency case for me and it was quite tricky to find one." (Participant C)

Participant D spoke about "a tension in the child psychotherapy training about how to gather up cases that we think might be good cases for intensive work." Both these participants allude to tension or discomfort in there being training needs that may influence clinical decision making.

<u>Intensive psychotherapy as a trick played upon the patient:</u>

Some participants reflected upon feelings of dishonesty at the point of proposing to the patient the move to intensive psychotherapy:

> "I said that the adults have decided that you're going to be coming more. I remember saying that she was doing really well. I'm laughing about that now as I don't know how true that was" (Participant B)

Participant B described feeling an intensifying of discomfort upon moving into intensive work with something that felt dishonest and a trick:

> "It was more like I'd had this space the whole time and I'm only waiting until now to give it to her. And just I remember feeling quite …a bit of a trickster in some way. Hard to explain, I'm trying to recall. I felt that I wasn't being completely honest with her. That me offering more felt like a bit of a trick. That I was withholding something, not telling her the complete truth about why she's coming more for example. Why I didn't give her more before. I was feeling a bit like why am I giving her more now? I felt uncomfortable about it. Not fully understanding myself why I was giving her more either. It wasn't an overly comfortable offer. When I actually said to her, 'You're going to be coming for more', it did feel very complicated." (Participant B)

Other participants questioned whether their patients perceived the offer of intensive psychotherapy as a trick. Participant D hypothesised about the patient fearing that they have been deceived by the offer of intensive psychotherapy:

> "Her fear might have been about the treatment – that it might have looked like a good offer three times a week with his lady, but actually it's rubbish." (Participant D)

<u>Intensive psychotherapy as cruel to the patient:</u>

Some participants questioned whether intensive psychotherapy was cruel, manipulating a child's clinical need to meet the training need of the trainee. Participant E shared feelings of guilt about bringing a child into an intensive relationship only to leave them after the trainee's needs are met:

> "Whose need is it? It does feel a bit of a cruelty. You can have it for this limited amount of time and you hope something will be taken in and you hope it will be sufficient…That's what I would take home. What a cruel thing I was doing: inviting this child in three times a week. Being in this intensive relationship then bringing it to an end." (Participant E)

Participant B reflected that moving a child from lesser to higher frequency felt cruel because it provoked awareness of earlier deprivation:

> "Working with adopted children, you can assume that because they feel neglected or unwanted or rejected that your offer of more is going to make them really happy. But in some way I think that gets more in touch with loss and separation than it did before. It highlights: this is what you didn't have before. In some way it can rub it in their faces." (Participant B)

In describing the patient's worry about missing school to attend the clinic three times weekly, Participant E reflected upon a cruel deprivation from which it felt impossible to escape:

> "Always that feeling of deprivation, that I would be depriving him of something with this offer of seeing me more. Something almost of a cruelty in what I was giving."

<u>Intensive psychotherapy as cruel to the therapist:</u>

For some therapist-patient dyads, moving into intensive work allowed the patients to inflict suffering upon the therapists. Participant B reflected upon feeling fear and distress at the hands of the patient that elicited profound feelings of antipathy:

> "Just really look at her and think I really don't like you. You're making me very anxious and distressed. You're making me very uncomfortable." (Participant B)

Participant B questioned whether the experience of feeling terrified was a meaningful communication of the patient's internal situation or whether the patient was being sadistic:

> "I was conflicted: is this actual work? Is this part of the patient she needs to show me? What it's like to be in absolute terror a lot of the time?" (Participant B)

For Participant D, the move to intensive work felt like an exposure to cruel humiliation:

> "It was hell. Really, really hell. Humiliating. Part of what she was projecting into me was humiliation. I'd feel humiliated talking about it with colleagues." (Participant D)

Participant D identified humiliation as a communication of the patient's own feelings of worthlessness, an example of projective identification in which the therapist receives the patient's own feelings to digest them on behalf of the patient. In this example, painful feelings of humiliation continue to afflict Participant D outside the boundary of the session:

> "She would have terrible stand offs in the waiting room; I would have to be completely humiliated before she felt she could come to session with me."

Participant E was able to reflect upon the patient's awareness of needing to make the therapist suffer:

> "He was keen to come to the room even when he was hiding. That might have been some of the sadism: he actually liked attacking me, and the screeching violence. Something about him that knew he needed it." (Participant E)

4.b) 3. Theme 3: Survival

LAAC, and all the children discussed in these interviews, are survivors of extreme deprivation. The experience of survival emerged as a significant preoccupation across the data set. For some participants, the experience of survival was more intense during once-weekly work while for others it emerged with the move into intensive work.

4.b) 3. A). Dread

When reflecting upon a feeling of surviving the sessions, one of the characteristics participants described was dread:

"I dreaded every session" (Participant B, after moving into intensive work)
"I didn't dread once-weekly. It shifted once it became intensive. That's when I began to dread the sessions. It was unbearable to be in the room with him." (Participant E)
"I would absolutely dread…the feeling of being so unhelpful, useless, the public humiliation" (Participant D)

Participant E was clear that these feelings of dread were an important communication from the patient:

> "That's the thing. It's a communication of early terror. Nameless dread."

Bion's concept of "nameless dread" articulates a process whereby the infant's terror of annihilation is not received and processed by a thinking parental object but is, instead, returned to the infant unprocessed and charged with fear of death (Bion,1962). Participant E reflected upon the experience of being positioned in the transference as the non-thinking parental object who cannot receive and process communications of early terror; this entailed feeling that all thinking apparatus was being attacked by the patient to render Participant E mindless:

> "Not having the resources internally that you rely on in your work. You know, you pride yourself on being someone who has empathy, who has some kind of insight, capacity to think, felt I was completely stripped of that." (Participant E)

4.b) 3.B). Surviving once-weekly sessions

Some participants found that once-weekly sessions seemed to reactivate harrowing early experiences of deprivation. Participant C reflected upon needing to survive a deathly experience without help in the once-weekly sessions:

> "I was so relieved to have my supervisor come in because there was something so deathly about the case and I was exhausted from the experience of seeing her that I felt really pleased to have somebody to hold it with me." (Participant C)

In the once-weekly sessions, Participant C described feeling positioned as the unreceptive, object that deprived the patient of care, warmth, love and understanding:

> "I really shut down the more loving very tender and vulnerable aspects of her way of relating. There just wasn't enough space in me and in the once-weekly work."

By depriving the therapist of internal space to receive the patient's communications, once-weekly work may be understood to have enabled the reactivation of the patient's earliest experience of extreme deprivation which was then interrupted by the move into intensive psychotherapy:

> "So when I put it into words: we keep feeling that it's not enough, and maybe actually if you had more that might be helpful, I think she was very pleased and relieved that I'd noticed and actually responded to it rather than continually deprive her." (Participant C)

Intensive work also allowed the therapist to receive and digest the patient's communications, enabling a shift into a more nurturing, need-meeting relationship:

> "One of the things my supervisor was always talking to me about was the experiment with the baby monkeys who are given …piece of fur on a coat hanger and a bottle. That also being a strong communication of early experiences and ways of relating. When I went on the computer and looked up photos of these poor little monkeys I got a sense of the cold steeliness that sometimes I felt she pushed into me as someone who really sort of unreceptive and uncaring that was really quite hard for me to sit with. Helped me understand and imagine a little baby who was probably fed in her cot, having to manage with lots of other little babies, and not having consistent carer meet her needs. And that's only in the orphanage, I don't know what it was like the very early experiences of a young mother who clearly couldn't manage. I think it was very powerful and, as therapy developed, her symbolic communications were so rich. She continued to bring a lot and prepare for sessions, but rather than me feeling it was her trying to be controlling or rejecting of the box and things in it, eventually I felt she was doing this incredible work really thinking about lots of different ways to communicate the ways that she was relating and feeling and experiencing." (Participant C)

Participant A described having to survive chaotic and frightening aggression from the patient in the once-weekly sessions:

> "I was very scared of her when I saw her once a week because she was so unpredictable and would hurt me very badly. She punched me full in the face. And kicked my shins and would throw hard things that would hit me on the head. It was an out and out assault." (Participant A)

Participant A described a dramatic reduction in aggressive attacks after moving to intensive work, which the researcher verified in the interview with a direct question:

- *Researcher: She stopped hitting you when it went to more intensive work?*
- *Participant A: Absolutely. Now it is almost zero.*

For this therapist-patient dyad, the once-weekly sessions enabled a situation of terrifying chaos to play out, this time with the therapist experiencing the attacks and the patient taking on the role of the attacker. Participant A reflected upon having survived this together:

> "We survived something incredibly dramatic and terrifying together. It was a very painful process." (Participant A)

Moving to intensive work brought an end to this chaotic and violent dynamic, allowing the patient to experience the therapist as a loved and loving maternal object:

> "I'm inclined to say [I am] possibly a bit of an idealised maternal figure but I'm a little bit older than her carers so sometimes she does call me Mum or Dad or grandma. Then she'lll say, 'Ooh sorry, no!' In the transference, I'm closer to grandma." (Participant A)

Participant A reflected upon the move to intensive work affirming the presence of a caring object:

> "That's what I would associate with the intensity: she allowed herself to experience me as someone who cares, and for her to be able to care as well. She can quite often say she doesn't care. Still holds onto that: 'I don't care!' If she runs amuk. The caring seems to be the definitive part of the intensity: being allowed to care." (Participant A)

<u>4.b) 3.c). Surviving intensive work:</u>

For some therapist-patient dyads, the move into intensive work brought out extreme disturbance and early deprivation. Participants B and E reflected upon once-weekly sessions

having allowed for what seemed, with hindsight, to be a manageable titration of contact; Participant B remembered the once-weekly sessions as having enabled the patient to play symbolically with toys:

> "With once-weekly it was more manageable, in the sense that she would come in and there would be these baby dolls. She really took to the baby dolls and would show just how well she knows how to look after babies." (Participant B)

Participant B describe the move into intensive psychotherapy as a move into a survival state of mind for both patient and therapist, in which the patient "couldn't really play" and the therapist felt stripped of a capacity to think and even to remember to bring the dolls:

> "But once we got into intensive work they [the dolls] were …not forgotten about…but there wasn't enough in my mind to even think about that. It was 'How can I get through each session?' I was on survival mode. And the capacity to think or reflect was really limited if not at all. Just trying to manage her behaviour all the time." (Participant B)

Participant B reflected upon the move to intensive work creating a situation of chaos and terror to be survived:

> "I had to battle each session to contain my own anxiety…I couldn't provide a box because she would smash it every time. I remember she had an obsession with tissues and would tear up all the tissues in the room. Then it got worse: she would start weeing and pooing in the room. She would strip as well. It felt absolutely uncontrollable." (Participant B)

The image evoked here is of a naked baby covered in urine and faeces in the midst of a tremendous mess, abandoned and without the care of a caring maternal object to warm, wipe and protect. This resonates with Participant B's description of the patient's earliest experience:

> "From what we know she suffered a lot of neglect, the mother struggled….the neglect sounded like it was the mother's neglect of herself. She couldn't really keep herself clean. They found the room with a lot of dirty nappies, bad smells. And my patient would be left for quite a while on her own." (Participant B)

Participant B expressed mixed feelings about intensive work enabling the patient's disturbance to be explored within the therapy:

> "I definitely think that as we moved towards more intensive work, more disturbing behaviours were emerging….I feel that with the intensive work we became a different pair. It allowed for more change and shift. I don't regret going to intensive work at all. But it did create a storm. And I think I was very naïve thinking that it would make her better not worse." (Participant B)

Participant E described feeling drugged and attacked by a virus in the move to intensive work, as if the change of frequency had precipitated a somatic survival situation. Participant E reflected upon the struggle to understand this as a countertransference response – a projection into the therapist of the patient's drugged, unresponsive mindless mother:

> "When I was in it, it was so difficult to understand what was going on and to receive it as a communication, because it was so hard to know ok this is a projection, it's projective identification, I'd never come across anything like this before." (Participant E)

Participant E described feeling helped to understand this in supervision, allowing for the projections to be digested and returned to the patient and bringing an end to the reactivation of the early situation:

> "Once I began to have intensive supervision and could be honest about how neglectful and crazy I felt, saying that I felt paralysed, it began to be possible to speak to him about the feeling in the room. Then after some time, it became possible to see this was his." (Participant E)

4.b) 4: Theme 4: Transition: Development or discontinuity

Change and changes were experienced variously across the data set, spanning a continuum from chaos to development. In contrast with the notion of change as discontinuity and

rupture, the idea of a transition that can be prepared for thoughtfully came across in some of the interviews. The notion of a transition entails movement between two states or experiences in time and requires some anticipatory bridge-building (Sorensen, 2000) to facilitate the movement from one to the other.

Preparing the child/family/network for the transition into intensive work

In some cases, the move from once-weekly to intensive work was prepared for carefully by discussions between the therapist and their service, confirming that the child was being held in mind by not only the therapist but also the wider team. Rather than a shock discontinuity to the once-weekly rhythm, Participant A reflected that the move into intensive was a process of transition characterised by links with the network and the team, involving "more discussions, more being needed, talking with my service supervisor and tutor, meeting with social worker, talking with guardians….was felt that if we could offer more it should be taken. Took a lot of thinking." Participant A also talked with the patient, reflecting upon having spent "a lot of time talking with her about the planning of the move". Consistent with this is Participant A's recollection that the patient began to bring transitional objects into sessions after moving into intensive work:

> "I remember that was when she started bringing in her own toys from home. She wasn't doing that when it was once a week… I saw it as something transitional from home but have come to understand that depending on which dragon or dinosaur she brings in, seems to represent an aspect of her personality of which there are many. So I could get a sense of which part she was bringing into the session." (Participant A)

Participant A's example suggests that the move to intensive work enabled the patient to develop a bridging function to manage the transitions between endings and beginnings, home and therapy, presence and absence.

Internal preparation for the move into intensive work:

Some participants reflected upon an internal process of preparation. Participant C spoke about a feeling of readiness-in-time to move into intensive work:

> "It came at a very important time in my training: I was in third year of my training, I was also maybe more conscious of different ways of working and how to focus in on a style of working that could really suit her. It just really changed how I work, in a fundamental way." (Participant C)

Participant C eloquently described an evolving sense that, as preparations were being made externally for the sessions to increase to three times weekly, the patient was evolving into an intensive patient in the mind of the therapist:

> ".. as I was getting myself there, and talking to the different relevant people about it, it felt more appropriate – I just wonder if somewhere I also shifted in the way I was working with her in the last period, as I was making the case for her becoming my intensive. Somehow she felt more claimed as I was claiming her in my mind." (Participant C)

<u>Evolution of routine via reliability</u>

For those therapist-patient dyads that experienced the move into intensive work as more of a transition than a discontinuity, there was a sense of evolution and development that took place within an ordering of time. Participant C reflected upon the patient's struggle during once-weekly therapy to develop enough of a sense of permanence upon which to build a sequence:

> "It was very difficult for her to symbolise and to keep something, to sustain a sequence in the play." (Participant C)

The move into intensive work was felt to enable this sense of permanence and Participant C reflected upon "substantial changes" since "I saw her intensively from February last year. So over a year and a half. So I think it evolved quite quickly." This sense of progress as evolution-in-time entailed a sense of continuity that allowed for a routine to develop:

> "We developed a routine where (sic) I'm guessing we also had in once-weekly work but in intensive work became more tender. We'd say goodbye to teddy, to the room, and we'd leave and she'd walk back with her fingers touching all the door signs saying whether it's vacant or engaged. Her reading skills weren't very good so she couldn't quite say the words correctly and each time there was a variation of what it

was. But there was a knowledge of emptiness or togetherness that she took us back to each time as we were getting ready to leave." (Participant C)

Participant C reflected upon a sense of time and consistency in the intensive work that facilitated a continuous dialogue between patient and therapist:

"It was very sustained, the play, and allowed us to talk over time." (Participant C)

The consistent rhythmic frequency of the intensive work seemed to allow this patient to develop a trust in the therapist being reliably present:

"After the negative transference was worked through, we got into something more developmental in terms of forming a relationship with a maternal object who is there and waiting. She'd be under the cupboard – and we'd tap to each other for long periods, doing these long rhythms that we'd mimic. Felt very primitive cosy sort of containing. Womb-like sometimes spaces that she was looking for in the therapy" (Participant C)

Similarly, Participant A also reflected upon the consistency of the intensive rhythm allowing the patient to build trust in the therapist's reliability:

"She is more contained and seems to have a different idea of time. She knows there will be another session and another and the gaps aren't so long. She can take the time that she needs and she has really got to grips with my being reliable: I'm a reliable object, there X is, that's where X sits. There is a familiarity and ordinariness: from chaos to ordinariness." (Participant A)

Participant A's reflections suggest that the reliability of the three-times-weekly contact enabled the patient to develop a sense of temporality after the chaotic atemporality experienced during the once-weekly psychotherapy.

Chapter 5

DISCUSSION

5. a) Overview:

This study has set out to research the clinician's experience of the transition from non-intensive to intensive psychotherapy with looked-after and adopted children. The literature confirms a universal expectation of and response to a steady, regular rhythm. Psychoanalytic thought links this expectation to the regularity and continuity of the maternal heartbeat that accompanies in-utero life and that becomes internalised as a rhythmic sound object as well as to the rhythmic experiences of need-meeting care (Shulman, 2019) in the early post-natal situation. The findings show that changing the rhythm of sessions has a meaning for each child and an impact upon each therapist-patient dyad. The literature suggests that a change in rhythm may have psychic equivalence to the in-utero disruptions to the rhythm of the maternal heartbeat, that elicits "life and death catastrophic anxiety" (Shulman, referencing Rey (1994) 2019, p.329).

Overall, the findings attest to intense feelings of pain, despair and, in some cases, hope. While this may be expected when working with looked-after and adopted children, it is perhaps significant that the exploration of transition from lesser to greater frequency should elicit such high levels of these feelings in clinicians in contact with children who have experienced catastrophic early upheaval and discontinuity. Through a psychoanalytic lens, these early discontinuities may be understood to create a poor sense of object constancy – the basis for the development of self, coherence (Shulman, 2019) and trust (Maiello, 2001) – and suggested across the data as dysregulation and difficulty with sustaining trusting contact. Of particular interest was the question of who the therapist understood themselves to have become in the mind of the patient after moving into intensive work; the advent of the new object, with the hope this might bring, was evidenced in the findings as developmental in some cases and devastating in others.

Changing the rhythm of a child's psychotherapy sessions can create, in the words of Participant B, "a storm"; the findings suggest that intensive psychotherapy in the NHS may not, in all cases, be the unalloyed good it is supposed to be but is, rather, an alloy of possibilities, positive and negative. The findings suggest that the meaning and outcome of the transition from less to more is likely to be different for each child. Without a deep understanding of the meaning of "more" for each child, conceivably the offer of more may not necessarily mean better: for some children, "more" seemed to mean "more frightening". Offering more sessions to a child who has adjusted to working at a lesser frequency is, suggests Participant B, fraught with potential risk, especially when that child is a looked- after or adopted child who is likely, early in life, to have suffered a traumatic move from deprivation (not enough) to a new environment able to meet their basic needs. Increasing sessions, these findings attest, may not always facilitate the developments hoped for by families and clinicians and can, in some cases, make things worse, as described by Participant D, whose patient became increasingly shut down in response to more intense contact with the therapist. This is a striking contrast with the "immediate result" of greater access to the child's internal world via play and dreams as well as increased thematic connection, shared by Sherick and Chopra in their 2014 paper on the transition to higher frequency sessions. Rather, this echoes the experience of Miller (1992) who found that high intensity contact stirred a terror of engulfment that mitigated against working through confusional states.

From the rich descriptions of responses elicited through the interviews, it seems that the move from less to more has the potential to allow for positive developments in the therapy but that it can, in other cases, also have a less positive effect on the therapy. To make sense of these movements, it is helpful to understand the phenomenon of repetition compulsion (Freud, 1920), in which the traumatic situation is repeated until it can be processed. Here, the traumatic situation can be understood to be the deprivation experienced in the early dyad in which an unavailable, depriving primary object leaves the infant's needs catastrophically unmet. This early traumatic dynamic, internalised as a blueprint for relating by the infant, can be seen to be relived in the transference (the therapist-patient dyad) and repeated until it can be adequately processed and transformation made possible. In some

cases, this internalised traumatic situation remained latent during once-weekly work but became stirred into life with the transition into intensive work. In other cases, once-weekly work stirred the traumatic situation into life and the move into intensive work was felt to disrupt traumatic re-enactments, respond to needs and facilitate development. This discussion section of the project will consider the meaning of the findings mapped in the results section, with reference to the literature explored in the Literature Review and through the lens of object relations psychoanalysis informed by the child psychotherapy training and personal analysis.

5.b) The challenge of coming together

The transition from less to more did not, the findings show, facilitate the process of coming together for all therapeutic dyads. Instead, the results of this section present a mosaic of painful experiences faced by patients and therapists in their attempts to come together.

As mentioned in the results section, there are three dyads alive in this data set:

i) The original baby-birth mother dyad
ii) The therapist-patient dyad
iii) The trainee-supervisor dyad

For the therapist-patient dyad, the notion of "coming together" can be understood to be the establishment of the analytic situation such that transference developments can be made. Each of the children in these interviews had experienced a catastrophic failure to come together with their birth mother. The findings suggest a link between this failure to come together and the threat of rejection that can be seen to be relived in the therapist-patient dyad and at risk of repetition again in the trainee-supervisor dyad if not appropriately contained. This threat of rejection can be seen to function as an active force that works hard to prevent coming together, suggesting the high level of risk that coming together presents.

As previously noted, the challenge of coming together was more intense for some therapeutic dyads in the once-weekly sessions; Participant C's reflection upon a once-weekly feeling of a "cold steeliness" that positioned her as unreceptive may be understood as an example of projective identification, in which the patient's earliest experience of feeling rejected by an uncaring object is transferred onto the figure of the therapist who then acts this out by rejecting the patient. Other participants described greater hurdles to coming together after moving into intensive work, like Participant D who described the move prompting the patient to use the therapy "to block me out, reject me." Participant D's description suggests an ongoing replaying of the patient's original trauma (enacted through the patient's sustained rejection of contact as described in the interview) that left the patient struggling to make full use of the containment offered by the therapist. This is the "double deprivation" of Henry's 'Doubly Deprived' (1974) paper that identifies the process whereby the child has internalised a rejecting primary object with whom it then identifies, depriving the child of new loving relationships and maintaining an ongoing state of rejection. Rustin's (2001) observation about "creating a context in which change might be risked" (p.274) suggests some attachment to familiar dynamics that, while destructive, may also serve as a psychic umbilical cord to the birth mother.

The findings attest to a risk that moving into intensive work can be experienced as a frightening feeling of being trapped, for patients and for therapists. Participant D's reflection that "a lot of the time it felt that I was really a prisoner" speaks to this sense of entrapment felt by the therapist while identifying also that the patient might feel "worried about being engulfed by me". Participant D's thoughtful embracing of this experience to learn more about claustrophobic phenomena through studying *The Claustrum* (Meltzer, 1992) suggests a lively connection with development (in this case, the therapist's own learning) that may have taken place outside the therapy room but that belonged to the therapy relationship, in keeping with Participant D's reflection that "therapy doesn't always happen in the room". This idea that development may take place outside the therapy room underlies the principle behind indirect work that aims to help children via working with parents or the network around them. It may be meaningful, given this creative development, that Participant D's therapeutic dyad was able to experience something more akin to coming together after intensive work ended and a transition back to once-weekly

contact. This is an interesting finding that resonates with the experience of transition to once-weekly work from intensive work described by Miller (1992), who found that the "more tightly defined boundaries" (p.129) within once-weekly sessions as helping to mitigate the patient's feeling of being trapped by intensive work.

The findings suggest that the successful coming together of a therapeutic dyad is not simply a matter of frequency of contact; Participant A's insight that a patient of similar background to the one featured in the interview, is doing "fine on once a week" testifies to this, in alignment with the conclusions of Skolnikoff (1990) and Gill (1984) that frequency does not define a fruitful analytic treatment. Rather, these findings suggest, a successful coming together depends upon (among other factors) the therapist's capacity to withstand powerful forces of rejection while creating conditions safe enough to risk coming together. The findings suggest that the trainee's capacity to contain their traumatised patients requires that the trainee feel contained within a helpful supervisory relationship while also feeling held within their team. The parallel to this might be the birth mother's need for support from her own parent/internal parent while feeling held within the wider group of the family to feel able to parent to her baby. While all participants referenced their patient's early experiences with birth mother, there were variations in the extent to which this lived in the mind of the individual participant. For Participants B, C and E, details of the patient's earliest trauma were present and shared through the interview while Participant D and A shared little detail about this. As the interviews did not include questions about the early trauma, this was an interesting finding and perhaps worthy of further research to understand better the impact upon therapy of the therapist's relationship to the primary trauma. Further, a successful coming together might also need to entail a coming together of training needs with clinical need; Participants A and C described the transition into intensive work as a successful coming together of their own training need with the patient's need.

Coming together in the supervisory relationship;

Absent from the interview schedule but present in the data-set was the trainee-supervisor relationship that comes into being with the move into intensive work. The findings propose a parallel between the claiming of the patients and the helpful supervisory relationship. For the trainee-supervisor dyad, 'coming together' might be thought of as providing containment and the insight to prevent enactments in the therapist-patient dyad, allowing for the gradual modification of the patient's object. For all the interviewees, this will have been a new, weekly individual relationship, one of the three training supervisions upon which the child psychotherapy training is based. It is interesting, therefore, to note variations in the centrality of this relationship across the different interviews; for Participant C, this supervisory relationship offered the containment and guidance needed to break the ongoing enactment of the cold metal mother and the baby monkey described in the once-weekly sessions and to steer the therapist-patient dyad into warmer more loving waters. The findings suggest that a successful coming together in the supervisory relationship may offer the transformative experience of a helpful third (Britton, 1989) to disrupt the enactments within the therapeutic dyad and triangulate a space for thinking.

Dissonance of emphasis as hurdle to coming together in supervisory relationship:

Participant C was the only participant to interrogate questions of theoretical orientation; Participant C's reflection upon the significance of supervisory emphasis speaks to widely understood developments in psychoanalytic thinking that highlight the need for adaptation in technique when working with looked-after and adopted children (Boston and Szur, 1983), (Lanyado and Horne, 1999). While more detailed discussion of this dissonance lies beyond the scope of this project, the findings suggest further research is needed to explore the effectiveness and suitability of different supervisory emphases for work with LAAC. Rustin's 2001 paper makes clear the need for adaptation and innovation when "all the established ways of going forward in a session seem[ed] useless" (p.274) an echo of Participant D's reflection that "interpretations were getting us nowhere". The coming together experienced within the supervisory-trainee relationship necessarily involves an attuned coming together of supervisory emphasis with the needs of the patient. The paucity of supervisory detail in

interviews with Participants B and D leaves open the possibility of some dissonance of emphasis.

Coming together of interviewee and interviewer:

It is significant that the coming together of interviewee and interviewer took place remotely during the first lockdown, and important to consider that the collective shock and trauma of this moment may have cast some shadow over the course of the interviews and the data collected; the interview questions invited participants to reflect upon a moment of profound change to the frame of their clinical work while both interviewer and interviewees were living through a moment of collective seismic change that entailed a total loss of contact. The shared defences that may have been employed to manage this traumatic moment by both parties could conceivably have influenced the extent to which exploration of the experience of change felt safe. By conducting interviews over the phone, neither researcher nor interviewees were able to come together physically, depriving both parties of the total sensory experience of reading body language or gestural cues, a deprivation that may have compounded painful reflections or even represented some repetition of the difficulty experienced in attempting to come together with their patient in the transference.

5.c) Making sense

The findings show that many participants struggled to make sense of the move into intensive work; some expressed feeling unclear as to the rationale before the move into intensive work while others expressed doubt after the move had taken place. Some participants asked questions, post-event, about the validity of moving a severely traumatised child out of the familiar once-weekly frequency of contact into a much more intensive relationship with their therapist. Participant B's experience of the move into intensive work creating a "storm" raised the question about whether going straight into intensive work, without establishing a once-weekly therapy first, would have been different. Only Participant A expressed conviction before the move about offering more to the patient. Reflecting upon the once-weekly therapy before the move, other participants queried the extent to which compelling evidence from those sessions could justify the proposal to move the patient into intensive work. Other participants reflected upon their

own difficulty in being able to assess the validity of the move based upon their lack of experience. This lack of experience was at the time of the transition felt by some trainees as "naivety" (Participant B), an absence of understanding as to the criteria and process for the transition. Participant D reflected upon the important learning about setting up intensive cases that came with later training cases. For some, the move to intensive work brought about parallel developments for both themselves as clinicians as well as for their patients. In these cases, it was possible to reflect that it made sense to move into intensive work and had been a meaningful beneficial experience for both clinician and patient. Participant A reflected upon the intensive psychotherapy as an enjoyable learning opportunity. While later able to reflect with hindsight that the move into intensive had helpfully allowed for disturbance and hate to emerge in the transference, Participant B's reflections upon the immediate post-move sessions conveyed a loss of hope about the move and greater confusion for the therapist.

Cruelty emerges as a significant finding from this exploration of the transition to intensive work, surprisingly as the offer of intensive psychotherapy is generally assumed to be beneficial. Speaking about the transition stirred up questions for some interviewees about whether they had done something cruel in disrupting their patient's established care plan and inviting them into a much more intensive relationship. Participant B's reflection that offering more to a child who has already made an adaptation to lower frequency contact is a cruelty identified by Bion (1959) as taking place at the first experience of containment when the patient "feels he is being allowed an opportunity of which he has hitherto been cheated; the poignancy of his deprivation is thereby rendered more acute and so are the feelings of resentment at the deprivation" (p.105). It is striking to note the recurrence of the word "cruel" across the data set and to consider that the interviews took place during the first lockdown, a time of extreme and sudden isolation from friends, family and work. To be deprived of social contact may have been experienced, consciously or unconsciously, as a cruelty to which participants and myself were victim. Perhaps it is worth considering the possibility that conducting interviews remotely, when they were designed to explore the participants' emotional experiences around profound change, may have felt like a further cruelty, compounding feelings of deprivation and loneliness.

The majority of participants attest to the costly nature of their learning from the cases discussed: With the exception of Participant C, participants described suffering fear and humiliation during either the once-weekly or the intensive work. Participant B's question "Should this be happening?" might conceivably be reframed in terms of the training: a question as to whether trainees should be expected to work with patients with such severe and complex trauma before the training has equipped them with the experience, skills and understanding to contain this. This question prompts a further question about whether there might be another, less "cruel" way to acquire the necessary understanding and skill to work as a child psychotherapist.

"Should this be happening?" might also be asked of the offer of increasing once weekly sessions to three times weekly, purportedly an offer for the child but driven by the need of the trainee. The recurrence of feelings of deception and trickery expressed by participants raised questions about the ethics of inviting a family to bring a child three times a week for intensive work (that may or may not benefit the child) to fulfil the requirements of the child psychotherapy training.

Across the sample, participants appear to have struggled with a lack of transparency about their own training needs, conveyed by Participant B not telling the "complete truth" that the move to intensive is a requirement of the child psychotherapy training. Those participants who lacked a clear grasp of compelling clinical evidence for moving the patient out of once-weekly work and into intensive work, shared a sense of dishonesty and trickery about the move while other participants verbalised guilt or discomfort that their training need (rather than the clinical need of the patient) could be driving the transition into intensive work, voiced in Participant C's discomfort that both the clinicians working on the once-weekly case were on the hunt for a training case. The hoped-for developments that Participant B felt disappointed not to see in the patient after moving into intensive work might also be mirrored by disappointments around the trainee's longed-for learning from the intensive case. Dreading the three-times weekly sessions, Participant B was left with unanswered questions about what actually is psychotherapy –"is this actual work?"– while questions about whether the experience in the therapy room could be described as therapy came to Participant D from colleagues and fellow trainees. Participant D's recollection of feeling

enraged may conceivably also belong in part to some of the disappointments around the intensive case experience described in this interview.

5.d) Survival

The findings suggest that the early traumatic situation – in which the infant felt itself to be fighting for survival – may have come to life in the transference at different sides of the transition; this fight for survival was enacted in the once-weekly work for some therapist-patient dyads, while other dyads felt it burst into life upon moving into intensive work. In varying detail, the findings evoke the therapist's awareness of the particular dynamic internalised in each child by their early traumatic situation. For Participant A, once-weekly work, with its long wait between sessions, seemed to have invited a reliving of an internal dynamic, in which the patient felt unwanted (by the therapist). Similarly, in the once-weekly work, Participant C described feeling pulled into enactments in which the patient's early dynamic of cold, institutional care was repeated. In both these cases, the transition to intensive work was felt to respond to communications of the need for more (Participant C) or the need to feel wanted (Participant A) in a way that allowed for some resolution to the compulsive reliving of the traumatic early dynamic; Participant A's patient was able to feel wanted while participant C's patient was able to feel less deprived and more claimed. Participant A's reflection of having survived something deeply frightening with her patient conveys the intensity of this relived fight for survival and the relief of arriving safely together on the other side of it, perhaps a corrective experience to the original fight for survival from which infant and birth mother may not have emerged together.

In other cases, the transition to intensive work brought to life the patient's traumatic early situation that may have remained latent during the once-weekly sessions. Participant E's description of the change from enjoyable once-weekly sessions to dreaded three-times-weekly experiences of feeling mentally under attack and drugged, suggests a powerful stirring of the patient's early traumatic situation (a baby with an unavailable, intoxicated mother) in the move to intensive work. Similarly, Participant B's description of the move into intensive work eliciting uncontrollable scenes of soiling and destructiveness appears

to recreate the traumatic dynamic of the patient's early dyad of a frantic filthy baby and an incapable parental figure. Participant B reflected upon this having stayed latent prior to the transition into intensive work to the extent that the patient had shown some capacity for symbolic play with the doll babies.

It is interesting to consider the significance of this finding in the light of the prolonged early neglect suffered at the hands of a chaotic birth mother, either due to incapacity (Participant B) or drug addiction (Participant E). Both these infants remained in the care of their birth mothers for at least the first six months of their lives, in contrast to the babies of Participant A and C's descriptions who were placed in reportedly reliable institutional or kinship care at birth. The common feature of chaos in Participant B and E's accounts of the patient's early history can be conceived to have created an experience of frightening unpredictability for the infant. Psychoanalytic thinking notes that this kind of early confusion can fixate the development of the personality at the "core complex" (Glasser, 1998) phase of development, in which the fear of abandonment exists alongside the terror of being engulfed by the object, both of which entail a catastrophic loss of self. Typically, core complex patients struggle with finding a manageable distance, either feeling too close or too far away. Through this lens, it is perhaps possible to understand the transition into intensive work as representing a terrifying threat of engulfment for these more core complex patients, as suggested by Participant D's perception of the extreme defences that the patient appeared to need after moving into intensive work.

The experience of dread evoked by participants is identified by Participant E as "nameless dread", a useful clinical concept proposed by Bion (1962) that equates the infant's experience of the unavailable parental mind with annihilatory terror (see Literature Review Findings 4.b)3A). In the transference, participants variously described experiencing themselves as the unavailable (and therefore deadly) parental object in their shared experience of being unable to receive the projections of the patients. It is particularly striking to note how faithfully the earliest experiences of nameless dread were brought to life in the intensive work, in particular Participant B's description of taking on the projections of the helpless, learning-disabled mother who could not contain or keep clean

the defecating infant in her care and Participant E's experience of taking on projections of the patient's substance-dependent birth mother. When confronted with projections of the patient's nameless dread, the therapist's task is to survive, the very task identified by Rustin's (2001) paper and implied in its title. The title speaks also to the claustrophobic anxiety that participants described – feeling "trapped" –that prompted Participant D's exploration of claustrophobic phenomena in Meltzer's *The Claustrum* (1992).

Also significant to the question of survival is the context of the pandemic; the interviews all took place during the first lockdown before the introduction of the Covid-19 vaccines, a time of collective terror and, for many, anguished loss. While the understandable and immediate need to survive the virus may have been universal, participants attempting to offer intensive psychotherapy online may have feared for the viability of their work: could therapy survive the sudden move to remote contact? It is likely that the feelings of guilt and doubt expressed by some of the participants may belong to this reality as well as the cases discussed.

It may be important to consider the wider context around the research and the various alternative fronts on which a battle for survival was being fought. Participants' questions about whether the right child was getting the high-value resource of intensive work may also speak to a wider anxiety about the survival of psychoanalytic work within the NHS. All the participants completed their psychoanalytic training at a time of drastic cuts and restructuring; most would have been witness to the replacing of senior staff with less experienced colleagues and sometimes finding themselves managed within a team by clinicians with little experience or understanding of psychoanalytic work. The interviews took place at a time when the Tavistock Centre was, itself, going through a strategic review that left many specialist teams, including the Fostering and Adoption Team, uncertain about their survival. These various battlefronts are likely to have created

5.e) How change is experienced.

The findings suggest clear differences between a change and a transition. They convey the complexity of moving from once-weekly to intensive psychotherapy with children who have

experienced traumatic early discontinuities (Shulman, 2014) and who present with poor object constancy, inferred from their emotional dysregulation or in their difficulties with sustaining contact. For some participants, the experience of moving from once-weekly to intensive psychotherapy with their looked-after and adopted patients felt like a "storm" (Participant B); a disruption to an established rhythm that felt as if it unleashed madness (Participant E) or danger (Participant B) or simply shut down contact even further (Participant D). These disturbing different impacts upon each therapist-patient dyad suggest that the move itself may have been experienced as a traumatic discontinuity, stirring the early catastrophic rupture of the original birth mother-baby dyad and repositioning the therapist as a "new object" (Hurry, 1998). While Sherick and Chopra (2014) refer to the therapist-as new-object in a positive light, suggesting that the figure of the therapist may become available to carry a newly enriched transference with new developmental possibilities, in the case of LAAC and other children who have suffered significant early and developmental trauma, the repositioning of the therapist as a new object has the potential to be experienced concretely as the therapist changing into a different person, a potentially terrifying possibility. Participants were asked directly to reflect upon who they perceived themselves to have become in the mind of the patient after moving into intensive work. Those participants who felt that the move to intensive work had been beneficial described feeling they had become more loving maternal figures in the minds of their patients, captured in Participant A's description of feeling transformed, in the once-weekly transference, from a terrifying figure into an almost idealised family figure. In a similarly positive development after moving into intensive work, Participant C reflected upon a transformation in the transference from a cold, rejecting figure into a warmer, waiting motherly figure.

For those participants who queried the validity of the move into intensive work, the experience of feeling themselves to have become a new object was less positive. The most extreme example of this was Participant E, who described feeling changed in the transference from a lively object in once-weekly work into a drugged, shut down object in intensive work. In response to the question about who she felt she had become in the mind of the patient, Participant B described feeling like "someone she thought was incapable of looking after her" and "somebody that she antagonises and messes up, really. I was used to

be denigrated rather than someone who could be helpful". Participant B's description of the once-weekly sessions having allowed for play with dolls suggests some transformation of the therapist into a more disabling, damaged object in the mind of the patient. Similarly to participants B and C, Participant D reflected upon feeling herself to have become dangerous and devouring after moving into intensive work.

For participants B, C and D, change was felt to have been a dangerous experience that unsettled and disrupted, exposing therapist and patient to intense feelings of terror, dread, rage and hate. By contrast to this experience of catastrophic disruption, Participants A and C reflected upon the move to intensive psychotherapy feeling closer to a managed transition. Both these participants described a process of preparation across the matrix of relationships – external and internal – within which the therapist-patient dyad was held; Participant A details preparatory conversations across the child's network in parallel with discussions across her own network of course tutor and service supervisor, emphasising the time taken to talk in sessions with the child about the move. Participant C described an internal process of preparation, making a claim for her patient as an intensive patient in her mind. This is in keeping with Sorensen's (2000) idea that the micro-bridges that scaffold transitions for the infant are built within the mind of the primary carer: "This process ….requires a mind which is sufficiently identified with the baby to see things from his point of view and sufficiently objective to achieve a different perspective" (p.50). Both participants A and C evoke a process that has its own unique timing, a "gestation period" of preparation for change. A transition might be said to take place within a relationship in which a sense of enough attuned caregiving has established a "relational knowing" (Maiello, 2001) such that the impact upon the infant/patient of change can be anticipated, thought about and the emotional experience received and digested by the parent/therapist.

The findings evidence a clear distinction between those therapeutic dyads (B, D and E) that experienced the move from once-weekly to intensive as a "change" that unsettled something existing and those therapeutic dyads for whom the move into intensive work was experienced as a transition. For the former, introducing external change on top of what was already an internal situation of unpredictability and discontinuity seemed to confirm this internal situation in terrifying and cruel ways. For those therapeutic dyads (A and C) that

managed to experience the move into intensive work as a transition, the internal situation of discontinuity seems to have undergone some modulation with the increased contact, perhaps conceivable in terms of the psychic "net sufficiently dense" (Alvarez and Furgiuele, 1997, pp.123-139) provided by sufficiently frequent contact that can "hold together" the parts of the self that could not be held in "a psychic net with too large holes and a mesh too widely spread apart" (Shulman, 2019, p.334). In both these cases – A and C – achieving a meaningful transition may in itself have been a corrective experience for the patient, perhaps a first experience of their needs and fears around change to have been held in mind, not only by their therapists but by the mind of the teams and supervisors holding the therapists.

As articulated in the results section, a transition can be understood to be a bridge (Sorensen, 2000) built between two different experiences that links them and sustains them in meaningful relationship to each other. This is different to the kind of change that the children in these interviews, and LAAC generally, are likely to have experienced early in life: a rupture and traumatic loss of one relationship that may exist without links to a new relationship, in what may be felt as random senselessness described by Kenrick (2000) and evoked by the meaninglessness felt by Participant A when attempting to manage the endings of once-weekly sessions. The transition that holds on the old and links it to the new may be said to protect the "right to meaningful continuity" (Rustin, 2006, p.111) of which LAAC are commonly deprived. In the cases of participants A and C, the transition between once-weekly to intensive psychotherapy allowed their patients to experience themselves as moving, within the relationship with their therapists, from a painful lesser-frequency contact through to a more satisfying relationship of greater contact. Crucially, the move is felt to be experienced together and the once-weekly therapist, held within the 'net' of the actively thinking team and supervisory relationship, is felt by the patient to be holding them through the emotional experience of the move. Through the work of preparation described by participants A and C, they can be seen to be weaving themselves and their relationship with the child into the transition, making a claim for more intense contact based upon what was felt to be not enough in the once-weekly work. This may be the "meaningful continuity" that Rustin proposes that allowed both therapists in these dyads to be felt by their patients to become more loving objects with the move into intensive work. This suggests a continuity

of contact in which the previous once-weekly relationship is not lost in a sudden change, but banked as a shared experience upon which to build the more intensive relationship, as suggested by Participant A's reflection of having survived a frightening experience together. The coherence of this process of transition in which the past can be linked to the present, the old with the new, within a relationship of meaningful continuity can be understood as the basis for causality and making meaning. The meaningful continuity of these transitions can be seen to have allowed for the development of greater object constancy in both patients of participants A and C. For Participant A, this was suggested by a development of temporality and the patient seeming to have a different concept of time. Temporality – a capacity for order and sequentiality – allowed for meaning to evolve after the meaninglessness and chaos that characterised this therapeutic dyad's once-weekly sessions, suggested by this participant's recognition of having become an ordinary, familiar and reliable object for her patient. Significantly, Participant A's patient found a way to manage the not-so-long gaps between sessions with what the interviewee described as "transitional objects", toy dinosaurs with different characters that the patient used to communicate their state of mind to the therapist. The sense of temporality, in which past, present and future can be differentiated and exist in meaningful relationship with each other, suggests that the chaos described by Participant A before moving into intensive work might be understood as a terrifying continuous present (Canham, 1999) of an early and traumatic rejection/feeling unwanted, without any sense that these feelings belonged in the past.

The emergence of object constancy in the patient of Participant C was conveyed in the evocative description of the patient's search for something very early, suggested by the womb-like cupboard hiding space and the dialogue of rhythmic tapping. The link here between womb-like spaces and tapped out rhythms suggests a psychic return to a pre-rupture state of dyadic union, as if finally meeting the preconception (Bion, 1962) of a "maternal object who is there and waiting". In this state, the infantile part of the personality may be understood to be having a corrective experience of rhythmic regularity, enabled by the consistency and regularity of the three times weekly sessions, that lies at the heart of building up a sense of object constancy. The word "waiting" is central to a sense of object constancy; a strongly enough internalised relationship with a dependable object can support the self with "going on being" (Winnicott, 1960) to survive ordinary comings and goings. In

other words, an internalised rhythmicity, built up from the repeated experiences of rhythmically attuned caregiving from birth, allows for waiting (the exact opposite of Participant B's patient who returned each week as if Participant B were a stranger), captured in Maiello's (2004) condensed statement that "rhythm combines presence and absence in a temporal dimension" (p.181).

Chapter 6

6.a) Limitations and further research:

While this qualitative study has yielded potentially valuable findings, it must be noted that there are certain limitations. It was conducted with a small sample size: five participants, all of whom were white women from a range of different cultures, suggesting some likelihood for shared cultural "blind spots" and assumptions that may have limited the possibilities for exploration of certain dynamics. It is interesting to consider the potential for gathering different data had the sample set been representative of greater diversity, including differences of gender, ethnicity, race and sexuality; what power dynamics or cultural trauma might inform the responses of clinicians from BAME backgrounds? Would a male child psychotherapist have been able to gather a more paternal transference that could mitigate against some of the more traumatising enactments of early maternal neglect? While the focus of the interview questions was upon the actual transition from once-weekly to intensive psychotherapy, it would be interesting to carry out follow up interviews with participants with more specific questions about the developments achieved by the end of therapy with these patients, which was not possible within the scope of the one-interview study carried out with each participant.

The unique circumstances of the Covid-19 pandemic during which the study was carried out are inextricably bound up in the project. It would be valuable to explore clinician's experiences of transitions at a time when life and work have not been derailed by drastic survival measures. It may be significant that all interviews were conducted over the telephone, limiting the communicative possibilities between interviewer and interviewee that would have been an integrated sensory experience had the meetings taken place in person. It would be interesting to conduct these interviews again in person to assess the extent to which the bodily presence of the participant and interviewer might influence descriptions and recollections.

Further research into the meaning of transitions across a wider sample size would enrich our understanding of this clinical experience. In particular, further research is needed to identify the potential indicators that a case may benefit moving into intensive work while sharpening clinical awareness of the signs that mitigate against the move. It would also be

interesting to research more about the stage of training at which the trainee takes on this demanding challenge; assessing the likelihood of a successful transition with more senior trainees would extend our understanding of the extent to which difficulties in the transition might be entrenched within the patient's psychopathology and what might be available to be worked through with the enhanced skill and understanding of the more experienced trainee. Further research would also be interesting into the part played by very early history in the capacity to manage the transition into intensive work; this study tentatively posits a relationship between an extended period of early chaotic care and a difficulty in tolerating the increased contact of intensive work. Greater understanding of this possible link may enable clinicians to assess more rigorously the risk of moving these patients into intensive work if once-weekly work is progressing adequately. The perspective of the patients themselves towards the transition into intensive psychotherapy lay beyond the scope of this study and would be a meaningful area for further research.

6.b) Recommendations: what's missing?

This study raises important questions for the continued practice of changing the care plan, particularly with LAAC patients but also more widely across the general patient population, in the child psychotherapy training. The study suggests that there is a need to capture more data on the process and impact of changes to care plan; one suggestion would be outcome reports that specifically monitor shifts in treatment across the transition: eg. Time 1 (before transition), Time 2 (at the point of transition) Time 3 (three months after transition). Also recommended is a more open discussion of the guilt and anxiety stirred by training needs; the study suggests that trainee child psychotherapists can feel alone with guilt about changing the care plan to meet their own training needs. Perhaps greater transparency about training needs when broaching the question of changing the care plan with parents or carers would relieve trainees from feelings of guilt while allowing for the possibility of a mutually beneficial experience.

6.c) Subjectivity

In the spirit of reflexive thematic analysis, this section will gather some of the subjective reflections woven through the study and offer reflections upon the research process. As a psychoanalytic research study, it feels important to explore the possible meaning of these subjective reflections in the service of greater understanding to which this study is aimed. In order to design, conduct and write this study, I sought sufficient distance from my own experience of moving a once-weekly LAAC patient into intensive treatment to be open to the emotional experience described by participants of this move at the same time as attempting to hold a standard frame of questions within which to make sense of their responses. The temptation as a psychoanalytic practitioner was to follow the responses of the participants while simultaneously tracking how this made me feel (my countertransference) but as a psychoanalytic practitioner-researcher I found myself pulled between this pursuit of meaning and emotional experience and simultaneously away from it by the reality of having to follow an agreed schedule of interview questions. Reflecting upon this tension, I am struck by the parallel with a parental couple, in which containment and limit-setting are combined and wonder about the role of research as a possible third (Britton, 1989) requiring some responsible accountability, outward-facing evidence of our deeply intimate psychoanalytic work.

The findings have highlighted feelings of guilt around undeclared training needs that demand changes to established care plans, even in those cases where the outcome is beneficial. This prompts some consideration of my own ambivalence in revisiting what was a disturbing clinical experience in my second year of training (rather than a well-managed transition from once-weekly sessions into intensive psychotherapy, my own experience was that the move felt like the destruction of a familiar, once-weekly relationship by a frightening and unknown three-times weekly force) and acknowledgement of feelings of guilt at having created this upheaval in my rush to start a training case, leaving both myself and my patient inadequately prepared and unpersuaded by the rationale that he was making good use of psychotherapy and that it might be helpful to meet more frequently. While not untrue, this was not the reason for changing the care plan. Given the psychoanalytic lens of the present study, it is perhaps helpful to consider the possible

blurring of my own undigested feelings of guilt and shock associated with the research question with some of the responses of the participants; how could we know whose guilt we were discussing in the interview and whose needs were trumping whose?

The questions in the interview schedule were intended to shine a light on the before, during and after of the move from once-weekly to intensive psychotherapy. Participants' responses to the prompt about how the change came about were evasive, offering similarly vague comments about the agreed rationale as my own when I had broached the subject with my patient. With hindsight, I wonder about a shared feeling of discomfort with this question coming so early in the interview, as if both participant and I may not have felt safe enough to bear the feelings of guilt it aroused. The general absence of recollected detail and strong impact of the first intensive sessions was surprising and raised questions about something possibly being avoided or defended against; while it is hard to overstate the highly defended state of mind of the first lockdown, the time during which these interviews took place by telephone, it is hard not to draw a link between the seismic shock of the pandemic and the possible psychic shock of the change addressed by the research question and it is possible that defences of denial may have been serving to protect both participant and interviewer from having to confront details of the painful or disturbing impact of change. Given that participants were directly asked how the move (from once-weekly to intensive sessions) made them feel, there was a paucity of subjectivity in responses, which tended instead to gravitate towards description of the patient's behaviour or towards theoretical ideas about projection into the therapist by the patient. My preconception of granular detail of the immediate impact of change did not meet its realisation, leaving me momentarily frustrated and disappointed, feelings that echo the earliest experiences of the children in treatment. While I sensed a heightened anxiety in all the interviews around the immediate impact of changing frequency, I was aware of feelings of guilt in the interviews with participants B, D and E as if the interview process itself was inflicting cruelty through revisiting a clinical experience of humiliation and disappointment. It is likely that these emotional responses will have had some unconscious influence upon the data and its thematising. It is perhaps meaningful to consider the possible side-lining of the participant's subjectivity as an echo of the eclipse of the patient's clinical need by the training need in driving the move.

The sharing of sensitive clinical experience put me in touch with an exposing dimension to the research process: I had also participated in the research studies of fellow trainees and wondered retrospectively about an insight into me that this experience had provided. The many days and weeks spent with the participant's experiences, mining their recollections and descriptions, brought me into unexpected contact with what felt like intimate details of their training and development. During the process of analysing data, there were moments in which it felt close to intrusive to be ascribing latent meaning where this may not have consciously intended; the feeling in this moment of being too close has evolved into a more integrated, less close-up position in which the participants as individuals somehow make up a whole mosaic of the total emotional experience of the child psychotherapy training: hope, despair, growth, stuckness, pleasure, hell, idealisation, denigration. This evolution parallels the psychic development of the infant from part object to whole object (Klein, 1952), in which the "concept of the mother as a whole and unique person develops out of a relation to parts of her body" (Klein, 1952, p.70). A similar evolution has taken place within the focus upon the attempt to understand more about transitions with LAAC as addressed by the research question. There has been a tendency to split the question into two aspects and to be pulled into either a greater focus upon more general aspects of working with LAAC or upon the phenomena of transition. It was easy to see how the study could have more simply been devoted to either an aspect of working with LAAC or to the transition from once-weekly to three times weekly with the general patient population and was felt keenly during the process of conducting the literature search, which felt complicated by this combined focus. However, over the course of digesting (Bion, 1962) the findings into the Discussion chapter, these two focal points achieved some integration – became a whole object (Klein, 1952) – and the heightened sensitivity of LAAC to change lent itself as a microscope to a more nuanced study of transition. It is interesting to reflect upon the question of cruelty that emerged from the findings and consider the extent to which, at an unconscious level, the practice of changing the care plan of a LAAC patient felt cruel. From this perspective, it is possible to consider how far this entire project to explore other clinicians' experience may represent a search for shared guilt of this perceived cruelty.

6.d) Conclusion

In setting out to explore the clinician's experience of the transition from once-weekly to intensive psychoanalytic psychotherapy with LAAC, this qualitative study has yielded valuable findings that can helpfully inform future practice and training. The study highlights the risk that, without the necessary time and care taken to scaffold a transition across frequencies that protects "meaningful continuity" (Rustin, 2009, p.111) this care plan change may be experienced as an unsettling discontinuity. When it comes to the possibility of this transition with LAAC, the study cautions against assuming sufficient internal apparatus for bridge-building (Sorensen, 2001) and suggests that clinicians anticipate the need to assemble externally the scaffolding required to support the transition; this scaffolding might entail discussion across the matrix of relationships within which the case is held and with the patient of the rationale for change in addition to exploration of its potential impact upon family, patient, network, team and therapy. Without this thoughtful scaffolding across frequencies, the study evidences the possibility that disrupting the familiar rhythm of once-weekly sessions may risk repeating an early traumatic discontinuity. The study tentatively proposes a more central role for service supervisors in providing the trainee child psychotherapist with a transition period of sustained focus upon the case (perhaps through more frequent supervision) to enable some claiming of the patient in their minds as a training case. The study shows a need for training requirements to be owned more transparently by the service and for the service supervisor to take a more active role in the ongoing assessment of suitability for intensive work and the development of the trainee's clear understanding of the clinical rationale behind the move. Without this, the study suggests a risk that the trainee may experience negative feelings of guilt around dishonesty and even cruelty, that may be assumed to communicate themselves unconsciously to the patient possibly to the detriment of the work. The cases studied in this research tentatively suggest a need for more attuned linking of training supervisors with potential training cases, particularly where LAAC are being considered for a move from once-weekly to intensive psychotherapy.

This study sheds significant light upon a frequently occurring clinical practice within the training of child psychotherapists; the findings make clear that moving a LAAC patient from once-weekly to intensive work is a vastly more delicate and complex undertaking than is

often acknowledged in the profession, in which intensive work can often be idealised. In addition to considerable support for the trainee by supervisors and the wider team, the move demands resilience and a capacity to take risks technically on the part of the trainee. It has been surprising to confront the paucity of literature on this practice, given its frequency in CAMHS, suggesting that the present study is an important new piece of research. Further research into clinical transitions is indicated to consolidate the findings of this study to enable the judicious allocation of precious child psychotherapy resources within the NHS in the service of delivering treatment to the vulnerable children most in need of therapeutic help.

Acknowledgements

There are many people who have contributed to this study, either directly or indirectly. To all of them, I offer my warmest thanks. I am very grateful to my research supervisor, Dr Miriam Creaser, whose insight, warmth and clarity enabled the gestation from idea to complete thesis of this study. Thanks also to Dr Jocelyn Catty, who has kept a lively focus on this study, as well as to Dr Brinley Yare for inspiring me about qualitative methodologies. Thank you to Phillip McGill for suggesting that the transition from once-weekly into intensive work could become a valid subject for my doctoral research and particular thanks to the participants who shared generously their time and sometimes painful experiences in the interviews. I was fortunate to complete my child psychotherapy training in the Tavistock's Fostering and Adoption team, where my interest in LAAC was nurtured. My learning continues.

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Appendices

Appendix A

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/

Rachel Lasserson

By Email

3 June 2020

Dear Rachel,

Re: Trust Research Ethics Application

Title: How do clinicians experience the transition from non-intensive to intensive psychoanalytic psychotherapy with looked-after and adopted children (LAAC)?

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

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

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

I am copying this communication to your supervisor.

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

Yours sincerely,

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

cc. Course Lead, Supervisor, Research Lead

Appendix B Recruitment Sheet

The Tavistock and Portman NHS
NHS Foundation Trust

Children and Young Adolescent Families
The Tavistock and Portman
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120 Belsize Lane
London NW3 5BA
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www.tavi-port.org

Recruitment Sheet

Looking for Child and Adolescent Psychotherapists to participate in a study:

"FROM LESS TO MORE: How do clinicians experience the transition from non-intensive to intensive psychoanalytic psychotherapy with LAAC?

- Have you worked or are you currently working intensively with a looked-after or adopted child? Was that child previously seeing you for once-weekly psychotherapy?

- If so, would you be willing to participate in a study that explores the move from non-intensive to intensive work?

If the answer to these questions is "yes", please contact me at rlasserson@tavi-port.nhs.uk.

I am a trainee CPT at the Tavistock and this research is for my DProf.

Thank you.

Appendix C Participant Information Sheet

The Tavistock and Portman NHS
NHS Foundation Trust

Children and Young Adolescent Families
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Participant Information Sheet

June 11th 2020

From less to more: How do clinicians experience the transition from non-intensive to intensive psychoanalytic psychotherapy with looked after and adopted children?

What is the purpose of the study?

The purpose of this study is to investigate Child and Adolescent Psychotherapists' experience of moving from non-intensive to intensive psychotherapy with Looked After and Adopted Children (LAAC).

This study is part of the researcher's Professional Doctorate in Psychoanalytic Child and Adolescent Psychotherapy.

What is the study about?

LAAC form a significant proportion of the CAMHS caseload. LAAC present with severe and complex mental health problems that can require long term and highly specialised intensive psychotherapy.

I'm interested in understanding more about the move from less to more in the treatment of these children, through the experience of CPTs who have progressed from once-weekly psychotherapy to three times weekly psychotherapy.

The project will investigate the impact of this transition on the following:

The transference - did the clinician perceive themselves to appear different to the child and if so, how?

The material - did the clinician perceive a change to the content or themes of sessions?

The project aims to explore what "more" could represent to the child who has adapted to "less", and what it might expose them to.

The project aims how to understand how "more" was presented to the child and thought about in the team, in terms of allocation of resources (intensive psychotherapy is a precious resource in the NHS).

Who is undertaking the study?

The lead researcher in this study is Rachel Lasserson, Child and Adolescent Psychotherapist in Doctoral Training. The study is supervised by Dr Miriam Creaser. Contact details for the research team can be found at the end of this information sheet.

What will happen if I choose to take part?

- If you decide to take part in the study you will need to complete a consent form. This will be completed just prior to the interview.
- You will be invited to participate in a telephone interview at time convenient for you.
- During this semi-structured telephone interview you will be invited to answer between 4 and 5 questions. Your answers will be recorded and collected as data. This data will be stored anonymously in accordance with GDPR guidelines.
- It is anticipated that the appointment will take no more than 1.5 hours and no further contact will be required.

Confidentiality: how will information about me and data gathered in the study be used and stored?

If you chose to participate in the study your data will be stored anonymously. You will be given a participation number by the researcher and this will be applied to all data collected from you. Your anonymity will be protected in the analysis of data and the report of findings. Data will initially be stored in a locked cupboard. It will then be transferred to an electronic file which will be password protected. Data will be kept for no more

than 2 years, at which point it will be destroyed. Data generated in the course of this study will be kept in accordance with the University of Essex Data Protection Policy.

Please note: The confidentiality of the information that you provide is subject to legal limitations in data confidentiality (i.e. the data may be subject to a subpoena, a freedom of information request or mandated reporting by some professions).

What will happen to the results of the study?

The results of the study will be written up as part of the researcher's Professional Doctorate in Psychoanalytic Child and Adolescent Psychotherapy. The study's findings may also be submitted for publication in professional journals or presented as conference papers. The study's findings may also form the basis for future research or presented in workshops or seminars.

Is there a benefit to taking part in the study?

There is no immediate benefit although you may value the experience of contributing to a wider discussion about your work.

It will provide you with the opportunity to participate in a wider professional discussion and share your experiences with someone who is interested in learning about your clinical practice and formulations.

Are there any risks or disadvantages to participating in the study?

There are no anticipated risks or disadvantages to participating in the study. It is not expected that this study will be out of the boundaries of normal working experiences but in the unlikely event that you have any questions about the study please contact me.

Further Support and Guidance:

Should you have any queries or concerns about the conduct of the research, please contact Simon Carrington who oversees the Tavistock Centre's Academic Governance and Quality Assurance.

Further support on debriefing or advising on adverse reactions can be sought by conducting Dr Creaser, the project's Research Supervisor, or through your own professional support networks (colleagues, supervisors, analysts).

In the highly unlikely event that risk to self or other be shared during the interview; statutory reporting will need to occur. I would initially need to consult with my Research Supervisor and the Head of Safeguarding at the Tavistock Centre who would guide me in managing this highly unlikely situation.

Withdrawing:

If you have a query about withdrawing your data please contact either myself or Dr Creaser. To preserve the study's data collection time line, should you wish to withdraw your data from the study please notify the Researcher within 6 weeks of the interview, after that time the data will be included as it will be too late to recruit another participant.

Thank you for taking time to read this information sheet.

If you have any questions about the study please contact:

Researcher: Rachel Lasserson, Child and Adolescent Psychotherapist in Doctoral Training
Email: rlasserson@tavi-port.nhs.uk

Research Supervisor: Dr Miriam Creaser
Email: miriamcreaser@hotmail.com

Any concerns about the conduct of the research:

Head of Academic Governance and Quality Assurance: Simon Carrington
Email: academicquality@tavi-port.nhs.uk

This project has been approved by: The Tavistock and Portman Research Ethics Committee (TREC). It is sponsored by Brian Rock on behalf of the Trust.

Appendix D

Consent Form

June 11th 2020

From Less to More: How do clinicians experience the transition from non-intensive to intensive psychoanalytic psychotherapy with LAAC?

	Please tick
I confirm that I have read and understood the information sheet provided for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation in this study is voluntary.	
I can confirm that I have a professional network to support me in the unlikely event that I need further support following the interview.	
I understand that the interview will be digitally audio recorded and then transcribed.	
Should I wish for my data to be removed from the study, I understand that I can utilise the 6 week cooling off period after the interview by contacting Rachel Lasserson.	
I understand that the information given in this interview may be used by the researcher in future publications, reports, presentations.	
I understand that any personal data that could be used to identify me will be removed from the transcript of my interview and that I will not be identified in any publications, reports or presentations.	
I understand that due to the small sample size of the study, as well as sampling of my colleagues who I worked with on the case I will talk about in the interview, it is likely that these colleagues will be able to recognize which data belongs to me. This is a limitation of the study that I am willing to accept.	

Participant's name:			
Participant's signature:		Date:	
Researcher's signature:		Date:	

Research Identification Number:

Thank you for agreeing to participate in this study.

Appendix E Debrief Form

The Tavistock and Portman NHS
NHS Foundation Trust

Children and Young Adolescent Families
The Tavistock and Portman
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Tavistock Centre
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Debrief Form

June 11th 2020

From Less to More: How do clinicians experience the transition from non-intensive to intensive psychoanalytic psychotherapy with looked after and adopted children?

Thank you for agreeing to participate in this study.

If you have any questions regarding the study or your involvement in it please contact:

Researcher: Rachel Lasserson, Child and Adolescent Psychotherapist in Doctoral Training
Email: rlasserson@tavi-port.nhs.uk

Or

Research Supervisor: Dr Miriam Creaser
Email: miriamcreaser@hotmail.com

Any concerns about the conduct of the research should be reported to Simon Carrington, Head of Academic Governance and Quality Assurance
Email: academicquality@tavi-port.nhs.uk

This project has been approved by: The Tavistock and Portman Research Ethics Committee (TREC)

Appendix F Interview Schedule

1. Can you tell me about a particular case when this happened?

Possible prompts:
How long had you been seeing the patient once-weekly?
How did the change come about – eg. Shifts in behaviour?

2. Did the therapy change and if so how?

Possible prompts:
What do you remember about the early intensive sessions
How did it change over time?
How do you think the child perceived you after the change?

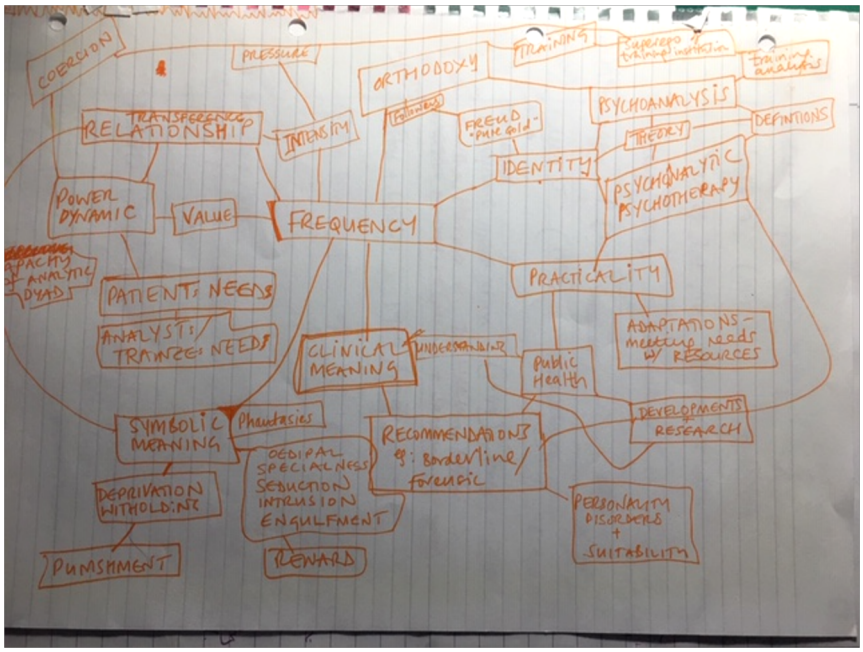
3. How did the move make you feel?

Possible prompts:
How did this change the dynamic in your relationship with the patient?
How did you feel about this?

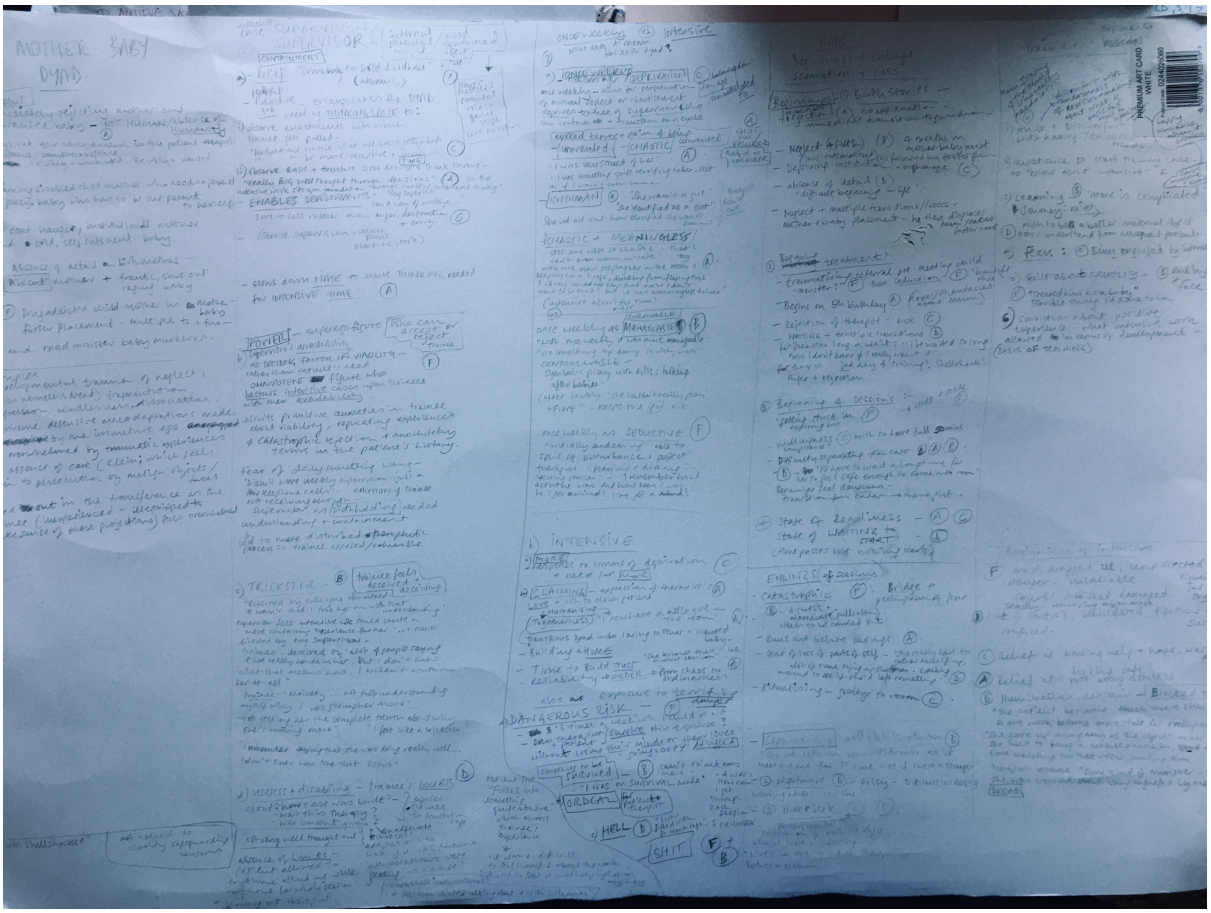
4. How do you think your perception of the child's needs influenced your feelings?

Possible prompts:
The therapist's awareness of patient's early deprivation/loss/multiple internal parents?
How much did the therapist perceive the move to stir patient's memories of early changes/losses?
Does the LAAC nature of the child give this impact a particularly violent/intensive/overwhelming quality?

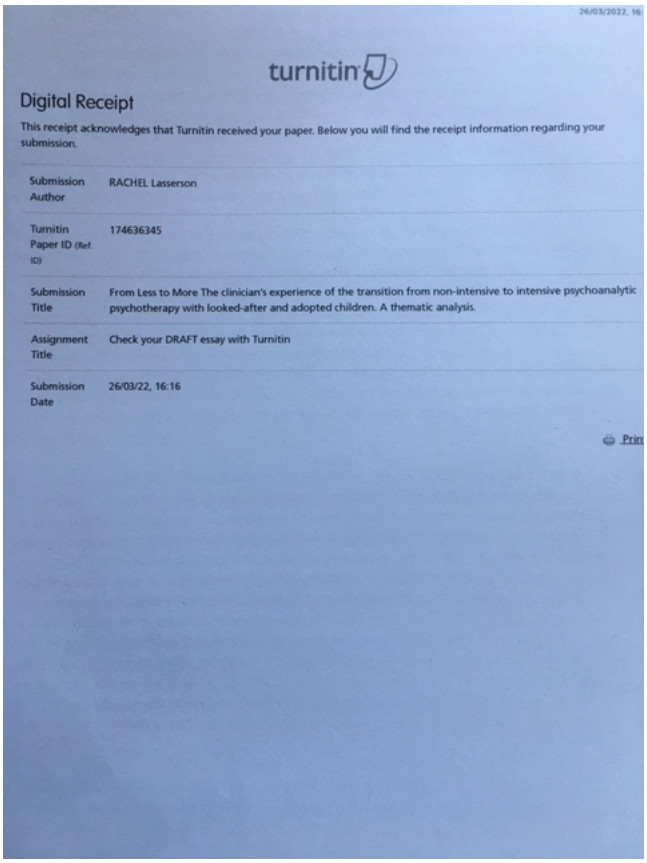
Appendix G Mind map of concepts for literature searches.



Appendix H Map of potential themes.



Appendix I Turnitin Receipt



26/03/2022, 16:

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Assignment Title	Check your DRAFT essay with Turnitin
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