When to wait and when to act? An exploration of child psychotherapists' work with risky adolescents

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

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March 2023

Abstract

Risks taken by adolescents presenting to mental health services can be seen as a communication that, through treatment, can be understood. Psychotherapy can be thought of as an *offer of time* in which 'waiting with' a patient is therapeutic. However, this approach can conflict with the culture of pressured CAMHS services where the pull to *act* in response to patients' distress is strong. This research looks at how Child and Adolescent Psychoanalytic Psychotherapists (CAPT) manage the tension between the theoretical stance of waiting and an organisational pull to act. It focuses on adolescent patients who pose a risk to themselves from serious self-harm or suicidal ideation. Five interviews were conducted with CAPTs from clinics within a single NHS Trust where the dominant culture is one of fast action, without psychoanalytic thinking at the fore. Grounded Theory was used to pull together psychoanalytic thinking with data generated through interviewing. Reflexivity of the researcher's framing of the study, and influence on the interviews, is explored. **Key findings**: (1) a strong focus was seen on a specific kind of thoughtful action described here as an *enhanced therapeutic dyad*. It involved a process in which parents were sensitively brought into the therapeutic relationship and requested to take responsibility for certain actions to ensure their child's safety. The purpose of this action is primarily patient safety, but also promotes long-term change. (2) The impact of an organisation's capacity to acknowledge the presence of anxieties arising from the work on the ability of clinicians to contain patient anxieties and wait rather than act was noted. The first finding was unexpected and a recommendation is made for an explicit focus, during CAPT training, on the use of thoughtful action as part of therapeutic work with risky adolescents in pressured NHS services.

Acknowledgements

I would like to express my gratitude to the participants of this study who generously gave their time and shared their interesting thoughts, insights and experiences with me. In particular, I would like to thank my supervisor, Dr Jocelyn Catty, for her steady support, clarity and generosity of thoughts as well as her encouragement throughout this process which has been absolutely invaluable. I would also like to thank colleagues and friends who have spent time discussing my project with me, as well as my excellent proof-reader. This has been a long journey for my husband and children; I am so grateful for their support and patience.

Contents

Introduction

Over recent years mental health issues have become more prominent in popular culture. Different perspectives on how to address them range from the recent trend in the area of Wellbeing on social media, to the focus on it at international sporting events. The 2020 Olympic coverage in the summer of 2021 interviewed past athletes asking how they dealt with, or managed, their own mental health, including breakdowns. The gymnast, Simone Biles, was highly praised for not competing in several Olympic finals saying that *'she needed to focus on her mental health'* (BBC news 2021). Alongside the prominent anti-racism stance, there was an implicit understanding of the importance of mental wellbeing from the English football team during Euro 2020. Far from being hidden from the public eye, as it seemed to be in the past, matters relating to 'mental health' are increasingly prominent in British society.

Casting a shadow over all of this, however, is the rather more ugly threat of suicide. The glamour of an influencer dictating how to 'be your best self' or a highly proficient, global-leading gymnast showing the genuine and commendable courage and bravery to step out of a competition and care for themselves, is a far cry from the misery, anger and loneliness that someone may feel behind closed doors. Focusing on general wellbeing can be a useful aspect of a protective life-style, but it does not cure states of mind where suicide or serious self-harm are felt to be the fitting, or only available course of action. In fact, the glamorisation of self-harm and suicide and social media's role in providing this platform are likely to be more prominent in the lives of those affected by it, and are often quoted by outraged families as contributory factors in the devastating, untimely and preventable deaths of their children.

The World Health Organisation estimated a global rate of 10.6 suicides per 100,000 in 2016. This amounts to an approximate global average of 800,000 deaths per annum accounting for 1.5% of all deaths worldwide (Fazel and Runeson 2020). In England, the Samaritans quote a rate of roughly 10 suicides per 100,000 over the period from 2006 to 2020 (ONS 2020). Interestingly, the global rate of suicide across the whole population decreased by eighteen percent between 2000 and 2016 (Fazel and Runeson 2020). However, while the suicide rates for 10 to 14-year-olds and 15 to 19-year-olds are substantially lower than the population rates (0.3 and 5.7 per 100,000 in 2019, and 0.4 and 4.7 per 100,000 in 2020 respectively), suicide remains the foremost cause of death worldwide for people aged between 15 to 24 years (Fazel and Runeson 2020).

Suicidal ideation and seriously self-harming adolescent presentations are, however, increasing in the UK: the rate of admissions to hospital after serious self-harm in young people (aged 10 to 24 years) increased by 37% in females between 2012 and 2020 and remained relatively stable in males (Nuffield Trust 2019). These figures don't include presentations at Accident and Emergency departments where an admission did not take place. The decision to admit is not solely based on severity of the self-harm, and where it is safe to do so, there is an aim to avoid it, particularly for young people as admission can exacerbate a problem. Therefore, these figures provide an indication of the increase in serious self-harm that most-likely reflects a larger issue. Anderson (2004 p.163) states that an attempted suicide increases the risk of suicide by 10-fold in adolescent males, and there is plenty of evidence to suggest that once suicide has been seen as a route to manage psychic pain it becomes a '*lifelong option'* (Campbell and Hale 2017 p.13). While the rates of adolescent suicide are

comparatively low at a population level, serious self-harming and suicidal feelings have increased, and so it follows that the rates of suicide are likely to increase.

There is a wide and varied literature on treatment and responses to suicidal patients, and it is beyond the scope of this study to encapsulate the nature of it from all disciplines. In short, the approach is often medically led focusing on demographics and social influences that aim to establish a risk level that can be used to quantify the problem and direct treatment decisions. For example, a US study describes the use of immediate assessment and implementation of safety management plans to prevent adolescent suicides (Szlyk *et al.* 2020 p.161). In the UK, it is common for medication to be offered without the requisite talking therapy that is stipulated in the NICE guidelines (The National Institute for Health and Care Excellence) as an accompaniment to medication (e.g. Fazel and Runeson 2020). However, Large *et al.* (2017) found that only 5% of suicides in adults arose from the population who had been classed as high risk, and roughly half of all suicides arose from a group who would be deemed low risk. While this may raise more questions than it answers, it indicates that an approach purely based on the categorisation and reducing of risk are not necessarily effective on their own. Instead, the necessity for a suite of treatments, not least psychoanalytic psychotherapy, which offer different approaches to management and treatment of suicidal and self-harming adolescents, is clear.

This research project aims to explore how Child and Adolescent Psychoanalytic Psychotherapists working in generic Child and Adolescent Mental Health Services (CAMHS) within a single NHS trust respond to and manage adolescents presenting as a risk to themselves. Specifically, what influences clinicians' decision to wait with

patients (as conceptualised by Sailsbury and Baraister 2020) and when action is taken. This will be addressed within the context of urgency generated by the material brought to clinicians by their patients, and the significant pressures that NHS services are currently operating under.

Literature review

Searching the literature

In order to identify relevant literature, two approaches were used: snowballing and database searches. The *Snowballing* method accounted for the majority of relevant literature found, possibly because the small and narrow field of study limits what was possible to find in database searches. Different search approaches identified different types of literature. Psychoanalytic theory, (including that relating to adolescent development, the psychoanalytic view of suicidal ideation, and the meaning and function of communication), was exclusively identified through Snowballing, as well as less psychoanalytically focused literature. Searching the databases contributed to more scientific literature on neuroscience, psychiatric papers, larger clinical trials that provide quantitative evidence for psychoanalytic work, and some aspects of the pressures faced by NHS services, much of which was already identified through Snowballing.

Snowballing

Snowballing involves identifying relevant literature from other relevant literature; both those that they reference and ones in which they are cited. This proved fruitful and the majority of the literature was identified in this way. Ridley (2012 p.56) highlights the value of this method for narrow fields of study.

Database search

In total 15 papers that were initially of interest were identified through searches of the databases. Several of these had already been identified through Snowballing. Of the remaining papers only two were found to be useful once the abstracts had been read; one relating to the neuroscience of risk and the other was a psychiatric study of predictors of adolescent suicide. Below is a detailed account of the database searches undertaken to highlight the extent to which data was sought.

Three databases were selected and searched on 9th Jan 2023: PEP Archive (Psychoanalytic Electronic Publishing), APA (American Psychological Association) Psycinfo and Psychology and Behavioural Sciences Collection. The first two were chosen as they focus on mental health publications, the former is a central database for psychoanalytic journals and literature, and the latter is focused on psychology and related fields. Psychology and Behavioural Sciences Collection was also selected as there is some cross over with psychotherapy literature and these fields. MEDLINE was initially considered but was not used. It is a large database for medical research literature and would have identified an unwieldly number of articles relating to suicide and risk which would primarily be from a psychiatric point of view and so outside of the main focus of this research.

<u>Search 1</u>

Initially three search concepts were used in this search: *Risk*, *Adolescent* and *Psychotherapy*. Synonyms for each concept were searched for using the Boolean operator OR to identify literature with any of these words (see Table 1 for the concepts and synonyms used). The synonyms *intervention* and *treatment* were not used as they

have broad meanings and would have obtained too many results. An asterisk (*) was applied to truncate synonyms to capture results with any suffix. Quotation marks captured literature containing words appearing together in the order specified. The outcomes of these three searches were combined using the Boolean operator AND to identify literature which related to all of these concepts. This retrieved 130,245 results from the databases. A fourth concept, *Organisation*, was then searched for and these four concepts were combined using AND, identifying 16,987 articles. Limiters were applied to the data to narrow the results. Table 2 shows the limiters used, the order they were applied, the rationale for their use, and the number of results identified. Of the 85 papers identified, five were initially of interest.

Table 1: Search 1. Synonyms of concepts and results for each search in Psycinfo, PEP Archive and Psychology and Behavioural Sciences Collection

Risk	**Adolescent**	**Psychotherapy**	**Organisation**
harm*	adol*	psychoth*	CAMHS
'self-harm*'	teenage*	counsel*	'child and adolescent mental health service'
death	child*	therap*	organisa*
ideation	young	psychoanaly*	'mental health service'
suicid*	'young-person'	'child-psycho*'	clinic
'self-injur*'	peadiat*	'therapeutic – alliance'	
depress*		psychodyn*	
anxi*			
'low-mood'			
risk*			
'risky-behav*'			
danger*			
respon*			
2,252,661	**1,500,410**	**1,249,233**	**438,601**

Table 2: Search 1 limiters used in order and results obtained

Limiter	Rationale	Results
No limiters		16,987
Year: 1970-2023	To access recent literature	16,644
English language	Limiting to accessible results	15,930
Peer reviewed	Assurance of literature quality	14,103
Subject Major: psychotherapy	Target subject	281
Subject Age: adolescent 13-17 years	Target group	85

Search 2

As the first search was not fruitful a second database search was undertaken. The concept *Adolescent* was removed as data relating to any age group could be of interest. The concept *Waiting* was added. This concept was not used initially as it is a broad term that could refer to a range of situation and many of the synonyms identified are also broad (see Table 3 for search concepts, synonyms and the number of results retrieved). These results were combined using AND to identify papers that referred to all of the concepts and 21,364 results were obtained. Limiters were applied to this search and are listed in Table 4.

Table 3: Search 2. Synonyms of concepts and results for each search in Psycinfo, PEP Archive and Psychology and Behavioural Sciences Collection

Waiting	Risk	Psychotherapy	Organisation
wait*	harm*	psychoth*	CAMHS
act*	self-harm*	counsel*	Child and adolescent mental health service
time	death	therap*	organisa*
stop*	ideation	psychoanaly*	mental health service
dela*	suicid*	child-psycho*	clinic
paus*	self-injur*	therapeutic - alliance	
hold*	depress*	psychodyn*	
	anxi*		
	low-mood		
	risk*		
	risky-behav*		
	danger*		
	respon*		
2,344,286	**2,252,661**	**1,249,233**	**438,601**

Table 4: Search 2 limiters used in order, rationale and results obtained

Limiter	Rationale	Results
No limiters		21,364
Year: 1970-2023	To access recent literature	21,019
English language	Limiting to accessible results	20,015
Peer reviewed	Quality control	**17,870**
Subject Major: psychotherapy	Target subject	422
Age: adolescents 13-17yrs	Target group	42

From the 42 papers identified, eight were initially of interest. In an attempt to find more papers six further mini-searches were undertaken. The starting point for these searches was the results identified after the limiter, *Peer reviewed* was applied which narrowed the search to 17,870 (highlighted in bold in Tables 4 and 5). From this point a variety of subject categories (called Subject Major) were examined sequentially. The search facility used allows findings to be limited to subject categories from within the search results by selecting from a list. Against each subject the number of results within the larger search are indicated within the database. Six subjects were selected and the literature identified was reviewed. These searches had to be undertaken separately as the way in which the limiters are applied to the search results affected the results obtained: when several subject categories are selected at once it seemed that AND is applied to the search and only results with both subjects are provided. As there is no facility to request they are searched with OR, it has to be done sequentially. Each time a new subject category was explored the previous limiter was removed (see Table 5 for the subject categories that were identified and the number of items identified). Two papers were identified through this process; one under the subject category Clinical Practice and the other under Psychotherapists.

Table 5: Search 2 Subject Major categories that were searched and the relevant results identified

Limiter	Results	Relevant results
No limiters	21,364	-
Year: 1970-2023	21,019	-
English language	20,015	-
Peer reviewed	**17,870**	**-**
SubjectMajor: healthcare provision	8	0
SubjectMajor: treatment	11	0
SubjectMajor: clinical practice	9	1
SubjectMajor: psychotherapists	9	1
SubjectMajor: community mental health services	5	0
SubjectMajor: therapeutic process	6	0

Search 3

A third database search was undertaken using the five concepts that had previously been used: *Risk, Adolescent, Organisation, Waiting, Psychotherapy* (see Table 6 for synonyms and results and Table 7 for limiters). The concepts were searched for and then combined using AND. Both the results found by limiting the data to a specific age range (34 results), and the previous limiter, Subject Major Psychotherapy (101), were reviewed. A large overlap was noted between this and previous searches so at this point the literature search was ended.

Table 6: Search 3. Synonyms of concepts and results for each search in Psycinfo, PEP Archive and Psychology and Behavioural Sciences Collection

Waiting	**Adolescent**	**Risk**	**Psychotherapy**	**Organisation**
wait*	adol*	harm*	psychoth*	CAMHS
act*	teenage*	self-harm*	counsel*	Child and adolescent mental health service
time	child*	death	therap*	organisa*
stop*	young	ideation	psychoanaly*	mental health service
dela*	'young-person'	suicid*	child-psycho*	clinic
paus*	peadiat*	self-injur*	therapeutic - alliance	
hold*		depress*	psychodyn*	
		anxi*		
		low-mood		
		risk*		
		risky-behav*		
		danger*		
		respon*		
2,344,286	**1,500,410**	**2,252,661**	**1,249,233**	**438,601**

Table 7: Search 3 limiters used in order, rationale and results obtained

Limiter	**Rationale**	**Results**
No limiters (concepts searched with AND)		6,149
Year: 1970-2023	To access recent literature	6,035
English language	Limiting to accessible results	5,790
Peer reviewed	Quality control	5,124
Subject Major: psychotherapy	Target subject	101
Age: adolescents 13-17yrs	Target group	34

Review

Below is an account of the literature identified through these searches, bringing together psychoanalytic theory and practice with findings from a broader range of literature. It begins with an exploration of the internal task of adolescence as a time that involves looking both forwards and backwards. Perspectives are described on the

interplay with the external world in terms of individuals' experiences, and the impact of society, particularly for those who have been subject to abuse or deprivation in childhood. Psychoanalytic theories that underlie modes of communication are explored, including risky behaviour used to convey the experience of adolescence, and of adverse experiences and how therapeutic situations may be used to master these difficulties. The psychoanalytic view of suicide is looked at including the phantasies that relate to a wish to destroy the body. Next, this is thought about in relation to how risky adolescents interact with services and clinicians, and the impact that communications can have on clinicians. Finally, the offer of time as a treatment (Salisbury and Baraitser 2020) and how this conflicts with services that are under pressure is considered.

Adolescence

Adolescence is the time between childhood and sexual maturity and is inherently a time of turmoil both internally and externally. Puberty hails a complex web of change and processes that end in a psychic and physical organisation that we describe as adulthood (Stambler 2017). Many have highlighted the dual focus of this time of change; looking forward to the unknown adult world and looking backwards to what is being lost or carried from childhood. Waddell (2018 p.188) describes the time as *Janus-faced* from Janus, the Roman God of transitions, caught between a resurgence of infantile dilemmas of love and hate, and the '*pain of extrication from family bonds'* bringing the question of '*Who am I becoming?'.* Catty (2021) uses lines from the T.S. Eliot poem *The Waste Land* - the '*shadow at morning striding behind you, Or your*

shadow at evening rising to meet you' - to draw our attention to the position of adolescence, arguing that this can be seen as a crisis of time. Freud (1917) likened adolescence to mourning the loss of internal objects of childhood when projections into the world are used as a form of reality testing, akin to mourning the loss of an external object.

The dual focus can be attributed to the co-existence of pre-genital, infantile phantasies that are re-evoked during adolescence, alongside the new genital sexual experiences that accompany the arrival of an adult body (Hoxter 1964 p.25). The push and pull of this period of life, therefore, is threaded with competing and contradicting desires for emotional closeness and for distance; conflicting desires of autonomy and inter-dependence, individuation and separation (Anderson 2004 p.164; Midgely *et al.* 2015; Parker 1993). The reworking of infantile dilemmas takes place simultaneously with a bid for freedom. The past colours the way the future ahead looks and the fears and hopes are assimilated, replayed, re-worked with the aim of belated mastery (Tonnesmann 1980). Defining what marks the endpoint and transition into adulthood is elusive and complex. Stambler (2017) emphasises the difficulties in pin-pointing what it amounts to. He describes a range of authors' views which together reflect a damping down, or reduced propensity for mindsets typical of adolescence and a gradual and undefined change which comes to resemble adulthood. Hoxter (1964) describes how adolescents *'evolve a synthesis of past-present and future adulthood….* [to generate] *a self-rooted personal history'*.

The reality of physical changes must also be contended with the, sometimes frightening, consequences of the adolescent's newly found capacity to have a real

impact on the world around them, whether that be in challenging the boundaries of home and institutions, or a newly found autonomy and freedom. The combination of these sees early oedipal rivalries and challenges played out by a larger, stronger, more independent person who really can fight, love, mate and kill (Anderson 2004). As an infant, these drives remained within the four walls of the home, but now they can be played out in the world and in a plethora of relationships beyond the confines of the family; a much more dangerous affair.

The stereotyped teenage gang or attitude can dominate society's negative image of adolescence. This image, however, may seem a little unfair when we consider the complexities and contradicting impulses that are being grappled with. Hoxter (1964 p.13) poses that adolescents are in fact providing a useful function for the rest of society. Oedipal rivalries and dilemmas present in the adult population are projected into, and safely stowed in this group, relieving the rest of society of their burden. Stambler (2017) warns that views of adolescents of today may not incorporate the additional pressures and dilemmas they are currently subject to, and in doing so can lead to pathologising anxieties that are, in fact, reasonable responses to the external stimuli. This culminates in a longer and more complex journey through adolescence making the stable endpoint more difficult to aim for and achieve.

Neuroscience

Interestingly, advances in neurological understanding of brain function and development has helped to clarify a picture of what makes adolescence unique, and to what extent the characteristics of this phase of life have a biological basis. Blakemore and Robbins (2012) found that adolescents are biologically predisposed to

take more risks than adults. They describe this, in part, as a consequence of a lag in the development of the impulse-control areas of the brain that limit risk-taking, behind the reward-processing regions that promote risk-taking. This valuable evolutionary adaption means that, at the age of sexual maturity, humans are more inclined to take the risk of moving away from the safety of their family group to mix their genes with unrelated individuals, and so promote the survival of the species.

Societal pressure

The present culture, and in particular the digital era and COVID-19 pandemic, have brought unprecedented changes to society. These changes contribute to, and are set against, a background '*maelstrom of a culture'* (Catty 2021 p.3) in which the predictable milestones of life for young people such as *'finding work, buy[ing] a home, or even, perhaps retir[ing]*' are no longer certain and are catastrophised in the press. The largely unregulated explosion of social media has changed life for everyone, but adolescents are managing the double impact of an industry that is largely being retrospectively regulated, and an adult population who are learning alongside young people about the pitfalls and dangers of this new and rapidly evolving mode of communication and information sharing. Companies experiment with different tactics to increase the time users spend on their platforms by improving digital strategies to increase addictive behaviour. In doing so they are, in effect, undertaking the largest experiment ever known and adolescents are a central target (e.g. The Social Dilemma, 2020). The sharpest minds in the technology industry are working hard to manipulate the population, and particularly young people, through the development of increasingly addictive social media platforms.

Inherent in adolescence is the move towards peer groups and away from the known family groups (Waddell 2018). Social media platforms provide an abundance of opportunities to escape the nest as the accessibility of online peer groups means that the scope for endorsement of any particular view is endless. With the drive towards independence, and away from dependence, this mode of contact with the outside world is immensely alluring as it can satisfy the innate need for separation. On the positive side, during this time of social trial and error, an appealing balance can be reached whereby one can reach out, via a device, and connect with like-minded people while also remaining hidden within the walls of your own home. However, the risks can be hidden too, not least the lost opportunity to gain the skills of interacting in the real world. Feelings of exclusion, isolation, negative body image, and the inability to allow embarrassing moments to get lost in people's memories, all add up to a highly stressful and complicated social interplay (Stambler 2017). At a time when the skills of social interaction are being played with and learnt about, mistakes are common, but when uploaded they aren't forgotten, but can be shared and re-emerge in perpetuity. The impact of technology on children and adolescents is captured in an increasing body of research which reveals negative associations between the use of screens and severity of mental health issues and addictive behaviours (Neophytou *et al.* 2021), quality of sleep (Hale and Guan 2015) and psychosomatic complaints in adolescents (Khan *et al.* 2022). Acheson (2022) provides an interesting summary of the literature on this.

The COVID-19 outbreak has no-doubt increased the impact of technology on the population and on adolescents as we all retreated behind a screen for reasons of safety (in some cases a welcome retreat). While nobody was immune to the impacts of the pandemic, and in particular the social restrictions, it hit those in adolescence at a

particularly difficult time. Just as adolescents were grappling with this tumultuous time of push and pull, they were pulled back into the nest, and the freedoms they need to explore the world and themselves were curtailed. As Catty (2021) elucidates, lockdown imposed a timelessness that does not equate with the adolescent time of change. We were asked to wait, but time is still passing and time moves fast when you're changing. The adolescent pace of life is inherently short-term which impacts upon the capacity to look ahead with the same perspective as an adult, giving lockdown an indeterminable quality. This is borne out in the data as an increase in the rate of referrals to CAMHS services has been linked to the lasting negative impacts of the pandemic (e.g. Royal College of Psychiatrists 2021).

Risk factors for adolescents

As described, the task of adolescence is not a meagre one. For some, however, the task is even more difficult. Children who have been exposed to traumas such as neglect, physical violence, sexual abuse and instability at home are at a disadvantage (Waddell 2018). Those who have experienced *'failures during infancy which lie outside the realm of infantile conflict'* (Tonnesmann 1980 p.16) are less likely to have successfully grappled with conflicts of infancy, such as the early oedipal situations, and consequently, have not had the same opportunities to establish strong foundations from which they can grow and develop. The necessity to return to infantile dilemmas is, therefore, more pressing. Compounding this are strategies, such as splitting-off rather than integrating experiences, necessary for the young infant to protect themselves, which can become habitual and maladaptive later in life. This can hamper the capacity to both return to infantile dilemmas, and to grapple with the tasks of separation in adolescence (Tonnesmann 1980). What does it mean to grow up when

you haven't been afforded time for infancy? In short, for this group, the task of looking forwards is further hampered by that of looking back.

This is borne out in the data. For example, a partially-randomised American psychiatric study that tracked 124 adolescents post-suicide attempt, identified a variety of social factors that could be used as predictors of the occurrence and timing of future attempted suicides. Among other things, a history of sexual abuse and a low cohesion of the adolescent's family were identified (Brent *et al.* 2009). In addition, the widely used and well-known Adverse Childhood Experiences study (Felitti *et al*. 2019) clearly shows that those who experience four or more categories of childhood exposure to adverse experiences have a four to 12-fold increased risk of depression and suicide attempts, among other health risks. In psychoanalytic terms this is similar to the concept of 'double deprivation' in which the external deprivation has created an internal deprivation (Henry 1974) that prevents a young person from accessing help: in this case the external deprivation has created a larger internal task that must be grappled with using blunter tools. Waddell (1989 p.16) quotes from Boston and Szur's book, *Psychotherapy with Severely deprived Children*:

> *The legacy of the abandoned child is usually not only the burden of being left with extremely inadequate mental resources to cope with a degree of pain which would overwhelm the most favourably brought-up child.*

Development of communication

It is not only the conflicts of the past that are re-evoked during adolescence, but so too are means of communication that were used in infancy. As infantile situations re-

emerge with the reworking of conflicts, there is an increased reliance on projective identification, particularly in relation to infantile impulses and to pre-verbal experiences. Acting out internal situations is also common and can be seen as a by-product of dis-regulation, but can also provide a clear communication of internal situations. Here, I am going to describe the development of modes of communication from a psychoanalytic perspective, and how these are returned to, or relied on in adolescence, particularly by those who are prone to serious self-harm or suicidal ideation.

Projective identification

Bion's (1962) concepts of reverie and containment shine a light on early communication. Building on Klein's (1946) description of projective identification as having a solely pathological function, Bion (1962) describes the use of projective identification between infant and parent as an essential aspect of normal, healthy development that can also become pathological.

According to Klein (1958) communication in the form of projection begins at the very start of life and arises '*as a means of deflecting the death instinct outwards'* to prevent the young child from '*being flooded by his self-destructive impulses'* (p238). Binding both the life and death instincts to the very start of life, Klein identified this need for self-protection as part of the reason for the life instinct's existence and which, in combating the death instinct '*leads to the ego taking in something life-giving (first of all food) and thus binding the death instinct working within'* (p.238). In practice, this relates to a young infant's need to remain in proximity to its caregiver and be fed in order to survive. When these needs are felt to be lacking, the infant may experience

an incomprehensible sensation related to an uncomfortable absence. Klein (1958) describes this as being experienced as anxiety that may overwhelm the ego. Similarly, Bion (1959) talks of the unbearable nature of these sensations that are not understood but are felt to be dangerous. In order to manage the threat felt to the young and undeveloped ego, the infant must expel the sensations, called *beta elements*. They are projected outwards and taken in by the parent. In experiencing this the parent identifies with the infant's experience of desperation in relation to the perceived threat. Generally, the parent is not as overwhelmed by this as the infant and instead translates it into a named feeling, e.g. hunger, and then resolves the problem i.e. feeds the baby. A parent uses their *alpha function* to convert the beta element into a processed alpha element (Bion 1962).

When contained, not only is the communication understood, and sometimes resolved, but the digested sensation can be named and can be re-introjected by the infant. The infant is 'fed' with milk, the modified beta element and a sense of the alpha function capacity of the parent. Winnicott (1963 p224) describes how '*the good-enough adaptation of the mother is essential'* for this process to be successful and that it must *'last over a long enough period of time'.* In a *good-enough* dyad, the infant introjects an object capable of thinking and digesting, which in turn enables the infant to build a capacity for alpha function for themselves (Bell 2001). Bion (1970) attributes this reciprocal communication to the root of language development. The infant is provided with a word that represents this particular set of stimuli, and over time, they are able to link the two and language can be used to communicate a feeling.

An adolescent subjected to trauma, neglect or insufficient reverie and containment, may not have had sufficient good enough experiences to allow them to have developed these capacities to contain themselves nor explain themselves. Instead, strategies such as deep splits between the fragile ego and terrifying, unmanageable anxieties are necessary and relied upon in infancy in order to survive the hostile environment. Klein (1958) describes how these deeply split fragments that are not synthesised with the ego, instead create internal instability and form the nub from which a harsh and punishing super-ego develops (p.243). The child, and then adolescent, does not benefit from the introjection of a containing object, and worse still, develops a harsh and hostile internal world that reflects the external world leaving them ill-equipped for the turmoil of adolescence. During psychotherapy treatment a patient can have a second opportunity to be contained and to introject the capacity to do that themselves and in doing so, revisit and hopefully amend the trials of infanthood.

Intrusive identification

Meltzer *et al.* (1982) used the term *intrusive identification* to describe the pathological or excessive use of projective identification, more akin to Klein's early descriptions. He describes an omnipotent and defensive process by which unwanted aspects of the self are forcibly projected and lodged inside another. This could be driven by an excessive, or extreme need to rid oneself of unbearable beta elements, possibly owing to a greater severity of perceived threat to the ego such as that arising from a frightening and dangerous environment. Likewise, a situation in which an infant's communications are not being met can lead to the need for more urgent means of communication; a stronger expulsion of beta elements that would, in turn, elicit a response in the care giver. This mechanism has a more aggressive, and, as the name suggests, intrusive

quality that can be an unpleasant experience for recipients. Strong visceral responses can be evoked in recipients, including clinicians, which are difficult to understand or to identify the source as arising from a primitive and unknown aspect of another person rather than from within themselves.

The personality is shaped by these experiences and defensive processes creating superficial and ridged structures that do not stand up to the burdens of the task of adolescence (Anderson 1998 p.72). Nonetheless, Tonnesmann (1980 p.3) highlights the presence of a desire for belated mastery that is perhaps more pressing. Just as the infant required the parent to engage in reverie to support the understanding of their minds, so too does the adolescent require the time and attention of another mind who can support them on this journey (Anderson 1998 p.74). Again, the Janus-faced aspect of adolescence can be seen as infantile conflicts and trauma are acted out on the world within the context of freedom and autonomous functioning. Children and adolescents who have been subject to this kind of childhood face a perfect storm; more to process with blunter tools.

Acting-out

Acting-out can be thought of as a developmentally appropriate form of expression that can form part of the task of adolescence (Stambler 2017 p.15) similar to play in young children (Slade 1997). Somatic experiences that are neither knowable nor say-able may instead be acted out in order to rid the self of associated feelings. Viscerally held experiences may have root in pre-oedipal and non-verbal infancy, they may relate to oedipal conflicts that are yet to be processed and understood (Stambler 2017 p.15) or they may relate to traumata, particularly, that which is enacted on the body (Bell 2001).

The obvious, and perhaps natural, mode of expression is therefore a physical one, as this is the place where the experience *is* known (Anderson 2004 p.164; Tonnesmann 1980 p.5). To avoid the pain of thought in adolescence, '*unbearable feelings are frequently followed by action'* (Anderson 2004 p.164) the power of which can relate to the extremity of the trauma experienced. Action of this kind can take the form of violent acts against the self (Waddell 2018) which serve to obliterate the capacity for thought about the unbearable feeling as well as the feeling itself (Hoxter 1964). In this sense the violent act is both internal and external. However, guilt is also evoked which, when added to the melee, further fuels the need to rid oneself of thought and so to repeat the action and further avoid past experiences to be encountered.

Freud (1914) described acting out as a compulsion to repeat previous experiences where the opportunity to process and understand had not taken place. Tonnesmann (1980) makes a distinction between *acting out* and *re-enactment*, the latter of which relates to normal developmental processes and the additional tasks faced by those who have experienced trauma. The former relates to instinctual impulses where there is a discharge of instinctual tensions associated with the 'wish' to evoke a response in others (Tonnesmann 1980 p.9). *Re-enactment* in adolescents is described as a '*phase-specific mode of communicating early traumata, deprivation and privation'* (p.5) where there is only partial awareness of the trauma. In this instance, there is a need for understanding in the '*service of ego development'* (p.15). Tonnesmann (1980) links this distinction to Freud's assertion that *need* must be responded to, as opposed to *wishes* which could be withstood and understood (Tonnesmann 1980 p.5).

In the case of re-enactment, not only does the content of the action provide '*material for the analysis'* (Tonnesmann 1980), but the repetition of this re-enactment can be seen as repeated attempts at self-cure and belated mastery (Tonnesmann 1980 p.16).

Projection into the body

> *You can't kill the body if it hasn't been split from the mind.* (Bell 2001).

During adolescence, projection into the body and acting out upon it is common and may relate to the high rates of self-harm (Waddell 2018). As a child's body develops it brings with it sexual maturation and the separation from parents; adult- and parent-hood appear on the horizon. At the same time as the excitement of new possibilities that come with a maturing body such as sexual potency and aggression, so too can this change be fearful, confusing and anxiety provoking (Campbell and Hale 2017 p.64). The changes can feel somewhat 'other' as rapid change to the known and familiar body turns it into something different. Particularly where trauma has been experienced, there can be a tendency to psychically split the body from the mind (Anderson 2004). As a feared or desired separate entity, it can then, as Bell (2001) describes, be acted upon, cut and damaged. This may be particularly necessary when damage has been done to the body in the form of physical or sexual abuse.

Motz (2010 p.84) has a more optimistic view of serious self-harming. She describes it as a communication that is object seeking: the damage to the body makes the psychic pain visible enabling it to be thought about which therefore encapsulates some hope of recovery. A pathway is opened for pain and trauma to be translocated from within

the body (on which the trauma was enacted) into verbal communication where words and language can be put to it, and understanding may follow. Unlike the calm desire to escape psychic pain altogether, which has a still, deathly quality to it, the desire to inflict pain on others or to witness their grief seems to have a similar object-seeking quality. The danger of course is that the satisfaction sought in phantasy can result in death which may in fact be accidental. The idea that a fatal blow to the body will also kill the mind in which it is housed, is not always clear.

An internal view of suicide

A psychoanalytic view of suicidal ideation in adolescence is complex. Beneath the surface of an adolescent presenting with suicidal ideation there is a heady mix of pressing internal tasks and external pressures. As we have seen, the capacity to manage these tasks is dependent on the internal landscape and the external environment. It is clear then that the additional tasks of those who have experienced trauma can tip this balance into becoming unbearable and perhaps death can be felt as the solution to unbearable pain. The rationale or phantasies around the meaning of the suicide or self-harm are as varied as human experience and relate specifically to experiences and meaning in that person's life. However, there seem to be some themes.

Federn (1929) locates the origin of suicide with the introjection of destructiveness, translated as, '*No one kills themselves who has not been wished dead by another*.' Attention is directed to a child who has introjected the carer's destructive impulses

which give rise to a dangerous interplay between infant and parent whereby guilt and the provocation of neglect exist within the dyad. This is introjected and what began as an introjection of destructiveness, becomes a dangerous internal self-destructive object; turned upon the self as a safer means discharge of aggression than to direct it outwards (Campbell and Hale 2017 p.70).

Anderson (2004) speculates on the appeal of death by suicide suggesting that '*suicide is an irrational act based on the very primitive idea that a psychological problem will be solved by the physical act of ending one's life.*' (p.164). This statement captures the relief gained from escaping an unbearable psychic pain, and perhaps the desperation that can lead to the desire to end one's life. In phantasy, the desire to escape unwanted aspects of the self may be felt possible by killing off a disliked part of one's self (Anderson 2004 p.165). Waddell (2018 p.191) describes a variety of meanings behind the desire to kill oneself that may be muddled and overlapping, but include identification with a betrayal, or a loss or abandonment by someone in the person's early history; it is from the feelings generated by these scenarios that the young person may be trying to escape (p.191). In addition, there can be confusion around what it is that will be killed, just the body and not the mind? Or the self but in identification with another? For instance, killing the body could be seen as a punishment or act of hatred towards the object who has let them down (p.188). All of these phantasies have in common an element of confusion to them. Equally, Campbell and Hale (2017) describe the deceptive calm demeanour of someone who has made the decision to end their own life who has finally found the solution to the interminable pain they are suffering.

Integral to these phantasies seems to be the desire to witness the effects that suicide might have on those left behind; the *'ultimate punishment'* (Waddell 2018 p.188). The timelessness of adolescence seems to engender this mindset where a part of the self could be killed off and another part would survive and be able to witness the grief and mourning at the loss. The late comedian Spike Milligan's (1918-2002) infamous joke that his gravestone would bear the words *'I told you I was ill'* seems to share this sentiment of getting your own back on the uncaring world that allows you to die rather than take your pain seriously. In the joke though, the irony of the price paid to make that point is captured.

Responding to risky patients

The complex stories and internal dilemmas that lie behind suicidal ideation and self-harm are brought into the clinic when a patient is referred to CAMHS. Communication of distress, fear and need are conveyed through a variety of means and are loaded with meaning accrued though the patient's developmental history and experience. A communication may have a function of ridding the patient of something, it may be object-seeking and linked with a desire for mastery of unconscious processes. Where a communication relates to infantile experiences, it may be non-verbal. Often, and particularly when non-verbal, the meaning behind a communication may be hidden from the patient, and also from the clinician at first. On receipt of a distressing non-verbal communication a clinician's response can only be appropriate when it is fully understood and may lead to a desire to turn away rather than towards a patient. While the aim may be to understand the communication, the process of bearing witness to

destruction, pain and risk is no light matter, as Motz describes of her adult patient (2010 p.89).

> *At times my awareness of her freshly scarred arms seemed to obliterate thought, and this seemed a form of projective identification with the function and motivation for her-self harming, where her violence against herself could replace thinking and blot out painful memory*.

The excruciating discomfort of the therapist is conveyed here and captures the bleak and painful difficulty of this work and how hard it can be to think in the face of such destruction. Sinason (1991) argues that it is precisely the disturbing, and at times cruel, nature of what is evoked within the clinician when in contact with dangerous and destructive aspects of the patient, that makes the work so difficult, and can lead clinicians to want to turn away, instead of towards pain.

This discomfort is also the patient's and there is a desire not to see the reality of their experiences. Waddell (2018 p.200) provides a rationale for a reluctance to relinquish defences that have so skilfully enabled the avoidance of pain: *'once hate is gone they will be forced to deal with pain'.* Motz (2010 p.91) emphasises the time required to build trust in order for someone to be supported in this task; something that has often been destroyed in the patients that she meets. Midgley *et al.* (2016 p.17) bring our attention to adolescent's awareness of the time required for trust to build in order for change to take place. The clinician is required to wait alongside the patient in difficult circumstances, sometimes keeping hold of the dangerous and aggressive or unpalatable aspects of the patient, while they move towards being able to think about them (Hoxter 1964 p.14). Papadima (2019) emphasises that clinicians must stop and

think before acting in the face of self-harm. Over time, though, in the same way as in the parent-infant dyad, a relationship and trust can build between therapist and patient and through this process, actions in the form of projection, and acting out using the body, are converted into language where they can be understood and thought about together as an alternative to violence (Motz 2010).

For adolescents in CAMHS, this process takes place during the complex time of developmental change when aspects of past and present experiences are being processed or re-worked. To engage in psychotherapy is a difficult task, even when change is desired and to catch an adolescent at the right time for them is also a difficult task. CAMHS services generally work with young people up to the age of 18 and not beyond. So, while the developmental age may be hampered by past events, '*the pressure on the individual to fall into step with a relentless march forward'* (Catty 2021) feels so troubling as time in childhood is limited by an end point arising from the requirements of a stretched service, and not from the needs of the patient. The relinquishment of projecting and acting out internal difficulties is challenging, and sadly, those most in need of support may not be able to use the window of opportunity available to them.

Further, a long wait for treatment can complicate the matter and result in treatment taking longer. Time spent on a waiting list can provide a feeling of security for some patients who, when they reach the clinic, no longer need support. However, in more disturbed patients it can evoke phantasies about those felt to be making you wait. The organisation and clinician may be seen to not care, or to be purposely making the wait particularly long. Or conversely, the patient and their family may have managed the

wait well and be hopeful of a ‘quick fix’, something that will solve all their problems. After this long and sometimes precarious wait, they are met by a clinician who has been imagined in phantasy for a long time. Inevitably, these ideas about their wait are projected into the clinician and into the treatment when it finally arrives and make take some time to unpick and for a true relationship with integral trust to build. Nonetheless, Parker (1993 p.10) stresses the reward for the time spent with patients: *‘When the baby has had enough, she will feel satisfied and not continue to cry’*. A link is made between the presence of infantile need in adolescence to what was missed when they were young as an adolescent will also cease to need to cry, or act out when their needs have been met. Therefore, there can be hope in risky behaviours and uncomfortable unconscious communications as object-seeking communications that relate to desire for belated mastery and possible change. Before something can be understood it may only be possible to communicate it in action – showing rather than telling (Motz 2010 p.86). Parker (1993) talks of delinquency as a sign of hope, as Motz (2010) so clearly describes in her patient and Anderson (1998) highlights the necessity for someone to accompany the adolescent with the terror of early trauma. The hope needs a home, and maybe that home can be in the clinician with whom they come into contact.

Psychotherapy aims to understand the communication or the dilemma behind risky or suicidal behaviours. Parker (1993) describes the need for reverie and understanding from an adult who, like in the early parent-infant dyad, can be ‘acted out on’ to enable what has happened to be processed so they can move forwards. Hoxter (1964) describes the use of the transference relationship in psychotherapy to aid an adolescent to bring their projections of danger and conflict back within themselves where they can be thought about and processed. The understanding of the patient’s

situation gained through counter transference and the experience of being projected into, enables the therapist to grasp the meaning behind the projections and actions so that they can be contained, understood and safely returned to the patient when they are ready. Although there is scant literature from the perspective of the patient, an empirical study by Paulson and Everall (2010) sought the perception of 37 suicidal adolescents' experience of psychotherapy and identified a variety of helpful aspects of the work, including enhanced self-understanding, the value of the therapeutic relationship and improved communication skills.

Time, waiting and services under pressure

Salisbury and Baraister (2020) conceptualised an idea of time that is waiting *with* as opposed to waiting *for* as a way of understanding what can take place in health care in which the value of time being allowed to pass is recognised. They use the Beckett play *Waiting for Godot* (1955) to emphasis the different state of mind and the impact on the subjective experience of time if one is not anticipating a certain end point, but instead focused on what is taking place as time passes. This, they link to the French philosopher in the early 20th Century, Henri Bergson (1859-1941), whose work and theories on time challenged the establishment of the day as he distinguished what he saw as *world time*, from *ego time*. Ego time, he explained, holds not only the passing time, but also the subjective experience of that time, citing the feelings one has whilst waiting for sugar to dissolve in water. Peter Høeg's novel, Borderliners (1993), about the experience of a looked after child trying to understand, and to escape from, a dogmatic and cruel children's home whose claustrophobic, strict adherence to time

keeps the institution running like clockwork, also explores this idea. The central character pursues detailed knowledge of all the timings and processes in the home to equip himself with information in the aid of internal mastery of this persecutory time. It also provides him with the practical capacity to evade capture as he wishes and plans to escape his timeless wait. The character, and perhaps the author, reflect on the *experience* of time:

> *When we say 'time', I believe we mean at least two things. We mean changes. And we mean something unchangeable. We mean something that moves. But against an unmoving background, and vice versa' …..'when we say that 'time has passed', then something must have changed – if nothing else, then the position of the hands on a clock, otherwise we would not know that anything had passed. At the same time something must have remained the same – if nothing else, then time itself, otherwise we could not recognise the new situation as something that has sprung from the starting point. The word 'time' contains a unity of movement and changelessness.* (p.230).

Whilst the character is straining to hold onto hope, his musings have a resonance with a more positive view of time passing in which something good can take place. Salisbury and Baraister (2020) describe psychoanalysis as an offer of time, *'a treatment* of *or* with *time'* (p.114) as the '*rhythm of psychic life fluctuates'.* They link this to the beginnings of psychoanalysis and Freud's elucidation of the process of 'remembering, repeating and working through' (1914) which does not ascribe a time frame for treatment, but that the treatment is the offer of repeatedly going over aspects of his patients' past until some point in the future when something may change. Salisbury and Baraister (2020) highlight the timelessness and a loss of perception of time as a feature of mental health difficulties from which a patient may emerge as their

condition improves. Catty (2021) relates the subjective experience of boundaried time within psychoanalytic practice that uses clocks and set days and locations as an aspect of treatment for a depressed person as they move from a timeless *ego time* back into contact with *world time*. Here the boundaries of the session can, in time, be felt as containing and supportive rather than harsh and cruel like in Høeg's children's home, but that realisation of their protective function may too, take time. The hope available to those who can allow themselves to wait '*with*' is highlighted by Salisbury and Baraister (2020) as they point out that the idea *'gestures towards at least the possibility of a future that might not merely be a repetition of a stuck past…*' (p.116).

The argument for an offer of time to treat mental health difficulties is strong, however, within the setting of stretched NHS service, it can't always be possible, and can at times be actively at odds with the culture of services. Osserman and Lê (2020) describe how reductions in NHS funding and a move towards 'efficiency' can be prioritised above the needs of patients and they describe how services can, at times, be run in a way that is counter to taking time; a situation that is understandable, given waiting lists and pressure on the NHS services. However, Wright (2022) undertook a study that introduced a waiting *with* approach to adults who seemed to be in a perpetual flux between crisis and being rescued which demonstrated how difficult it can be to wait with patients. Mirroring psychoanalytic practices, mental health staff in the study were encouraged and supported to take a thoughtful stance during their patients' crises, rather than to leap into rescue. Wright found that this was difficult for staff as the pull towards rescuing, or action, was strong, and at times, was felt necessary not only for the patient but also for the staff's own wellbeing. Patients who evoke urgent responses in clinicians may be providing the opportunity for the clinician

to fix something bringing relief to a clinician as their need resonates with the atmosphere of a wider organisation, and so there can be some satisfaction in the fast response. *Doing* avoids the pain of contact with feelings that can be so hard to manage, particularly when there are limited support structures in place (Waddell 1989). This approach can sweep in and as action takes hold there is a displacement of a slower pace, and work that may be focused on the less exciting, but important, field of preventative work. Wright (2022) saw this take place in a live way during her research project as clinicians' attention was drawn away from the clinical supervision space to address patients' crises that came directly into the space via telephone calls.

Wright (2022) emphasises the pressures that the NHS and its staff are under and links this with what was seen. She focuses on the temporal incompatibility of a '*crisis-stricken care system'* whose crisis has become *'chronic and enduring'.* A crisis by nature is short term and involves adopting an approach used to manage until it is over. A crisis holds the possibility of discovering what lies beneath; it provides a *'temporality upon which once can act, and in which critique and thus change are possible'* (p.316). However, crisis as an enduring phenomenon is different; as the hope of change diminishes what remains is an inclination towards action in the services of crisis management. An aspect of being 'in-crisis' is the perception of there not being enough time so when time feels short the inclination is to shift away from thought and reflection and focus on action, which can feel as if it takes less time and is therefore a solution to the crisis (p.318). She argues that the sensational aspects of this can also appeal to the public as they too *'defer the unknowability of the social and psychological'* (p.136).

Under the pressurised circumstances of a stretched service, prioritisation must take place to determine who can be seen and who must wait. The '*temporal hierarchy of risk (the likelihood of self-harm or suicide)'* (Catty 2021 p196) is a factor as the prioritisation of those engaging in physically risky acts are seen as more urgent than those whose words about suicide and self-harm may be metaphorical. As Catty (2021) illustrates, services have become structured around these notions using systems that identify those at greatest risk, and so must be seen soon, and those who are more able to wait. The *'shadow of potential catastrophe'* (p.197) affects and impacts upon the work of the clinicians and the use of safety plans and time frames within which patients must be seen can predominate. For instance, a requirement for a 'seven-day follow up' after presentation at Accident and Emergency may be as much about safeguarding the clinicians as the patients themselves. The fact that these measures of urgency may not relate to the actual relative need of the individual cases is perhaps known, but the certainty of procedures that set out a structure from which to work and prioritise can alleviate some of the anxieties that form the backdrop of the work.

A long wait for services and prioritisation of those who are seen to be at greater risk can perpetuate the problem. If resources are scant, then those who shout loud, and are alarming are in fact the ones who are seen. This doesn't necessarily lead to earlier treatment, but does bring them into the system and sets up a questionable dynamic whereby dangerous activity is responded to. Acheson and Papadima (2023) illustrate this point well as they describe a type of adolescent presentation they have noted that indicates an alarming level of disturbance, but once in treatment a responsiveness to therapy that indicates a far less disturbed picture than the symptoms would suggest. These comparatively well patients are seen quickly, but also respond quickly to

treatment. They attribute this to an unwell identity developed by adolescents under the influence of social media and current culture both on- and off-line which amounts to an '*adolescent crisis'* being told through the language of mental health, rather than an '*adolescent mental health crisis',* as they argue, it could seem to be. This group of adolescents cause great concern to those around them and, if left unchecked or if their unwell identities are reinforced by a failure to provide a culturally containing narrative, this way of presenting can, and has, perpetuated. The adolescents' drive for independence and an identity that differs from their parents can couple with dangerous ways of thinking that have the potential to involve extreme risk taking. It is up to the adult population to provide a calming narrative to guide and ground young people faced with this. Also, to differentiate those who are at serious need of help and those who can wait. This mirrors the unhappy task of deciphering when an individual patient needs time in therapy for the '*rhythm of psychic life* [to] *fluctuate(s)'* and who must be asked to wait for support.

This project

This review of the literature looked at the psychoanalytic view of adolescence. Against a backdrop of societal pressure, the wealth of work on the internal processes was considered and linked to more recent findings in neuroscience research. There is a large amount of literature on the negative impact on adolescents of early failures in care, and other adverse childhood experiences that make the task of adolescence more difficult. Literature exploring the link between the nature of early experiences and the development of verbal and non-verbal communication, including through risk

taking is described. The opportunity to address these issues with adolescents through psychotherapy is written about widely and in particular the need for time in order to treat patients. Literature on the offer of psychotherapy and the disconnect between an offer of time and the pressures on time within services is growing. However, no literature was identified that looked specifically at the particular impact of risky adolescents on psychotherapists in CAMHS clinics and how these clinicians manage this group of patients using psychoanalytic techniques, whilst also working within the context of a pressured service. As societal pressures on adolescents appear to be increasing, so too are the pressures on NHS services. A perfect storm seems inevitable (and may already exist) where these two factors meet and the pressures of clinicians working on this frontier, it seems, will increase meaning that greater understanding of this situation will be necessary. While there are many aspects of this that could be explored, such as the triage of patients or wider aspects of child psychotherapists' work, this study focuses on how the dual pressures that child and adolescent psychoanalytic psychotherapists are under affects the interplay between a pull to action and waiting with a patient.

Methods

This qualitative research project aims to examine the ways in which child psychotherapists respond to suicidal and seriously self-harming adolescent patients within CAMHS settings, specifically focusing on the pull to action or the capacity to wait and hold anxiety to allow things to unfold. Data was gathered through interviews with four child and adolescent psychoanalytic psychotherapists from the same NHS trust and aimed to capture the thoughts, experiences and views of their work with this group of patients.

Ethical approval for the study was granted by the Tavistock and Portman Research Ethics board (TREC).

Grounded Theory

Using the Grounded Theory approach (GT), I have sought to bring together the clinicians' experiences to gather an understanding of the factors that affect them and how this manifests in their work. Grounded Theory is a versatile approach that *'can adopt any epistemological perspective appropriate to the data and the ontological stance of the researcher'* (Holden 2007 p.269). It lends itself to this study as it allows different perspectives on the same issue to be brought together by examining the data from the ground up. Sbaraini *et al.* (2011) describe looking at data from the ground up as '*ask*[ing] *about what happens and how people interact'* (p.2). In practice, the rationale for a particular decision made by clinicians may arise from a variety of conscious and unconscious factors, for example, the clinician's specific training, the

patient and the circumstances in which they are seeing the patient. Grounded Theory does not attribute meaning but offers an explanation for patterns that are '*significant within the social setting under study'* (Holden 2007 p.268), consequently it will allow a variety of factors to integrate in order to generate a fuller picture of what is happening. Holden (2007) suggests that the hardest aspect of GT is the capacity of the researcher to be open to theories that differ from their preconceptions and to avoid prescribing the scope. Bearing this in mind from the outset enables greater reflection on what I bring as the researcher and the bearing of this on the results.

Data collection

Recruitment

Interviews took place with four Association of Child Psychotherapy (ACP) registered child and adolescent psychoanalytic psychotherapists who were working, or had recently finished working, in a Child and Adolescent Mental Health Service (CAMHS) Getting More Help clinic (GMH) within one specific NHS trust. Participants were initially recruited via direct emails sent to all eligible clinicians currently employed by the Trust. The email gave some details of the project the inclusion criteria and made a request for contact should they be interested in taking part (see Appendix 1).

Inclusion criteria meant that the pool from which to recruit was limited and only two participants were recruited in this way. To increase the sample size, several follow-up emails were sent and eventually direct contact was made with clinicians who had recently left the service; two additional participants were recruited in this way. It had

been anticipated that recruitment may be difficult and provision was made within the TREC application for inclusion of past employees, should this be necessary.

The sample size reflects both the size of the study and projected ability to recruit to the project. Between four and six participants were originally sought and while the final number of participants was at the low end of this, it represents roughly a third of the eligible participants.

Inclusion criteria and rationale

Inclusion criteria were child psychotherapists' registration with the ACP with at least two years post-qualification experience in a CAMHS clinic within this NHS Trust. The premise for the project was to look at how a certain theoretical stance interplays with the pressures of a CAMHS clinic when encountering adolescents presenting as a risk to themselves. Therefore, it was imperative that participants' theoretical underpinning was consistent with this and with one another. Registration with the ACP and employment as a child psychotherapist in the NHS requires training of this nature, and was therefore taken as a proxy for this.

The trust in which I undertook this research covers a large, predominantly rural, geographic area. The i-THRIVE framework organises service delivery; patients are directed into one of four groups dictated by their level of need. Child psychotherapists are solely employed within Getting More Help (GMH) teams catering for '*Those who need more extensive and specialised goal-based help'* (National i-Thrive Programme 2023).

Across the Trust, GMH teams have similar profiles; child psychotherapists typically work alone or as part of a small group of part-time psychotherapists in a wider team in which psychoanalytic thinking is not at the fore. Instead, shorter therapies such as Cognitive Behavioural Therapy (CBT) predominate and are delivered by trained CBT clinicians as well as Mental Health Practitioners, such as social workers and nurses. The Trust is commissioned to work with 5- to 18-year olds but as risky adolescents place the most pressure on the services in terms of numbers and nature of their presentations, delivery becomes structured around responding to this group and dominates the workload of the majority of clinicians.

It was this particular culture and organisational set-up that I was interested in understanding more about and so recruitment was focused here. Owing to the similarities of the set-up of GMH clinics across the Trust it was anticipated that the cultural or institutional pressures that clinicians are subject to is similar. In limiting data collection to this trust, I aimed to limit the external variation between the clinicians and thereby increase the comparability of the data and aid the process of data analysis. A consequence was that I had existing relationships with all potential participants. This was beneficial as, to varying degrees, an existing level of trust between myself and the participants appeared to facilitate the discussion of sensitive material. However, the challenge for both myself and participants was to adopt different roles with one another and interact as interviewer and interviewee. Thoughts and issues that arose during the interviews that related to the implication of particular existing relationships and my knowledge of their experience and position in the organisation were recorded using memos (see below) to ensure that they were captured and the bearing on the

data and findings could be considered to ensure they were enriched rather than constrained.

The requirement for two years post-qualification ensured that substantial experience of working in the setting had been gained beyond the time when the clinician's caseload and experience would have been determined by their status as a trainee. The latter would have enabled the clinician to hold a smaller case load with closer support and supervision, and an assumption was therefore made that the pressures on this group of clinicians would differ from those post-qualification.

Although valuable and interesting perspectives on this area of research reside in the minds of the young people in question, I decided to focus on the perspectives of the clinicians working with this group, rather than the young people themselves. I took this decision for a number of reasons: first, it was anticipated that recruitment may be skewed towards those who had experiences at different ends of the spectrum, either positive experiences in treatment, or perhaps negative experience of CAMHS and this may have a disproportionate bearing on findings. Second, ethical issues around seeking adolescents with whom I have no prior relationships to recount details of highly distressing episodes in their life would be complex. Finally, and perhaps most importantly, clinicians are in a position to draw on a range of experiences with patients. I anticipated that this breadth of exposure would enable participants to identify trends and commonalities in the way young people present to the service, and in the way that they, and the organisation, respond. It was this aspect of the relationship between suicidal young people, and CAMHS that I was most interested.

Setting up the data collection

Interviews were planned to take place in person if possible, but where necessary, for example under COVID-19 related restrictions, an online platform was used. In practice, two of the interviews were held during periods of restriction that prevented face to face meeting, and a further two were undertaken remotely due to the distance that would have been required to travel in order to meet in person. The normalisation of meeting via online platforms during the COVID-19 pandemic influenced the decisions not to meet in person.

All interviews were recorded on two devices to ensure they were captured. Unfortunately, one interview was affected by technical issues that prevented the participant from being heard and impacted upon the audio recordings of the interview. Consequently, a second interview with the same participant was conducted. This was done in person as the COVID- 19 lockdown restrictions had changed.

Morse (2007) describes, when using Grounded Theory, the first interviews should have a scoping element to them and influence the data that is sought in subsequent interviews. To this end, the initial aim was to begin the interviews with the most experienced clinician who, it was anticipated, may have the most relevant experience with which to shape the research direction and boundaries. Building on this with data from subsequent interviews, the plan was to undertake Theoretical Sampling which aims to reach saturation point of understanding for areas of research (Bryant and Charmaz 2007) by seeking out individuals who can '*serve the developing theory'* (Sbaraini *et al.* 2011 p.3). In this way, understanding of the areas of interest are

shaped including exploration of ideas that pose different viewpoints, thereby preventing the phenomena being too narrowly defined (Morse 2007).

In practice this wasn't possible: the small pool of potential participants meant that an opportunity to interview someone could not be lost once interest was shown. Consequently, when interest was shown in the project the momentum was seized upon and an interview was arranged as soon as possible regardless of how they may have influenced the direction of data collection. Nonetheless, earlier interviews did inform the content and approach of later interviews and adjustments were made to improve the quality of the data collected. For example, during latter interviews participant were guided towards case examples earlier on in the interview as a hesitancy to speak about the details of cases was noted. A pilot interview was undertaken prior to seeking participants in order to get a sense of the process and to refine the questions if necessary.

Interviews

Five interviews were conducted; four digitally and one in person. They were semi-structured which allows for similar information to be gathered from each participant whilst also allowing for some flexibility about the thoughts and ideas that were shared (Hollway and Jefferson 2000). A document was shared with participants in advance of the interviews to provide some additional context of the study. It was felt that this may be helpful as participants could reflect on the issues in advance and identify relevant case examples (Appendix 2).

Participants were asked to share details of their roles with their specific CAMHS team and the nature of their contact with adolescents at risk from themselves. They were asked to think about cases or situations in which difficult decisions had to be made around risk, what they felt influenced their decisions, and the short and long term impact that this had on them. In particular, the focus of interest was situations where action was taken in relation to a presentation of risk and how the clinician came to a decision on what to do, or what not to do. The impact of COVID-19 restrictions was also discussed.

Interviews were informal and guided towards the information that was of relevance to the project. Given the subject matter, and the request for clinicians to reflect upon their own actions and responses to distressing cases and situations meant that this approach was essential. As described by Morse (2007), an interview in which trust is gained and the interview is guided rather than rigidly directed is '*essential for obtaining good data'* (p.230).

Memo writing

Thoughts and ideas that occurred to me during data collection and analysis were noted down and recorded in the form of memos. These were dated and linked to the stage of the research when they arose. Memos were drawn upon when during analysis, writing up the results and when discussing the findings. This aspect of the data collection process provides the essential element of GT by keeping the analysis grounded in the data and incorporating the researcher's position on the data in order to inform the analysis and growing theory (Bryant and Charmaz 2007).

Data analysis

All interview recordings were listened to and transcribed. The transcripts were read through at least twice to gather first impressions and thoughts on what had been said and to get a sense of the commonalities and differences between the participants. Hollway and Jefferson (2000) emphasise the intrinsic value of understanding the context in which research participants are speaking, and in particular how the relationship between researcher and interviewee impacts upon what is and isn't shared. Consequently, data was not anonymised during the analysis and results to allow for thoughts on reflexivity and to ensure the particular relationships between myself and the interviewees could be taken into account.

Transcripts were analysed line by line and open codes were attributed to each line or section of text. Multiple codes were attributed to text where appropriate. Each transcript was coded after the interviews and then earlier transcripts were returned to in order to validate that the process had not evolved significantly as experience was gained. This process revealed that it was necessary to re-code the first transcript, but that subsequent transcripts had a sufficient degree of homogeny in approach. Had there been a greater number of interviews a process of selective coding to latter transcripts would have been performed whereby only data pertaining to the areas of interest would have been coded. This serves to augment the developing theories as part of the process of Theoretical Sampling as described above (Sbaraini *et al.* 2011).

Open codes were gathered into theoretical codes and were checked and re-checked for meaning to ensure they fit within the same group (Holden 2007). Initially fifteen theoretical codes with several sub-themes were identified. Over time and through repeated reading and checking, these were reduced and some were discarded as they were not relevant to the research question. The process of honing the codes and of eliminating data felt to be superfluous is complex and challenging but is necessary to ensure the data is robust (Holden 2007). With repeated examination, some of the themes and subthemes were not considered to be independent categories, for example, there was initially a theme called *Communication* which was later felt to be obsolete as this set of codes were common to several other themes and were more informative when considered within the specific context of what was being communicated. Eventually five themes were identified.

Results

Five themes were identified from the data.

Theme A: Acting and waiting: clinicians' responses to patients

1) Allowing time to pass: waiting with a patient as a form of treatment

2) Action as part of the therapeutic process of waiting with a patient

3) When action is necessary

4) Action without thought

5) Experience acquired over time

Theme B: Management of risk by the organisation and by psychotherapists

1) Organisation resists acknowledging systemic anxieties

2) Psychotherapy interventions reduce risk

3) Unspoken acknowledgement of psychotherapist's capacity to carry risk

4) A defended culture is difficult to change

Theme C: '*No clinician should act as an island*'. Sharing the load

1) Like-minded colleagues

2) Time for sharing

3) The action of sharing

Theme D: The difficulties posed by working with risky adolescents

Theme E: Impact of COVID-19 lockdowns on work with risky adolescents

Introduction to results

Below, these five themes will be discussed and evidence for them will be provided. Unconventionally the first Themes to be explored will be D and E. The rationale for this is that these themes are not directly relevant to the research focus, but are crucial contextual aspects of the project. Theme D: *The difficulties posed by working with risky adolescents*, is contextually important as the strain that arises from anxieties associated with risky adolescents is significant. It can deepen cracks and unhelpful formations within individuals and within systems. Specific attention was not drawn to this through questions put to the participants, but thoughts on it were central features of all interviews. Theme E: *Impact of COVID-19 lockdowns on work with risky adolescents*, is included because, in the era of COVID-19 and its aftermath including the fears and strains of the lockdowns, it would not be appropriate to exclude it. Data on this arose from asking specific questions about the impact of the pandemic as it may have had a bearing on decisions made by clinicians to act or wait with patients.

Theme D: The difficulties posed by working with risky adolescents

All participants unequivocally shared how difficult it is to work with adolescents who are prone to, or engage in, risky activities. High levels of anxiety are associated with this patient group for participants and the organisation as a whole, as well as for patients and their families. This was expressed explicitly in what was said, and through the manner of the participants' communication. For instance, a sense of pressure and anguish was conveyed in tone and mannerisms such as mid-sentence sighs, laughing or through the use of certain phrasing. Furthermore, how and when information on this was shared during the interviews varied. This may be accounted for by relative levels of experience, as well as the personal style of the participants, but seemed to relate to how comfortable participants were to share the personal impact it had upon them.

Participant 1 (P1) was the sole male in the study. He was an experienced clinician working as a lone psychotherapist in a rural clinic. He had support from a line-manager based in a neighbouring clinic. The interview began by focusing on the difficulty of working with risk for all clinicians. He expressed how this is particularly difficult for psychotherapists especially when working alone. He shared how underprepared he felt when he was a newly qualified therapist, giving the sense of abandoning training school, which in some respects I was representing as a current trainee.

It is important to note that P1's sense of ill-preparedness when newly qualified reflected his unique training experience and was not necessarily the experience of

other participants, nor my own experience. While all participants were trained at the same institution, none were concurrent.

Similarly, Participant 2 (P2), was an experienced clinician working as a lone psychotherapist in a small clinic. Difficulties posed by the work were conveyed in less explicit terms than P1. However, the manner of delivery and sighs set into speech gave a clear indication of the presence of stress and tension. Our existing professional relationship may have impacted upon what was comfortable to explicitly share; maintaining the position of a containing, senior colleague as well as shielding me from the difficulties of this work may have curtailed her freedom of expression. Further, her confident parlance around this topic perhaps reflects the ways in which she personally engages with, and manages, the difficulties and complexities of working with this group.

Participant 3 (P3) was the most experienced clinician in the study. She had spent the previous 20 years working in a remote CAMHS clinic and had recently retired. I felt that confidence in her opinion and the clear and wide gap between our levels of experience, as well as her direct style of communication, freed her to be clear and honest about how very hard this work can be.

Participant 4 (P4) was interviewed twice because of technical difficulties during the first interview. She was the least experienced clinician and had recently left a CAMHS clinic. While not explicitly expressed, her reasons for leaving appeared to relate to difficulties posed by working with risky patients without sufficient support. The difficulties were implicitly conveyed and appeared embedded within her thinking.

Explicit expressions of the personal impact of the work were made, but later in the interviews when compared to other clinicians, and more so during the second interview. Again, I felt that her style of managing difficulties of the work were reflected in the delay in explicit discussion of this topic, and emphasis at the start of the interviews was particularly around deficiencies within the organisation that compounded the difficulties. It may be that increasing trust between us during the interviews enabled thoughts on this to be spoken, or perhaps issues around the organisation were initially more pressing so filled the early part of the interview.

Working with risk has a significant impact upon clinicians

All participants reported that work with this group has a negative impact upon them. This point was made particularly strongly by P1, the only participant who had experienced a patient's suicide within their team. There is a genuine risk to clinicians as P3 points out, '*You have to live with the fact that* [the patient] *might have done something dangerous'.* Clinicians must manage their own feelings and thoughts about these difficult and frightening possibilities, alongside projections from the patients of anxieties and uncomfortable or unpalatable feelings. The tone of communication, at times, conveyed the insurmountable difficulties that this poses and how complicated it is to find a way of working through this.

In describing a patient who had a knife at home, P1 took a heavy breath mid-sentence conveying the weight and anxiety that he holds in relation to this case:

> *You know, I wasn't looking for a hundred percent that he was going to give it to his mum, he was going to hand it over, but there was some degree of*

> (breath in)…… *you know recognition, of what the limit would be in terms of…. Things weren't safe enough.*

As well as the clear strain of this situation on P1, the lack of clarity conveyed how complicated and difficult it can be to report upon actions, thoughts and decisions that relate to this case, and more widely, to this topic.

Impact of communications within the work

Clinicians described difficulties with the essential therapeutic task of being open to communications from distressed patients. This particularly relates to taking in communications, and holding and tolerating projections of anger, fear, helplessness etc., sometimes for extended periods of time.

The quality of the impact that a patient's communication has on the clinician was discussed widely and included those causing confusion which creates difficulty in ascertaining whether a risk is genuine, and difficulties in deciphering phantasy from a much more dangerous acting out in reality. The latter was felt to be particularly true when risky behaviours arise from a drive to express something that resides in the unconscious and is not yet understood as it will inevitably be forceful and liable to repetition. P3 described the necessity to understand the meaning of risky behaviour as the task of psychotherapy in order to reduce risk by preventing the need for repetition of risky acts.

Provocative communication was described by P1 and P4, such as the glint of a knife that was hidden beneath P1's patient's pillow and then forgotten about the following

week, and P4's patient who was felt to be using risky activities to highjack the therapy and pull the therapist out of her role:

> *Well, in some ways, there was an attempt to drag me away from being a therapist and to become, you know…. It was quite tantalising, you know, 'Oh, I feel dizzy…I've only had a cup of tea today' and to see, would I ignore that and carry on? Or would I be dragged into 'doing'?*

Here, the pull to *do* something is strong and the capacity of the therapist to remain in a thinking mode is challenged. This was also true of another patient of P4's whose communication was described as having a helplessness, sadistic quality whereby she seemed to take some pleasure in disavowing her own volition and passing all of the concern and agency to the clinician. The clinician is left holding the baby, as it were, and also the safeguarding issue:

> *So, they're letting you know about something because they're basically saying, I'm, I'm helpless. I can't manage without you. I need you to, you know, call the hospital because I've taken an overdose. I'm coming here to tell you.*

By contrast, P2 shared an example of when the necessary course of action is clear but nonetheless anxiety provoking:

> *I guess it could be that there's a young person that talks to you with such conviction, unwavering conviction, that this is their plan of action. Then that is more than enough*....[trails off].

The phrase that P2 uses, *'more than enough'* gave the sense of a collection of different aspects of the communication leading to the conclusion that it is to be taken seriously and there is a genuine risk here. The trailing off sentence gives the sense of there not

being enough known and I too get an experience of the uncertainty and anxiety evoked by not knowing.

Participants also remarked on young people consciously deciding to do certain risky things in order to be seen by the organisation. These were attributed to a young person's knowledge of how the organisation operates and the necessity of the organisation to respond to them.

Bearing the load

It was acknowledged (particularly by P3 and P4) that bearing the psychological load of the work can be impactful, however, Child Psychotherapy training and practice develop the capacity to do just this, to hold significant anxieties and distress. P1 identified how powerful this can be; one can have '*a real kind of impact'* on patient's lives for the better, but warned of the importance of being careful and delicate with that power.

Participants described the capacity to support colleagues to hold and bear distress. P2 described supervision of a colleague for whom anxiety was evoked by a patient in their penultimate session. The patient said that they may not live long enough to come to the next session. P2, who knew the case well, felt confident there was no risk in this communication, and instead attributed the anxiety evoked to the message behind the statement of riskiness as an unconscious response to the sessions ending with the clinician:

> *She said to the worker, I won't see you next week for the review because I won't be here. So, the worker understandably was very anxious. There*

> *was very much a sense that this was a test. It was, it was, it was punishing. It was a test about 'Can you tolerate this?'.*

The patient's communication was powerful and it is clear that the clinician is put under pressure.

Theme E: Impact of COVID-19 lockdowns on work with risky adolescents

The impact of COVID-19 restrictions did not have any relevant bearing on Participants 3 or 4: neither clinician held a Child Psychotherapy post within the NHS during the pandemic, consequentially both interviews solely focused on work prior to this.

Participants 1 and 2 spoke clearly about their responses to working with risky patients during the various phases of the COVID-19 lockdowns. The message was unequivocal: if there was an indication of risk the patient must be seen in person, particularly when assessing patients whom they didn't know, for example P2 said:

> *Bottom line, if I have to assess an adolescent that I feel is high risk, and it's a new assessment, I meet them face-to-face.*

The clarity and firmness conveyed a sense of the absolute necessity of seeing the patient in person. The emotional communication told of the dangers of working with this group; dangers that could outweigh the risks related to coronavirus.

P2's rationale for meeting in person was, '*You miss so much in regard to non-verbal communication, the nuances etcetera', and* P1's rationale was similar: *'I suppose, at the end of the day, my attitude was actually, you know, there's far more from face to face work that you get from video work.'*

The importance of meeting in person to *'peace of mind'* was shared by both P1 and P2, giving a sense that they felt more able to accurately assess the patient, and therefore be confident that appropriate steps would be taken to ensure patient safety

when working face to face. The period of time during which in-person contact was not possible at all was relatively short, a matter of weeks. Despite this, P2 shared how difficult this was: '*At the beginning of lockdown, there wasn't that option. So that was, that was very tricky'.* Her tone conveyed the weight of this on her.

Meeting during the pandemic required the use of Personal Protective Equipment (PPE) and involved wearing surgical gloves, plastic aprons, a face mask and in P2's case, also a clear plastic visor. Both clinicians felt that the barrier of PPE equipment, particularly masks covering the face, did not outweigh the advantages of meeting in person. Due to the huge changes in the external world both participants found patients to be amenable to the necessity of PPE.

Transition to remote work was felt to be possible and effective when a sufficiently holding relationship had developed prior to the lockdowns.

Theme A: Acting and waiting: clinicians' responses to patients

Allowing time to pass: waiting with a patient as a form of treatment

All participants reported the value and benefit of time with patients describing it as essential to their work and to the success of treatment. This was particularly true for patients exhibiting risky behaviour or suicidal ideas.

Knowing a patient informs work with them

First and foremost, participants highlighted that time is needed to understand patients' presentation, and to think about, and decide, what to do. For instance, P3 described extensive discussions between herself, a patient, the parents and a psychiatrist about whether antidepressants should be recommended. Time was required to think about different aspects of the dilemma including taking into consideration the patient's presentation, relationships between different parties and potential impacts of a given decision.

Over time patients are able to share their stories and have an experience of someone listening: *'Simple. Young people want a chance to be heard',* P1 said of his patient who had previously been in a series of short-term task-focused therapy treatments. In addition, P1 explained that knowing a patient allows you to '*get a feeling'* about the level of risk behind communications so they can be understood in context. In this way responses can be tailored to that patient at that time, and so increase the therapeutic nature of the interaction. Participants reported that understanding a patient in this way can help the psychotherapist avoid reacting too quickly which can be '*actively*

unhelpful to act' (P2) in circumstances when pathology would be reinforced by taking action. Conversely, it can also serve to ensure timely reactions to risky situations. For instance, P4's cumulative knowledge of her patient meant that she understood the significance of a casual comment made about skipping a meal:

> *There had been other indications. But at this point, you know, I said, I feel that it's important that we just make sure…that you're ok, that you're safe, in practical terms first.*

P4 was aware that her patient was asking her to hold anxiety about health on her behalf, leaving the patient free to feel unconcerned about herself. This understanding made the dangers to the patient clear to P4 and she made a swift decision to step out of the classic psychotherapy stance of interpretation, and shift her attention to physical care of the patient. The full significance of a small and casual comment could be understood as something warranting of her attention, and perhaps immediate action.

The value of time spent with a patient

Participants linked appropriate responses to patients with the development of trust within the therapeutic relationship acquired over time. A patient who trusts the clinician is more likely to remain in therapy and continue to build the relationship. P2 shared how a strong relationship can and improve the clinician's capacity to contain the patient's anxieties:

> *And I've been seeing her over a length of time. And she knows that she has a session with me next week. Where we can, we can, we can pick this up.*

The quality of this description was calming and containing and the feeling of being held was conveyed to me through P2's tone. I gained an experiential understanding of the feeling she conveys to her patients, and the stability and calmness that she is able to evoke in them as they begin to trust her.

Participants reported that knowing a patient enables them to risk increasing a patient's level of distress by addressing more difficult issues through interpretation. P2 took a teaching stance as she warned that this must be done carefully. She also made the counter point: at the other end of the spectrum when you don't know a patient at all, it simply isn't safe to interpret as you don't know what the impact will be on the patient; they are not yet able to rely upon their relationship with the clinician to support them if an interpretation elicits difficult and uncomfortable feelings, to do that takes time.

Waiting enables change in the patient

Participants highlighted that it can take time for patients to develop the capacity to clarify their own thoughts, learn how to put them into words and to begin to accept new or different ways of thinking. Prior to a verbal engagement in psychotherapy, reliance on behavioural acting-out continues as the primary form of communication or defence. During this time clinicians described needing to hold angry, frightening, hopeless, anxiety-provoking projections on behalf of the patient whilst they develop the capacity and strength to accept their return.

Participants described patients' ambivalence about engaging in psychotherapy enacted through a form of closeness and distance. Patients were perceived to maintain some distance as this felt safer, but were also drawn towards clinicians in the

hope of some support and change. Participants shared that as time passes the benefits of the therapeutic alliance, such as trust building, become more obvious, enabling patients to engage more fully in the therapy. For example, P1 described a patient who chose to be in psychotherapy and would share aspects of his experience during sessions, but would *'only go so far'*. This closeness seemed troublesome to the patient and would be followed by a period of pulling away. Non-verbal, risky communications, or acting-out, followed which inevitably brought them back into contact. P1 felt the patient needed to have some control over the interactions which took P1 on '*a merry old dance'.*

P1 described this work, apologetically, as '*Applied Psychotherapy'* through which he kept the patient in mind, responded when the patient was able to engage therapeutically or when he was acting in risky ways. He anticipated that, over time, the patient's capacity for verbal communication would continue to improve hand-in-hand with increased trust in P1. This would allow him to engage more fully in psychotherapy and reduce the need to act-out, but for now this was what he could manage:

> *So there seems to be enough in terms of structure from these contacts that we have. As a team, that seem to sort of be enough to hold him, but um, you know, so there's a bit sort of a sense of him coming…I know that's not very psychoanalytic but er, he sort of comes so far and wants to get so close to somebody but then wanting to back away, and that seems to be his pattern.*

P1 apologises for this as if there is some problem with being 'un-psychoanalytic' and uses this term of *Applied Psychotherapy* rather defensively, as if he is pre-empting a

criticism of this work. However, as he talked more about this patient, his apologies for the approach reduced and he conveyed how closely and carefully he was following this patient, allowing him to have as much contact as he could manage, and in this way, begin to benefit from their contact.

Patients with complex external situations need more time

All participants reported that the complexity of a patient's external situation impacts upon the time needed in therapy. For example, P2 described the additional time needed for a patient to settle into the work after a recent discharge from an inpatient unit.

The rationale given by P1 is that the complexity of the external world can cause the internal world to be more complex; in other words, the nature of a person's difficulties is more complex so takes more time to understand, it often needs to be thought about with a network of professionals, perhaps with competing priorities, and more complicated decisions need to be made. P4 described the same phenomenon from a different perspective: change can be surprisingly fast when external factors are not complex, such as supportive family structures and young people who are:

> *….relatively high functioning, who have a specific problem that is affecting them like a pressure point in a very kind of profound way. And they are desperate to get out of that. They have a real desire to change. So, in those, but those cases they can, it's amazing how quickly they can work.*

Reduced time pressure on treatments can reduce risk

A decoupling of risky behaviour, or improvements seen in patients, from the offer of treatment can reduce the level of risk in some patients. P3 described a patient who had been seen in CAMHS for a number of years and *'nothing was changing'*. She had been offered a series of short interventions that had been closed each time signs of improvement were noted. Repeated escalations in risk followed, as did subsequent re-referrals. P3 felt the underlying reasons for her distress were not yet understood and that the patient was communicating her distress through risky activities which elicited the support that she needed, i.e. a therapeutic intervention, and were perhaps being perpetuated by the risk of discharge. P3 described the implicit dangers in this set up and emphasised that improvements are disincentivised as they lead to discharge. P3 addressed this issue with the offer of a year of work regardless of improvements or risk:

> *'It'll be a year', you know, 'and even if you get better within the year, we are not going to stop. We are going to stick with it. It's not going to be that if in three months' time, you're feeling a bit better, we're going to stop. So, whatever happens if you're feeling better, or if you're not feeling better we're going to carry on'. And that actually made a massive difference to her*.

Action as part of the therapeutic process of waiting with a patient

When referring to action, participants made reference to a variety of processes that P4 named safeguarding. These were actions required by the organisation to protect both the patient and the organisation by ensuring physical steps are taken to reduce

the possibility of harm and to ensure that people in the position to support the patient are aware of the issues and risks relating to them. Action of this nature was referred to in passing and described as separate to psychotherapy, even when it was with the same patient. Action included *safety planning* with the patient and family, drawing up risk assessments, and escalating concerns to social services. Sometimes the action was identifying a colleague who could take responsibility for these kinds of actions. There was a sense that these actions just had to be done, but were not the main focus of participant's thoughts on action.

Instead, the form of action that seemed the most powerful, and appeared to preoccupy the participants, were dilemmas around whether or not to share information with parents (and sometimes the network) and when to do so. All examples given were of patients living with their parents rather than with carers. The decision to act in this way, stepping outside of the theoretical bounds of the psychotherapist's role, was difficult but was reported as a necessary aspect of treatment with this group of patients. Action was more prevalent while clinicians got to know their patients, and before patients were able to understand their own actions as communications related to their internal worlds.

There were times when participants felt they were given no choice by the patient to share information about them even if it would have an impact on the therapy. For example, P4 took action when a patient with dangerously low weight shared that she had not eaten that day. The advantage to the patient of taking action was felt to be gained through discussion afterwards as they may begin to feel contained and

understood. It was also felt to play an essential role in the patient's assessment and gathering experience of the clinician's trustworthiness and strength.

In addition, P4 links this to the resurgence of infantile impulses during adolescence which elicit a response to be both physically and emotionally cared for:

> *So, they stand together, so, I guess, in my mind, it's you know, I guess babies need emotional connection, but they also need physical connection. So, I think that the, the role of the therapist-mother is to think about the baby but they can't ignore the fact that the baby needs physically holding.*

Participants explained that discussion with patients about planned action was integral to their work, and aimed to build or retain trust rather than destroy it. P3 describes gaining her patient's agreement to share concerns with her mother:

> *I mean, I would just come to a point in the session where I would sort of say something about the fact that I was really worried and I was thinking she couldn't do it all on her own, and that we would need to think with her mum about how her mum perhaps could support her. So, when we called her mum in it was always with her agreement.*

Again, here it seemed that the complexity of a case impacts upon decisions around taking action; the greater the deficiencies in the external holding structure for the patient, the more that may be required of the clinician outside of the therapy space. P4 explains that the reality of a patient's situation must be considered:

> *And, you know, you can think together about what you're prepared to do. Of course, it also depends on what, you know, in reality, what external support does this young person have?*

P3 described a situation in which a patient's worryingly low weight was compounded by deficient care at home. Consequently, P3's threshold for taking action was lower and she more readily alerted the parent when she felt concerned:

> *I mean she was very, very thin anyway. But of course, not eating was, it was never quite clear how much she actually provided for herself, you know, and not being provided for, and the tension was so massive within the family that if they did sit round the table, she just couldn't eat, because it knotted her stomach. Basically, she felt sick. But she was very, very thin so that was a big worry. …. But I think with her, it ended up that we took a slightly differ tack, in as much as, in some ways it was clearer, I think in my mind it was clearer when she was, when she couldn't do it on her own, and when I felt that I needed to talk to the mum.*

Not only do deficiencies in the home environment lead to earlier or more frequent interventions, but participants described inflated risk levels and greater dangers with the same risks for patients with complex external circumstances, which again led to sooner or more frequently interventions. For examples, P3 described a lonely patient with a *'distracted'* and '*busy'* mother whose suicide attempt was more dangerous owing to the deficits of her environment:

> *She'd at one time, I think she went into a field and I don't know what she'd taken, but she'd gone with the intent to kill herself. And I think it was very, very close. And I can't quite remember if they'd found her before…….. I think she did let somebody know where she was in the*

end and what she was planning to do. So, I think somebody got to her before she could do it, but it was, you know, it was close.

As this patient was described, my countertransference informed my understanding of what P3 was conveying. Before the loneliness of the suicide attempt was verbalised, I felt a profound sense of foreboding at the same time as feeling distant, out of reach and out of touch with P3 as if she had turned away from me and was speaking to someone else far away leaving me unable to fully grasp what she was saying, nor respond to it. The feelings of disconnect and fear alerted me to the dangers faced by this patient and gave P3's description of the suicide attempt a more dangerous quality. The patient's feeling of being alone and desperate were powerfully conveyed to P3 and then to me giving clarity on the necessity to act to keep her safe.

When action is necessary

All clinicians talked of two situations in which action was necessary.

A red line

All participants were clear that there are certain activities or communications that necessitate action owing to implicit or explicit high risk. Paramount is the survival of the patient and this must always be the most important consideration. In all interviews this was reported in a frank and matter of fact manner that differed from the atmosphere and general flow of the rest of the material in the interviews. The severity and dangers involved were conveyed.

P2 shared the impact of a patient who not only talked about a desire to tie ligatures around his neck, but also reported taking steps towards it by buying rope:

> *That creates a lot for me, a lot more anxiety and a lot more anxiety in the system, because there's not, you're not coming back from ligature tying.*

P2 was in no doubt that this was a high-risk situation that must, without hesitation, be responded to. There is no discussion or thought about waiting here; something must be done even if the therapy is negatively affected, or destroyed. It is notable that the term death isn't used, but the more euphemistic, *'not coming back'* which may indicate the difficulty of speaking explicitly about the terror of suicide or what could have happened.

Similarly, when there is less clarity on the specific risks, P2 described physical safety as paramount:

> *This is a young person presenting in crisis, so actually the immediate task is keeping that young person safe.*

In relation to taking action, P1 simply said '*You just gotta*'. He was the only clinician who had an experience of patient suicide within his team; three linked suicides had taken place several years ago in a previous clinic. Though none were his patients P1 described how profoundly affected he was by their deaths. The gravity of his communication conveyed this and brought into focus the dangers of suicide; the reality of the devastation of it as a concrete act in contrast to phantasies of suicide or risky activities as communications. Later in the interview, when thinking about a different case, P1 conveyed the unthinkable nature of suicide, and perhaps death, as he let me

know that he didn't want to think about what might have happened in a given situation had he not taken action.

'Not enough'

In contrast to the clarity described above, participants described situations where there was *'not enough'* information or knowledge of a patient to enable the clinician *not* to act. A kind of a tipping point in which the absence of understanding alongside indications of risk built to leave clinicians feeling they didn't have enough information to be sure that the patient was safe, and consequently they needed to take some action. It was the unknown quality of the risk that seemed to lead to action, and all participants conveyed a sense of having no choice but to act to keep patients safe. The situation of *'not enough'* applied more often to patients who weren't well known, but P4 also talked of a tipping point being reached with a patient who seemed to hold no curiosity about the reasons behind their risky behaviour, and with a patient whom P1 described as withholding.

Action without thought

Participants did not make reference to acting into unconscious dynamics between themselves and their patients. In other words, no thoughtless action was described, even in situations in which action was taken and thought about later. However, examples were given of non-psychotherapy colleagues who had acted without thought and whom they had supported to understand the presence of an unconscious pull to act. My assumption is that it is reasonable to expect that all clinicians act into

unconscious dynamics at some point and that sometimes this is noted later on, reflected on and can be used as a powerful tool to inform work. Therefore, the absence of this in the interviews is conspicuous by its absence. However, it may be that in some way the interview structure made this aspect of the work difficult to acknowledge, or an aspect of the dynamics of the interview had a bearing on why it was not brought into the interviews. This will be addressed in more detail in the discussion.

Nonetheless, situations were described by P1, 2 and 4 in which they had felt pushed into taking action and took the decision to act when they would rather not have. For instance, P4 described a patient who attempted to pull her into action by passing the responsibility for an acute situation around calorie intake. Had she managed to pull her into action, P4 felt the risks would have increased:

> *And actually, this will increase the risk, and these patients are often kind of, you know, pre-diagnosed personality disorder, pull us into action, and we will thereby increase the risk.*

By explanation, she went on to say that *'a doing therapist isn't as helpful as a thinking therapist'*. She explained that the therapeutic element of the interaction is the capacity in the clinician to notice that there is a pull into action before they respond to it. P4 spoke about the fear a patient may have of a therapist who spends time thinking about the patient, leading to an unconscious desire to prevent them from doing so by pulling them into action. Ultimately, though, she felt that her patient would have felt let down (and consequently be at greater risk) if she had gone along with their wishes and acted in.

Experience acquired over time

Participants described an ever-increasing body of experience gathered over time through repeated exposure to this group of patients, including retrospective assessment of decisions that had negative impacts on patients. From this an internal gauge develops and is used to inform decision-making. Experience increased the participant's capacity to respond appropriately to patients. For example, experience informs participants of warning signs of increased risk, and enables them to note a shift from suicidal phantasies into something more concrete and therefore dangerous. Specifically, when deciding not to take action in relation to a risky presentation P2 explicitly described the value of her experience: '*My clinical judgement tells me that she was stable enough to wait'.* P1 implicitly demonstrates this when describing how he decided what to respond to: *'But you know, as a, as a clinician, it's just one of those, you think you can, for me, I didn't think I could sit on that until next time, and just sort of see'*. Broadly, participants described reduced levels of anxiety when they felt more certain about their judgements in relation to patients.

Participants explained how their experience had been gathered through training as child psychotherapists, time spent working as clinicians, and from previous careers through which the participants were exposed to risk. P1 illustrated this as he explained that as a newly qualified psychotherapist he almost entirely drew on his previous experience as a social worker in order to assess and respond to risk. He described feeling ill-prepared for working with risk when he began and feels that he has developed a capacity to do so through repeated exposure and gathering experience of risky adolescents.

P2 explained that experience enables clinicians to think on their feet and to be intuitive in their responses to patients:

> *I think then, I guess you might have clinicians saying that it's a sort of intuitive sense about, sort of, what I guess we could think about the transference, that sort of what's being communicated that, that it's difficult to sort of name or put your finger on. But actually, it creates a lot of anxiety.*

P2 demonstrates through what is said, and in her style of speech that it is not easy to define what is gathered through experience, but that it is central to her way of working with patients. The language she uses is not exact, and she isn't able to specifically name what it is that she notices, but in contrast there is clarity to her response to risky patients: *'it creates a lot of anxiety'*. I understood this as a conclusion drawn not only from this experience with a patient, but that it drew upon her internal gauge generated by her wealth of experience.

It is interesting to note that P3 said little on this theme, instead the wealth of her experience was evident in the ways she described interactions with patients. At the very end of the interview after saying goodbye she seemed to be reflecting on what she had shared and almost as a warning said: *'You know, I could only do all of that because I was well known in the team. You know, this is much harder for people just beginning'*. It seemed that she wanted to protect me in a way and emphasise to me that her way of working both with young people, and in relation to her team, was built upon years of experience and of well-earned respect that was held for her within the team.

Theme B: Management of risk by the organisation and psychotherapists

Organisations resist acknowledging systemic anxieties

Organisational defence against anxieties was reported by participants in the form of resistance to a full acknowledgment of the presence and impact of anxieties relating to the work of CAMHS. Anxiety was felt to be endemic in the system and appeared multifaceted arising from patients, their families, clinicians and the organisation. P4 highlighted the impossibility of the task the organisation has before it and referred to the organisation as functioning with *'paranoid anxiety about something happening'* leading to a defensive approach to risk management. Participants felt that the denial of anxieties by the organisation perpetuates an inability to address issues brought to it by patients. The view of external networks, including pressure to have noted and dealt with risky situations was felt to increase the pressure on the organisation to be seen to be 'doing' something, rather than giving patients time. The consequence is a less full engagement with patients (the opposite to time spent with patients, as described above), in which participants saw risky activities not decreasing, but potentially increasing. Specifically, P4 described a need to defend the frequency of contact with patients and attributed it to an organisational culture in which the level of need in patients is not acknowledged. P1 spoke of a de-prioritisation of time for thought about difficulties within the organisation because it is *'just too hard to do'*.

It was reported that the cost of spending time thinking about difficulties is compounded by limited resources. P4 spoke of this in a general sense in relation to the organisation, and P1 shared his own reluctance to communicate with colleagues about the

dilemmas he faces when they too have little spare capacity or time. P4 lamented that care plans for patients were decided upon before thought has been allowed to happen and a concern she had shared with her team on many occasions: *'Why are we doing something when we don't know what the problem is yet?'*. She quoted a phrase often used to highlight dysfunction in a system in which action takes place too quickly, and without thought: *'Don't just do something, stand there'*.

P3 described the dangers of avoiding the significance of a patient's trauma, including aspects that are projected into clinicians, as leading to higher risk for patients. She identified this as being a particular problem when the risk is not held by a clinician, but passed back to patients prematurely.

Interestingly, participants also shared the converse view that the organisation can function as an authority that can figuratively hold risk and take ultimate responsibility. The value of this was particularly noticeable in circumstances where patients do not agree that action is necessary, here the organisation can figuratively hold the responsibility, freeing the clinician and patient to think about the consequences together. P3 shared how acutely she felt the loss of the organisation's supportive function in the unusual situation of a patient remaining with her for three months beyond 18. The organisation agreed to the extension of the work but were not able to offer psychiatric support, which was taken on by the GP, nor the support of the crisis management team who would normally be available to help with practical risk management should an acute situation arise.

Psychotherapy interventions reduce risk

All participants conveyed their belief in the capacity of psychotherapy as an intervention to reduce risky activities and suicidal ideation. This was attributed to the capacity of psychotherapists to hold and manage anxieties, which is partly enabled by freedom to see patients for long periods of time. Participants did not feel that this capacity was unique to psychotherapists, but attributable to a certain way of viewing risk and anxiety which is prevalent in psychotherapists as it is central to training.

P2 describes a case example early on in the interview. Embedded in her description, in a matter of fact way, is the notion that psychotherapy reduces risk in the severest of cases when other interventions have not been able to:

> *So, she was an inpatient and moved home about half a year ago. She's had various interventions before psychotherapy, she's had CBT. She was an inpatient. So, she was an inpatient, because the very severe self-harm, multiple overdoses, restrictive eating, she came out of the unit and I took her on for a child psychotherapy assessment. She was suitable for the treatment so I've been seeing her on an ongoing basis. The risks to her have considerably reduced although there's a lot of trauma that she hasn't discussed or worked through; she often dissociates.*

This patient had a traumatic history including dangerous self-harm and suicide attempts and within six months of starting P2's intervention, *'the risks to her have considerably reduced'* and P2 attributed this to an intervention in which the patient's anxieties could be held and thought about.

P1 attributes the lower risk levels of a patient engaged in psychotherapy to the containment offered by a transference relationship with the therapist. When it seemed to him that his patient may engage in risky activity, P1 felt his capacity to help the young person to see they were *'going too far'* and said:

> *There does seem to be some sort of function about, you know that sort of paternal function with decision making.*

P1 felt that for this particular patient, he represented a father who could listen and hear the distress, unlike his own father who was preoccupied with difficulties of his own. P1 explained psychotherapy enables you to follow the patient's lead, *'to go with where they're at'*, by contrast to other types of intervention it means that you can face the difficulties the patient has and build the kind of trusting relationship required to bring about change, and thereby reduce risk.

P4 attributes the value and containing function of psychotherapy as the aim to *do* as little as possible and instead to think about the problems and anxieties that are faced and can be discussed. Through this, she described the capacity for psychotherapists to understand their patients' unconscious communications and their capacity to hold on to patient's projections and anxieties, at a time when the patient is not able to.

Communication about the power of psychotherapy within the interviews

It was notable how differently this idea was described by participants, and the point at which it arose during interviews. At times it felt as if it was controversial to point out the value and power of psychotherapy. For instance, I noted a hesitancy to speak candidly about these aspects of the culture during P1's interview. At the start, P1s

expressed views and approaches that seemed to be very much in line with the organisation's approach and conveyed his confidence in psychotherapy as a successful intervention with an apologetic tone:

> *I suppose there are some cases that I work with where I think, you know, psychodynamic approach can really kind of contain it, hold a case. Where there was previous acting out it can really pull it together and reduce the impact and can really contain those kinds of dynamics. You can see a real shift.*

As time went on, he became more open about his feeling that psychotherapy was a powerful form of treatment, and although not explicit, he was more critical of the organisation's *'non-thinking approach'*. As he began to express this more, it felt as if he was making a confession.

My sense was that this was not a hesitation on P1's part, nor an uncertainty about his view, but a way of promoting psychotherapy without evoking negative responses from colleagues who may disagree. This point was elucidated towards the end of the interview when he became effusive about the power and value of psychotherapy using an example about another organisation with psychoanalytic thinking at its heart:

> *I worked in a therapeutic community so that's where I got interested in psychodynamic work…..So, I know the brilliance it does in terms of what a therapeutic melee can offer. So yeah, I think there's something difficult that we kind of do, and it's got very medical and they're looking to sort of discharge people as soon as they arrive, so it's not as helpful as it could be.*

The example P1 used demonstrates his feelings about psychodynamic work and what he felt was lacking in his current organisation.

By contrast, P3 more explicitly conveyed her view of the value of psychotherapy which may reflect the senior position she held within her team. P2 did not explicitly say how successful she feels psychotherapy can be, but in the example above she implicitly describes its power and value. P4 was open about her views on this and spoke of the value of psychotherapy from the very start of the first interview. The rationale for undertaking a second interview, in part, related to how much time was used to think about this during the first interview (as well as technical difficulties). She had recently left a service, and my sense was that the organisational denial, and subsequent isolated position she felt left in played a part in her decision to leave. P4 also shared that changes to the management structure and the departure of a like-minded colleague made her position untenable.

Unspoken acknowledgement of psychotherapist's capacity to carry risk

All clinicians described an unspoken acknowledgement that psychotherapists hold and manage risky cases on behalf of the organisation. It was suggested that the organisation is aware of this capacity and the necessity for it. To greater or lesser degrees, however, a denial of this fact was felt by participants, and this was described as preventing full acknowledgement of the magnitude of the task of a CAMHS clinic, and of what psychotherapists are asked to manage. Rationales for denial included the

inherent difficulty in acknowledging anxieties present in the system, as well as limited resources available to tackle problems, should they be acknowledged.

Participants described expectations to formally and informally support colleagues managing anxieties, and to take on complex cases often when all other avenues had been exhausted. For example, P3 shared the following:

> *The team were so worried that they were thinking, 'Well, you know, we've tried what we could'. You know, like it is with psychotherapy, you try everything else and then when that doesn't work, then you sort of refer for psychotherapy.*

P3 described the passing of complex cases to her as a common occurrence, and some recognition of the value of this to the team. Similarly, P4 noted the reliance on her to hold difficult cases and anxiety on behalf of the organisation as a whole, even as a newly qualified, lone psychotherapist:

> *So as part of the role, beyond the spoken part, was that you would help contain institutional anxiety and the anxiety for other clinicians.*

In contrast to P3, P4 described a lack of acknowledgement and value by team managers, leading to unsustainable requirement to provide this function to colleagues: She and a psychiatrist colleague recorded the number of formal and informal consultations offered to colleagues which functioned as a containment of anxieties. The total amounted to four-fold higher than was agreed with the organisation and suggestions of increasing this were not met. P4 felt that this amounted to a denial of the presence of, and the need to address, anxieties within the team. Further she

expressed how the *'trouble'* with the organisation can also be located in the psychotherapists who are '*upsetting the apple cart*' by suggesting that more time thinking about things may be beneficial. P1 described this as akin to adolescents who split off, project and deny their anxieties when they themselves are unable to hold them.

A defended culture is difficult to change

P1 set up a space within his organisation to think and reflect on cases that evoke anxiety in the team. Despite being well attended, he conveyed how difficult it was to keep people on task: The group did not manage to remain focused on the pain and distress evoked by thinking about these patients, and, at the time of the interview, he felt it was not functioning as a container for these anxieties.

P4 more directly conveyed the difficulties in challenging the organisational culture and how it can be felt to be destructive rather than productive. This may be especially true when there is a degree of denial about the anxieties present and how the organisation is managing these:

> *I think the role of a psychotherapist is difficult because, it's also, it's a lightning rod for, you know, it angers people when you're felt to be destructive to the unconscious function of the system.*

Theme C: '*No clinician should act as an island'*. Sharing the load

Like-minded colleagues

All participants described their preference for working alongside *'like-minded colleagues'* and the positive impact that this could have for patients, not least in reducing the risks. P2 describes her relationship with a colleague:

> *So, I would share my concerns or anxieties with the primary worker, who I had a really good working relationship with, about the dilemma about whether to take action in terms of letting parents know about risk*.

The value of being 'like-minded' centred around a capacity to hold and think about aspects of the work, particularly risk, rather than to be quick to take action, even when the pain and anxiety of not acting was difficult to bear. P3 shared gratitude about a like-minded colleague available to discuss a patient, giving a sense of the rarity of it:

> *I think I was incredibly lucky that I had a co-worker who could also hold risk without having to jump into action.*

A multitude of advantages were attributed to the availability of like-minded colleagues including, greater confidence in decision-making, particularly around risky patients, leading to a reduction in anxiety; improved understanding of patients as they could be thought about in greater depth; greater capacity to understand and process unconscious material; reduced impact of the patient on the clinician, and more concretely, participants felt more able to focus on therapeutic work rather than being pulled into case management. The latter was seen as particularly valuable with

complex cases involving a large amount of case work and high levels of risk. Further, whilst participants talked of the need to retain the trust of their patients should they have to take action, it was described as less disruptive to the treatment if action was undertaken by someone else, particularly when the person was known to the patient. Without a trusted colleague, participants shared their difficulties in holding conflicting roles of case worker and clinician which compromised their therapeutic capacity, reducing the quality of therapeutic work, and treatment was described as slower when working alone.

The ideal situation was described as joint work with one clinician holding responsibility for case management, leaving the other free to carry out therapeutic work. However, all participants shared that this was rarely available, instead they informally sought support from well-known, trusted colleagues who shared their approach to thinking and risk management. P2 conveyed the imperative nature of sharing stating, '*No clinician should act as an island'* and conveyed the responsibility a clinician has to their organisation to make information about risk available to colleagues.

Thoughts about the organisation's denial of anxieties were less prominent in interviews with participants who also described a strong alliance with at least one colleague, notably P2 and P3. This led me to wonder if the presence of the colleague countered some of the difficulties created by this organisational stance. Further, these clinicians both described supporting other colleagues within their teams to manage anxiety and risk, thereby increasing the team's capacity to hold risk. P4 also described her role as consultant to colleagues, but the anecdote depicted an organisation not able to recognise the value of this role. Where a like-minded colleague was not

available, or if they were situated in a different team, participants described their situations in more difficult terms, and more time was spent during the interview thinking about lack of support and deficits within the organisation.

Time for sharing

P1 conveyed a clear sense of there being too little time available to think about the impact of the high levels of anxiety and pressure that he and his colleagues are managing, and expressed a resulting loneliness to this work.

> *I think it can be a very sort of lonely individual experience when you work with someone, you know, you have your supervision, um, and you can talk to colleagues, you know, they're all full up with their own things.*

P1 talked at length at the start of the interview about how little support there is for psychotherapists within CAMHS, and how little time is given to think about what is being communicated by his patients. It seemed that during the *time* of the interview some of the work required to process material was taking place, which may have been some of the appeal of taking part: while thinking about a patient who was contemplating cutting himself in an attempt to end his life, P1 shared how the patient *'only went so far'* and then withdrew from contact with P1 leaving him uncertain about the patient's safety. Whilst he was describing this to me I had the sense of P1 pulling away from me and he left sentences unfinished, without drawing his message to a conclusion mirroring what he was describing in the patient. Uncertainty expressed by the clinician reflected the uncertainty in the patient and something of quality of the communication from the patient was passed onto me:

> *I did speak to him about how he would manage that and if he could keep himself safe, would he talk to anyone if he was feeling like he was….*

The sentence ended here leaving the rest unsaid, available to be concluded by the imagination. The vagueness and withdrawn quality indicated that I was a witness to the process of understanding what is being communicated. My countertransference of the distance between myself and P1 led me to thoughts of the unknown aspects of P1's experience of the young person, and therefore perhaps indicating a confused state that the young person finds himself in.

The action of sharing

Participants described sharing as a form of action that can have the function of reducing risky activities and increasing trust between patient and clinician. This was particularly for patients involved in acting out, and generally during the earlier stages of treatment. P2 shared the necessity to take action in the form of sharing information with colleagues and parents as an essential aspect of working within a CAMHS team:

> *You might be working with a young person for whom you feel incredibly responsible for their risk, but actually, that needs to be shared within the team. Yes. It should be a team shared risk.*

P1 described his rationale for sharing his thinking in the form of inviting a parent into the therapy session:

> *I think there is something about him being taken seriously; his needs being taken seriously.*

P4 described a decision to share aspects of the patient's experience with the parent could demonstrate her own capacity to bear the patient's hatred. Through this, the patient was able to gain a sense of her strength and in that, have an experience of adults able to hold and manage powerful emotions:

> *'We need to tell your mum about this'...And though I wouldn't say she liked it, she almost accepted it. So, she could be angry with me. But I think she was also, I suspect it gave her a little bit of relief.*

As described earlier, the focus of participant's descriptions of action was sharing information. This generally began with a colleague, which was seen as an essential precursor to other action, and then involved sharing information with a parent. Often this involved inviting a parent into a session, other times a phone call after the session was made by a colleague. The described purpose was to pass some of the responsibility for the patient back to the parents and always had the aim of risk moderation. This action appeared to build upon risk assessments and safety-planning that had taken place at earlier stages of the treatment. Participants also described the benefits of involving patients in this process as they too were invited to take some of the responsibility, and could also feel held by a clinician who was seen to act as a responsible adult ensuring their patient was properly attended to and cared for.

Discussion

This project sought to explore the interplay between taking action and waiting with patients by child psychotherapists working in various CAMHS clinics within a single NHS Trust and working under the dual pressures of anxieties evoked by patients and a service under pressure. My attention was drawn to the topic of waiting and taking action in the context of risky or alarming adolescent presentations as I noticed a contrast between theories and psychoanalytic approaches that were thought about and taught at my training school and the situation in practice within my clinic. Broadly, the sense that I had of the clinic was of a polarised situation: there was a predominant culture of respect and admiration for fast and decisive action, with slower placed work and acknowledgement of the pain of patients' situations being marginalised and, at times, viewed as arising from clinicians' personal weakness.

To an extent my hypothesis as I approached the project was that child psychotherapists are at odds with the predominant organisational culture; they lean towards thinking and waiting in contrast to the norm of fast and perhaps thoughtless action. The situation is of course much more complex. The psychoanalytic stance of thinking and waiting was seen in the study, and clinicians worked hard to understand the meaning of their patients' communications and noted the pull towards action in themselves, and in others. However, it was also clear that, where necessary, action was common practice, particularly when working with the focal group of high-risk adolescents. In fact, the polarisation of action as negative and *thoughtless* versus waiting as a preferred and revered outcome of *thoughtfulness* is not a particularly helpful framework through which to view the situation. Indeed, action can be absolutely necessary at times, not least in situations of high risk, or when too little information is

known to be certain that a patient is safe. Interestingly, despite the clarity of the rationale for action, there was clear unease in participants as they spoke of their own use of action. The presence of a like-minded colleague to whom clinicians could turn to share thoughts and impressions of a patient played a central role in the participants' capacity to wait with patients and to be thoughtful and take appropriate action when necessary. A central but unexpected finding was the extent to which organisational dynamics emerged as linked in clinicians' minds to their use of waiting and taking action. Further, it seems that the availability of time for reflection, and of these necessary colleagues, was determined by the atmosphere and culture of each clinic.

The inspiration for this study was a talk by Donald Campbell in 2019 in which he described his decision not to take action, and the tangible risks and difficult dilemma he encountered when his five times weekly patient talked, on a Friday, of not expecting to be alive by the session on Monday. The patient had made attempts on his life in the past. Campbell's premise was that, in the transference, he represented a father who was being challenged to withstand something (in a way that the patient's actual father was felt to be unable to). Had he acted and alerted someone of the potential dangers, Campbell felt it would have been detrimental for his patient as, in the transference, he would rediscover the father's inability to hold him, and would evoke repetition of this challenge, dangerous as it was. The approach paid off and the patient did not harm himself and progress was made in the paternal transference relationship.

Through the analysis of five interviews with four clinicians five themes were described. A: *Acting and waiting: clinicians' responses to patients.* B: *Management of risky by the organisation and by psychotherapists.* C: *'No clinician should act as an island.'*

Sharing the load. D: *The difficulties posed by working with risky adolescents,* and E: *Impacts of COVID-19 lockdowns on work with risky adolescents.* Below, I will outline some thoughts on these findings. I will discuss the value of waiting and suggest the reasons for the prevalence of action seen in this study relates to the time available to see and get to know CAMHS patients. I will go on to think about reflexivity and discuss the ways in which action was reported by participants and the implications of this. Finally, I will focus on the relationship between acting and waiting, and the organisational dynamics of particular clinics.

Waiting and the centrality of action when working with high-risk adolescents

Waiting

There are numerous, perhaps innumerable, benefits to waiting within the framework of a productive therapeutic setting; allowing time to pass with no particular agenda other than waiting to see. The value of waiting and therefore of time is central to psychoanalytic work and not a tool that is interchangeable with action, they are separate. 'Time will tell' meaning, *'The truth about something will be established in the future'* (Oxford English Dictionary. Soanes 2000 p.1206) seems fitting. Or waiting with someone 'For the time being', meaning *'Until some other arrangement is made'* (p.1205) also gives a sense of an aspirational state of mind in which time can be suspended to allow for growth and development to take place. When discussing the temporalities of care in general, Baraitser and Salisbury (2020) warn that: *'When we overlook care that takes time, or is itself a practise that waits to see what giving time to a situation may bring, we enact the antithesis of care. We fail to think carefully about*

care'. This is linked to a concept of 'watchful waiting', an approach used across healthcare, and is a central tenant of psychotherapy treatments described as *'the slow unfolding of trust required to communicate psychological distress that forms a vital part of the therapeutic alliance in mental health treatment'* (p.4).

In fact, time is a central to Bion's concepts of containment and reverie (1962): the repeated understanding and processing of unpalatable aspects of the self that are evacuated and received by another via projective identification, understood and returned to the patient, or the child as Bion (1962) described. The repeated experience of this process takes time and is in essence what underpins a patient's developing capacity to integrate disavowed and distressing aspects of themselves. Over time patients change and can begin to trust and to examine the things that have brought them into CAMHS, leaving them less likely to act-out and to harm themselves. Likewise, over time patients can internalise a listening and waiting object who is there and can be relied upon, and can be turned to, in time, when needed. Through this process, clinicians gather and add nuance to their own knowledge and understanding, and so they become more experienced with each patient and within themselves. Experience gathered over time informs their work.

Action

It is clear that, for participants in this study, action played a central role in therapeutic work with this group of patients and formed part of the ebb and flow of treatment that, in the broad sense and conceptualised by Salisbury and Baraitser (2020), used 'waiting' as a treatment approach. It was found that action doesn't counter waiting, but critically, when it was thought about and taken with care, augments treatment. This

appears to differ from the well-known stance of thinking and 'not-doing' that psychotherapists are trained in. Taken in the extreme is to stick to the quip, '*Don't just do something, stand there'*. When applied to psychoanalytic thinking, this popular saying encompasses a desire to avoid acting into unconscious dynamics without thinking about the communication nor understanding why action is taken. It follows then, that if the outcome of a thoughtful process is to take action then it is not contradictory and can aid the patient along their treatment journey.

When grappling with fundamental ideas in the rich and diverse psychoanalytic literature, it is notable how many case examples and theories arise from long-term work with adult patients (e.g. Freud 1914, Bell 2001), and also with intensive work with children (e.g. Waddell 2018, Campbell 2019), much of which is not impinged upon by the pressures and time constraints that NHS services, including CAMHS, are under (e.g. Baraitser and Brook 2021). I want to suggest that the relative prevalence of action found in this study exists because of two factors that both relate to this. Firstly, the focal age group differs from the adult population in a specific way; they are dependents and not yet fully *in*dependent and the study participants are working in the context of an organisation in which clinicians are, to an extent, in *loco parentis*. Second, in busy CAMHS clinics where patients are rarely seen more than once a week, I would argue that the situation where 'not-enough' is known about patients to interpret in place of action is commonplace.

When thinking about action, it is important to consider that literature emphasising waiting that is based upon long-term, intensive work, may not be entirely applicable in an NHS service, particularly in the early stages of work and when working with

particularly high-risk patients. It was Campbell's experience as an analyst and his deep knowledge of his patient's internal world which enabled him to wait. Under different conditions action may be necessary more frequently and in a wider range of circumstances. Even so, in circumstances where time constraints mean there is limited scope for intensive work, the core tools fundamental to psychoanalytic work can be expanded though learning about powerful work of experienced psychoanalysts who have the opportunity for intensive work. Furthermore, it is important to note that psychoanalytic approaches can and are applied in lower intensity. A notable illustration is the Short-Term Psychoanalytic Psychotherapy (STPP) model (Cregeen *et al.* 2017) which gave solid endorsement to the understanding that thorough psychoanalytic work can be achieved at depth in once weekly therapy over a relatively short time frame (28 weeks). The suggestion therefore, is not that psychoanalytic work is watered-down outside of intensive work, but that adjustments to case management are necessary depending upon the circumstances. In fact, the rationale for, and timing of, stepping outside of the dyad of therapeutic work when undertaking STPP is explored by Cregeen *et al.* (2017).

Janus-faced work

Adolescents are dependents of someone, at least in law, and for this reason, it is appropriate for this group to rely on adults for some of their care. Interestingly, in this study the predominant dilemmas around action related to decisions about when or what information to convey to the patients' parents; when to provide the parental containment in the transference and when to pass it back to the actual parent. The relationship between independence and dependence is complex, as described earlier, and certainly more complex than adults who are almost always independent in terms

of being responsible for themselves. As adolescents sit on this frontier between infancy and adulthood, childhood dependence and adult independence, finding the right path with this group is more acute owing to the precarious nature of life as an adolescent. Working with the infantile aspects of patients is central to psychoanalytic work, but with children, including adolescents, sometimes their infantile selves must be physically cared for as well as psychically cared for: the infant can't survive with psychic care alone, the two are intertwined. For instance, a participant shared an example of an anorexic patient who, at this point in their work, was unable to introject the therapist's interpretations nor the understanding this may convey, instead it was decided that concrete external support was needed to prevent starvation and so keep the patient safe.

While a variety of actions such as safety plans were discussed in the interviews, thoughts around handing this responsibility back to the parent were central. It was felt that the parents must be informed in a careful and sensitive manner in order to support them to support their child with a closer watchful eye. Further, it felt important to enable the patient to witness an adult (the therapist) knowing when it is right for something to be done, even when this is not what the adolescent wants. Perhaps this is the psychic equivalent to physically holding a distressed and determined toddler to prevent them from doing something that the adult knows would be unsafe, such as running defiantly towards a busy road unaware of the full danger it poses. It isn't a pleasant experience for the toddler, nor the adult, but is unquestionably necessary.

Action of this nature extends child psychotherapy beyond the boundaries of the therapeutic dyad and, in a sensitive and delicate manner, invites parents into the

thinking about the patient, alongside requiring, or requesting, them to take responsibility for necessary action. The clinicians in this study appeared to have weighed up the cost of this action and have, it seems, quite often taken the decision to risk a disruption to the therapeutic alliance firstly to ensure safety, but also in the service of improvements for the patient. It is possible that this extended model of child psychotherapy could have developed as a result of the pressures on time and resources within CAMHS settings in the hope of creating an external environment more conducive to growth and development, where aspects of the therapeutic relationship can more readily take hold. The phrase, *It takes a village to raise a child* comes to mind here where the psychotherapist may be able to instigate a change to a different kind of a village, one which is safe and growth promoting.

Action without thought

It is notable that participants did not share experiences of having been drawn into taking action without thought. It would be reasonable to expect that this has happened, certainly verbally within sessions, and perhaps outside of the sessions, too. The reasons for this absence in the data perhaps relates to it going unnoticed by participants, or, as I will explore later, owing to the general difficulties in discussing thoughts and feelings around action.

Reporting on action

The difficulty of work with unwell adolescents extends to a difficulty in discussing the work. In this study, despite a clear rationale for taking thoughtful action, it was evidently

not easy for participants to discuss what they had done. It is also true to say that the subject matter itself is difficult to talk about, and also to think about. The manner and style of communications in the interviews generated a kind of 'cut-off' dialogue when referring to the gritty detail of suicidal attempts, risk and self-harm which had the effect of dampening the distress of the material. Avoidance of the use of the word 'death' and sentences that faded away perhaps mirror the internal struggle with *actually* facing the reality of these incredibly difficult and deep-seated anxieties related to death. The tendency to avoid, distract, deny and discharge is a strong, and possibly welcome pull but indicates the presence of complicated struggles that seemed to relate to the conflicting ideas of waiting and interpreting in preference to acting. In general, the difficulties arising for participants discussing these topics seemed to be two-fold: firstly, a perception of a 'Tavistock' viewpoint that I may have represented seems to have affected how and what was shared. Second, the nature of this work seems to mean that clinicians are questioning of their own decisions and judgements.

Hollway and Jefferson (2000) describe how unconscious defences preclude the full story from being told in research interviews as '…*defended subjects are motivated, largely unconsciously, to disguise the meaning of at least some of their feelings and actions'* (p.26). Thinking reflexively in this way, it may be that my status as a current trainee shaped responses as the harsh super-ego of the training school represented a view that action is the poor cousin of thinking, reserved for those unable to *Stand There* in the face of a demand for action. Apologies were made for actions taken as if there were some problem with being 'un-psychoanalytic' and, as described earlier, the term *Applied Psychotherapy* was used defensively, pre-empting criticism.

Further, reflecting on the aims and structure of this project led me to wonder if polarisation of acting and waiting was reinforced at the outset. The research question is asking how participants manage to 'not act' against the pressure of an organisation that is pushing them 'to act', as if there is a right and a wrong. While the idea that the training school *'makes you think I'm not doing it properly'* was present, as its '*sneary'* attitude towards '*the outside world'* was overtly commented upon in the interviews, the biased notion embedded in the structure of the research may have both set up and exacerbated this dynamic and the projections of the training school's critical eye cast upon participants.

Whilst holding this in mind, it is important to note the prevalence of self-questioning that took place within the interviews. When managing so much anxiety, risk and uncertainty projected from patients, self-reproach is inevitable as clinicians must manage this alongside their own feelings arising from the work. This vulnerability was conveyed during the interviews through a sense of introspection and unanswerable self-questioning and the re-telling of stories as well as the provision of additional background information, as if to shore-up the argument to one's self, as well as to me. *'How can we know the counter-factual?*' one participant asked when thinking about decisions about responding to risky patients. We can't know what could have been, only what we thought may have been, and in retrospect, what did happen. The more experienced clinicians appeared less concerned about my view on the action they took, and I had a sense of greater certainty in all decisions that were made despite the presence of self-questioning. Other participants took a teaching stance intellectualising the material which, according to Hollway and Jefferson (2000), could

provide the *'comfort of comprehension'* (p.33) and in doing so both protected me from, and warned me of, how difficult and dangerous this work could be.

Further, the complexity and unconscious projections that can amass around risky, and often complex patients, were conveyed and I was given the experience of being feeling confused by what a patient may do or shocked by the seriousness of the situation. Phrases such as *'You can't give therapy to someone who's in a box'*, and *'You can't do therapy with dead people'* were used highlighting the alarm that resides in the shadows of this work. I wondered if the value of this language of alarm was used to ensure that this essential point is never forgotten by the clinician, nor by her patients. It certainly made the point to me. As Chard (2021) points out, it can be hard to convey the full power of an emotional experience to those who have not been exposed to the particularities of a given situation, less so in words.

Nonetheless, as trust developed between myself and the participants through the course of the interviews, more was shared around the impacts of making these decisions with less emphasis on feeling compelled to protect or scare me, nor to justify their actions. In the round, the presence and varying styles of these communications relating to risk may mirror what takes place in a therapeutic session. In this way the interview seemed to form part of the process of digestion of material, something that there was too little time for, as will be discussed below. The value of time and waiting and allowing things to develop was alive in the interviews, at the same time as being the topic of discussion.

Risk and the organisation

A relationship between clinicians' responses to patients and aspects of organisational dynamics was an unexpected but central finding in this study. The existence of defences against anxieties within organisations is well described (e.g. Obholster and Roberts 2019, Anderson and Rustin 2015 Canham 2002) and build upon Isabel Menzies-Lyth's (1988) consultation to a hospital in which she identified defensive strategies against anxieties as the source of low levels of patient care and high staff turn-over. The recommendations she made were not taken on board by the hospital and latterly Halton (2015) suggested that difficulties for managers to take back projections that had been attributed to staff members prevented the changes happening. However, in another organisation, The National Orthopedic Centre, Halton (2015 p.36) describes how change was possible and attributes it to the Ward Sisters' capacity to trust and nurture their subordinates.

Overdetermined organisational anxieties

In this study, the presence of anxieties and pressures within the CAMHS clinics appeared severe and overdetermined. Lack of full acknowledgement of the presence of anxiety was identified and instead it was felt that there was a denial of anxieties alongside projection of 'the problem' into certain members of the group, for example the *'troublesome'* psychotherapists '*upsetting the apple cart'*, or even psychotherapists lamenting the difficulties posed by managers that don't recognise the need for thought. Canham's (2002) *'gang state of mind'* (p.115) feels relevant here. It is a state in which vulnerability is disavowed and the different view-points are feared as they may unsettle the status quo (*'upset the apple cart'*!), projective processes dominate and

responsibility for the difficulties can be located outside the group or in other group members. This sets up a situation in which thought or 'watchful waiting' as described earlier, is difficult as Stokoe (2019 p.10) states, *'In the organisation, a disrupting level of anxiety will evoke a procedural system to replace thinking and an accompanying powerful belief system replaces investigation'.* In turn this perpetuates deterioration of the organisation and paradoxically, as anxieties rise *'thinking and facing reality are abandoned'* (p.9). It was felt by clinicians that the organisation's relationship with anxieties impacted upon their own capacity to hold and manage risk and anxiety on behalf of their patients, and so it was linked to a reduced quality of care.

Thinking together to manage organisational anxieties

In order for an organisation to bear and manage severe anxieties there must be a culture both at the top of the organisation, and between team members (Stokoe 2019) more akin to Canham's *'group state of mind'* (2002 p.113) which he links with Klein's depressive position (1940, 1945) and is characterised by a capacity to tolerate different points of views and concomitant tensions and ambivalent feelings, including the capacity to remain in contact with one's own deficiencies. In essence, thinking is allowed and can be kept alive.

While the organisation as a whole was not reported to be acting in a group state of mind, the immeasurable value of even a single, available '*like-minded'* colleague with whom the unconscious and conscious burden of the work could be shared, was clear. Sharing was both a form of action and a way to manage and process anxieties enabling clinicians to be thoughtful in their decisions about patients. There was a stark difference in the way the wider organisation was described by those who felt supported

in this way and those who didn't. Participants who felt supported spoke frankly about the necessity for support, and those who didn't, spoke in starkly troubled tones. In addition, less emphasis was placed on organisational dysfunction by those who felt supported, and they generally appeared to be under less pressure. Perhaps hand-in-hand with the capacity of an organisation to acknowledge the presence of anxieties and the requirement to address them, comes a certain respect for the clinicians who are adept at this; their presence may feel less like it upsets the apple cart, and instead a welcome and valuable asset of the team. These clinicians have the hallmarks of being in a group state of mind. Indications of this were that they did not convey feeling overwhelmed by anxieties of the group and instead conveyed independent thought that, at times, differed from the team, along with confidence about promoting this way of thinking within their teams. Nevertheless, it takes great strength to remain in a thinking position if this means standing apart from the group, as acknowledgement of different perspectives can put people more in touch with the reality of painful feelings (Chuard 2021 p.21).

The general feel of communications from clinicians without a like-minded colleague had a more defended quality, such as obscured narratives on how they maintained their view-points within their team. The quality of these communications may not only relate to the distress around the absence of support, but also to the presence of the unburdened load being carried (both aspects of their own work, and the weight of organisational dynamics pulling away from thinking).

Time for thought

In effect, what is being described is the presence of well-functioning, informal (or perhaps also, formal) supervision space or other time dedicated to thinking about cases with colleagues. Chuard (2021 p.28) emphasises the role of supervision as providing a time for thinking that functions to both shine a light on the unconscious dynamics at play and to keep thinking alive thereby preventing the group taking on a gang-state of mind devoid of original thought. Waddell (1989) conveys how thinking is the very thing that can feel the most anxiety provoking, but it is necessary to do in order to engage with the anxieties, and enable things to feel better: *'Pain can be more easily borne, ultimately, if it can be thought about'* (p.2).

The value and necessity of thinking is clear but, as seen in the data (Defended cultures are difficult to change, p.84), setting up a thinking space, or offering the opportunity for consultation is not an easy task, and at times participants felt it was viewed as disruptive. Kraemer (2015 p.146) warns that these kinds of groups are routinely resisted as *'There seems to be an inherent fragility about meetings whose purpose is to reflect rather than to produce'.* Roberts (2019) explains that *'our neurological response to new information can be experienced as unpleasant, leading to repressing what disrupts the stories we have been using to make sense of our lives and our organizations'.* In this study, a loneliness was conveyed by those trying to promote thinking spaces. For those who had some supportive thinking space, the necessity not to be a lone island, but at minimum an island of two, seemed to be the basic requirement from which a more thought-infused culture could develop. The island is nonetheless dependent upon the strength of the particular individuals involved and their capacity to share their experience. It was clear from one participant that this

fragile duo had existed, and the departure of their colleague quickly led to their own departure. Without the possibility of sharing and all that this entails and offers, the position wasn't tenable.

With this in mind, I speculate that in clinics where sufficient time is available for reflection and thought, a capacity for the team to remain as a thinking group is perpetuated. A team that has *supported*, and *supportive* clinicians can hold and process anxieties and unconscious stimuli, and a virtuous circle can ensue whereby, over time, this mode of operating proliferates. As time passes mutually-supportive clinicians gain experience and expertise, their capacity to support others grows and enables the fragile group state of mind to exist. Providing others, and in this case colleagues, with a space, or mind to think with is described by Waddell (1989) as an action that *'can offer hope of development to others'* (p.13). Psychotherapists are well placed to do this as the mode of treatment is to examine anxieties and resistances to it, and to identify underlying process in pursuit of improvements in their patients. It could be argued that, as this capacity within the team increases, the unconscious pressures on the organisation reduce as there is some easing of anxieties, and so the capacity for thought continues to increase. As described above, the Ward Sisters' capacity to trust and nurture their subordinates at the National Orthopaedic Centre was thought to be central to the organisation's capacity to change. It may be that a positive culture of containment and trust can proliferate when individual members of the group contain anxieties for one another, as in doing so, they perpetuate the whole team's capacity for anxieties to be acknowledged, so mutual trust and containment can bloom.

Limitations

It is not possible to extrapolate the findings from this study to other NHS Trusts and therefore to the experience of other clinicians, as each clinic's culture is unique. The small sample size and the fact that my experience as well as the participant's experience relate to the same trust has an impact on the extent to which the wider picture can be commented on.

Further, this study was undertaken from the point of view of Child Psychotherapists and as such, is not an ethnological study of a CAMHS service. Consequently, the data and therefore what has been drawn from it must be viewed through this lens. For a broader picture of the culture and climate of specific organisation, a more general examination would be required that looked at these aspects of the organisation and the experiences from a variety of perspectives. A study of that nature is beyond the scope of this project, but I imagine the outcome of that kind of research would provide interesting reading that could be overlaid and compared with the findings here.

Conclusions and recommendations

This study sought to examine the interplay between waiting and taking action with adolescent patients presenting as a risk to themselves by Child and Adolescent Psychoanalytic Psychotherapists working in CAMHS clinics within a single NHS Trust. The findings were considered within the context of the anxieties evoked by the patients and the pressures of a stretched NHS service.

A central clinical finding was, when working with risky adolescent patients, clinicians take action through thoughtful involvement of parents as an enhancement of the dyadic relationship. This action involved conferring with like-minded colleagues, and then through a collaboration with parents who were invited to share some of the understanding of their child's situation. Much thought was given to how this was executed and the impact on the therapeutic relationship, however, it was driven by a desire to promote patients' safety, and in the hope of more positive longer-term outcomes. Action of this nature held importance for all participants and while it wasn't the only action described, it was the central focus of thought and reflection around action in response to risky adolescents by all participants. It indicates towards an important aspect of the alliance between clinicians, patients and their parent which I speculate could arise from the knowledge that the offer of time from CAMHS clinicians cannot match the needs of the patients, and consequently inclusion of parents in the work feels important. This finding differed from my expectations as I anticipated that clinicians' thoughts around their responses to risk would have encompassed a wider range of actions. It differed from my expectations in another way, as I had assumed

that action would have a less prominent role in the work. Instead I found that for the participants of this study, action is an integral part of work with risky adolescents.

Generally, it was difficult for participants to discuss action they had taken and there was a hesitancy to do so expressed both verbally and non-verbally, which eased over the course of the interviews. When thinking about the research project reflexively, my position as a Tavistock trainee may have brought a critical superego into the interviews in the form of a stance against action affecting what felt comfortable to share. Nonetheless, there was pronounced discomfort in talking about action taken that went beyond that evoked by my presence or the structure of the interviews and research project.

The study shone a light on how difficult it is for organisations, clinicians and for child psychotherapists to think about, talk about and to create and maintain time to focus on the profound anxieties aroused by work with this patient group. Yet it is clear that time is crucial in assessing and managing these anxieties for the individual and the wider organisation. In clinics where there was some scope for thought and reflection it seemed that this capacity could grow and develop within the team, but without it, the situation felt more difficult. It seems inevitable that the perfect storm of acute pressures that the NHS is under alongside societal pressures affecting adolescents will increase and so too will the desire to turn away from, instead of towards the pain of facing anxieties. The role for child psychotherapist to continue to join and support colleagues in the difficult task of thinking about and addressing anxiety is clear.

Child psychotherapists are employed in a range of posts during and post-qualification. It seems important that the specific interplay between waiting and taking thoughtful action is explicitly discussed within the child psychotherapy training in order to promote a nuanced understanding of these situations and avoid feelings of discomfort around action that is taken, as discussed above.

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Appendix 1. Participant information sheet

The Tavistock and Portman NHS
NHS Foundation Trust

Doctoral Research Project:

Suicidality in teenagers: When to wait and when to act?

Clinicians' experience of balancing time for reflection with action when working with suicidal adolescents.

Information for Participants

The project:

This project seeks to further the understanding of when action is taken in response to adolescents at risk of dangerous self-harm or suicide, and when attentive waiting with them can be used as an active tool of treatment.

Psychoanalytic literature reports on the driving force of unconscious phantasies behind suicidal states of mind. It indicates that allowing a patient time to explore these ideas within a secure therapeutic relationship may be the safest and most appropriate treatment. However, in a busy clinic, time for reflection may be regarded as unduly risky rendering it unavailable as a treatment. Instead the necessity for taking action on the grounds of safety can be promoted. The drive for the latter may arise in a variety of ways including an external promotion from organisational culture, or internally arising from the clinician's fear of what the patient might 'do'.

I would like to explore the difficulties involved in holding these conflicting impulses in mind and how clinicians have addressed this.

This research project is sponsored by the Tavistock & Portman NHS Trust and has received formal approval from the Tavistock Research Ethics Committee (TREC).

Inviting clinicians to take part who are:

- *ACP registered child and adolescent psychotherapists*
- *At least 2 years post qualification*
- *Based in Oxford Health Foundation Trust*

Taking part:

If you are interested in taking part or for more information please contact the principal investigator, Rebecca Bolam. Contact details below.

Interviews

Participants are invited to take part in one hour-long, face to face or digital interview in a confidential space. There may be opportunities for follow up interviews, but it is not a requirement of participation.

Interviews will seek to explore participants' thoughts and experiences on the research topic.

Confidentiality

Confidentiality will be maintained throughout

- *I will record interviews and use the recordings to inform the research.*
- *Recordings will be used, stored and transcribed securely in accordance with the University's data protection policy (for more information see below).*
- *Key identifiable data will only be used to contact you; it will not be shared, and along with all generated data, will be held for 3 to 5 years and then securely destroyed.*
- *Identifying features of clinicians (and any patients described in interviews) will be removed when reported in the findings.*
  NB: The small number of participants in this study (max. 6 clinicians) may result in some identifiable details by inference.

Consent

Participation in the study is voluntary; you are free to withdraw your consent prior to data analysis, and to withdraw any unprocessed data previously supplied. However, your rights to access, change or move your information are limited, as I need to manage your information in specific ways in order for the research to be reliable and accurate.

Appendix 2. Thought points for participants

Doctoral Research Project:

Suicidality in teenagers: When to wait and when to act?

Clinicians' experience of balancing time for reflection with action when working with suicidal adolescents.

Thank you for agreeing to take part in this research project.

During the interview

I will ask you about your experience of working with suicidal or dangerously self-harming adolescent patients and hope that you will be able to share case examples. Specifically, I am interested in when you have had to consider stepping out of your specific role as the patient's psychotherapist in response to risks that you perceive.

Before the interview

The following points may be useful to consider prior to the interview.

- Difficult decisions around responses to risk when working with suicidal adolescent patients.
- Reflections of the impact of decisions taken upon the therapy or therapeutic alliance.
- The impacts of not taking actions in the face of risk, both positive and negative.
- Conflicts between your understanding of patients' phantasies surrounding suicidality and any action taken in response to risk.
- The point at which it is imperative that you 'do' something in order to ensure that a child is physically safe.
- Pressures from the organisation that impact upon this.
- The impact that thinking about this area of your work has on you.

Please feel free to alter any identifying features of patients to protect their identity. However, all data will be anonymised in the process of data analysis to prevent individual cases from being identifiable.

I look forward to speaking to you soon