Child psychotherapists' perspectives on the links between personal analysis during training and practice

Literature Review

Empirical Research Project

Reflective Commentary

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DECLARATION

I declare that the material submitted for examination is my own work. The ideas and findings of others have been referenced in accordance with the guidelines provided and any work by others has been acknowledged.

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The role of personal analysis in the training of child psychotherapists:

A literature review

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Abstract

This paper presents a literature review of current knowledge and perspectives on the role of personal analysis in the training of child psychotherapists. As no literature was found on the subject of the role of analysis in the training of child psychotherapists, wider research was conducted on the role of personal therapy in the training of therapists. This research included an exploration of the history of the role of personal analysis in the training of psychoanalysts and psychotherapists, as well as a non-systematic review of empirical research on the role of personal analysis in the training of therapists. The findings showed that personal analysis was often considered by psychotherapists as the only way to learn some essential professional skills which have to be learned by experience rather than by being taught; such as a sense of what it is to be a patient, and a strong trust that even very difficult and painful feelings can be tolerated. The mandatory part of the personal analysis appeared to be much more controversial as the lack of choice and the connection between the training school and the personal analysis can be a hindrance to the development of the therapeutic relationship between the trainee and their analyst. A need for further research into the links between personal therapy in the training of therapists and patient outcomes was identified, as well as a need for research that would be specific to child psychotherapy training.

The role of personal analysis in the training of the child psychotherapist:

Literature review

An important part of the training of a child psychotherapist is the personal analysis that all trainees attend during the whole duration of their training. Personal analysis is described as a central and essential requirement of the training as a child psychotherapist, but to date there is no published research that explores this subject in depth. As will be described in this paper there is a fair amount of theoretical literature on personal analysis in the training of adult therapists. Generally, there is a strong tradition of personal analysis during training in psychodynamically oriented trainings, but there is no current research on either the effects of personal analysis on training or the effect of personal analysis on patient outcomes for child psychotherapists. This is surprising considering that personal analysis is a central requirement of the training. The fact that the trainee's analysis is part funded by the National Health Service (NHS) would also logically increase the need for research on this subject: Stakeholders may want proof of the usefulness of personal analysis for the training of child psychotherapists training, especially on patient outcomes. Even though personal analysis is a requirement for becoming a child psychotherapist, and this prerequisite has a significant cost both for the NHS and for the trainees themselves, it seems that this area has been neglected by research.

This review paper aims at bringing together theory and empirical research findings on the subject of how personal analysis or personal therapy influences the therapist's training and their future practice. The paper aims to shed further light onto the requirement for personal analysis in the training of therapists and the rationale behind it. Because this particular area has not been researched in the context of child and adolescent psychotherapy, studies that have been published on the role of personal analysis or personal therapy in the training of adult therapists will be reviewed. The findings will be discussed, taking into account the

differences between the job of child psychotherapist and that of adult psychotherapist. For example, child psychotherapy is often play based whereas adult psychoanalysis or psychotherapy is based on talk. Child psychotherapists also have various other roles such as communicating with the child's network such as their parents and their schools. As such, levels of confidentiality are different in child psychotherapy practice and child psychotherapists will alert social services rapidly if a disclosure is made or if they are worried about the child's safety. Throughout this review links will be made between the findings related to the role of personal therapy in the training of adult psychotherapists and the work requirements of child psychotherapists.

Personal therapy in the training of psychotherapists: History, theoretical views and current requirements

After defining what is a training analysis and how it differs from a classic analysis this section will begin with a short history of the issue of analysis in the training of therapists. Theoretical views on the subject will be presented. The current requirements for personal analysis in the training of child psychotherapists, and the main reasons provided by the training schools regarding the need for personal analysis in the training will then be presented and discussed. Furthermore, for comparison purposes the personal therapy requirements in the training of adult therapists in the UK will be presented.

Shapiro (1976) wrote that training analyses (because they are mandated) differ from classic personal (without the extra motivation of a training) analysis. Training analyses are entered for professional development as well as for relief of personal difficulties. In the relevant literature, there has been a lot of discussion on the nature of training analysis and how exactly it differs from therapeutic only personal analysis. It is generally thought that the mandatory nature of a training analysis necessarily complicates the analytic process, because of the multiple roles the trainee has to take regarding their own analysis. Anna Freud (1938,

published in English in 1968) described the three functions of the training analysis: experiencing the unconscious, demonstrating technique, and increasing the trainee's perceptiveness for internal events. The first function is similar to any analysis but the other two are particular to the training analysis. There is also the sense that the analyst plays a real-life role as opposed to a fantasy role in the life of the trainee as they are often involved in the process of selection and potentially other aspects of the training and selection process. Furthermore, in a training analysis there is often an underlying and implicit expectation that a trainee therapist is mentally well enough (sufficiently mentally healthy) to see patients. This might put a strain on the relationship as the trainee might be tempted to hide difficulties from their analyst, especially if there is contact or strong links between the training school and the analyst. Additionally, there is the question of the motivation to have analysis; trainees do not have to show any particular desire or motivation to have analysis as it is mandatory. The ability to ask for help and to recognise one's weaknesses or difficulties might come later in the analysis.

History and theoretical views on the training analysis. The idea of having personal analysis as part of training comes from the training of psychoanalysts, who began the tradition of having analysis as a mandatory and central part of their training. The earliest writings about personal analysis in the training of psychoanalysts can be found in 'Analysis terminable and interminable' (Freud, 1937). In this paper Freud proposed a model in which the candidate analyst should have a necessarily short analysis, although of course all analyses at the time would be considered very short by today's standards. Freud's analysis of Dora lasted only a few weeks. At the time, the training analysis was carried out by a colleague and was not supposed to be finished. The training analysis aimed to make the aspiring analyst aware of the presence and working of his own unconscious mind. The purpose was not then to fully analyse the aspiring analyst but only to help them believe in and recognise the

unconscious mind. This method was known as the ‘demonstration method’. It might be interesting to note that the safeguarding of the patient was not one of the initial reasons why personal analysis became part of psychoanalytic training. This is surprising given that psychoanalysts often treat unwell and/or vulnerable patients, and analysis could be a way to ensure that they have good intentions and remove blind spots that could lead them to cause harm to their patients. According to Balint (1954), Ferenczi in some unpublished letters to Freud argued that it was unacceptable that a patient should be better analysed than his/her analyst. This idea was met by Freud with considerable resistance, as he argued that personal character was the work tool of the analyst and should only be altered with extreme caution.

In time, however, things did change in the psychoanalytic community and gradually training analysis became longer and longer. According to Balint (1954), Ferenczi argued that a training analysis similar in duration to a therapeutic analysis would not be sufficient for the psychoanalyst. The analysis of the psychoanalyst would be complete when full psychological normality was achieved. Even though the idea of normality in psychological life is controversial, it does seem to be the case that in practice many training analyses today are indeed much longer than most classic personal analyses. The question of what constitutes a complete or good enough analysis is beyond the scope of this paper but would also be an interesting question. To take the case of training in child psychotherapy, the trainees will have at least five years of analysis at a frequency of four times a week. Through their training in clinical placements, child psychotherapy trainees usually see patients for a maximum of three weekly sessions and for a smaller number of years.

Traditionally, the training analysis was also used as a means of selection of candidates for psychoanalytic training and was considered the main way to select the best clinicians according to training analysts. In the beginning, the training analysis was also used as supervision, but this was later changed when it was felt that for the trainee to fully experience

the analysis it needed to be kept separate from supervision arrangements (Bloomfield, 1985). In the training of child psychotherapists, personal analysis has an element of selection to it, as when a candidate applies for training the trainee's analyst is involved in the decision about the trainee beginning their training and qualifying as a child psychotherapist. This issue will be discussed in greater detail later in this paper.

The training analysis has long been considered the most important part of the psychoanalytic training (Balint 1954). In the training of the child psychotherapist personal analysis is described as essential and central but is not given superiority over the other components of the training such as seminars and supervision.

Apart from early history, a number of authors subsequently wrote about the importance of personal therapy in the training of therapists. Fromm-Reichmann (1950) proposed that personal therapy enhances the sensitivity and awareness of the therapist. She also wrote about the improved technique and increased conviction about the validity of the theoretical model used, as well as decreased symptomatology from the therapist. Fromm-Reichmann argued that there is a fine line between a training analysis and a personal analysis. The idea of decreased symptomatology suggests that the trainee begins their training analysis with some symptoms, and that getting relief from symptoms can be a motivation for trainees to begin personal analysis quite separately from course requirements. There is also generally an idea that personal therapy might increase the safety of the therapy for the patients. Farrell (1996) suggested that personal analysis helps the therapist fully understand the position of the patient. For this author, personal therapy also reduces the occurrence of blind spots in the therapist as they gradually acquire better knowledge of themselves, their psychological makeup and internal conflicts.

Kernberg (2014) has virulently criticized the training analysis system. He has argued that the idea that trainees learn the techniques of analysis in their own training analysis is a fantasy. He further argued that the trainees who learn the most and the best techniques from their analysts do so as a defence against the difficulty of really using the analysis to resolve personal painful conflicts and anxieties. Kernberg (2014) described those trainees who learn the most techniques as exhibiting narcissistic psychopathology and great difficulty in accepting the inherent dependency that one is compelled to feel in analysis. This goes against the frequently quoted idea that one of the roles of personal analysis in the training of psychotherapists is the role of providing a model of psychoanalytic work. Kernberg also disapproved of the anti-research attitude generated by the training analysis system, as well as a general infantilization of the candidate. It might be interesting to point out that even though Kernberg's criticisms are mainly directed towards the training of psychoanalysts his criticisms might have some relevance for the training of child psychotherapists. In the training of child psychotherapists, unlike most other psychotherapy trainings, the trainee's analyst is consulted by the training institution at least twice during the analysis of the trainee. As already mentioned, the analyst is consulted before the trainee begins training, confirming the trainee's personal suitability for undertaking training as a child psychotherapist and beginning intensive work with their own patients. At the end of the training the trainee's analyst is consulted again and asked whether in their opinion the trainee is fit to start independent work as a child psychotherapist. Trainees' analysts might also be contacted by the training school at any time during the training if there is a concern about the trainee. It might also lead to the infantilization of the trainee who is dependent on their analyst to complete their professional training. Kernberg (2014) suggested an approach in which training analysis would be completely separate from the training school (in both choice of analysts and contact with the training institution), and the emphasis of the training of

psychoanalysts would be more based on supervision as well as on clinical and theoretical seminars. Other writers like Nielsen (1954) suggested doing a preparatory analysis "beginning the training where the therapeutic analysis ends'' (p247).

The training of the child psychotherapist relies heavily on supervision as well as clinical and theoretical seminars, but one might ask the question of the pertinence of having the training analysis so linked to the training school. Kernberg is not the only author who criticized the training analysis system. Masson (1992) warns against the indoctrination potential of personal therapy in the training of therapists. Another argument by Schlesinger (1990) is the difficulty of finding out the impact on patient outcomes from having personal therapy.

After having given an overview of the history of personal analysis in the training of psychotherapists and theoretical views on this topic, the current requirements for personal therapy in the training of UK therapists will be presented to gain an understanding of the state of therapy in training for therapists.

Current requirements of personal analysis in the training of psychotherapists in the UK. The Association of Child Psychotherapists (ACP) is the main professional body for psychoanalytic child psychotherapists in the UK. The ACP sets the training requirements for the five training schools currently providing training in the UK: Birmingham Trust for Psychoanalytic Psychotherapy, British Psychotherapy Foundation (BPF), Human Development Scotland, Northern School of Child and Adolescent Psychotherapy, Tavistock and Portman NHS Foundation Trust. According to the ACP, personal analysis is a requirement that is both essential and central to the training of the child psychotherapist. In practical terms it means that it is recommended that trainees are in analysis for a minimum of 12 months before beginning their training and remain in analysis for the four years of training. Current ACP requirements call for four weekly sessions. As part of their training, child psychotherapy trainees are placed in Child and Adolescent Mental Health services (CAMHS) as part of the National Health Service NHS (ACP, 2016). The analysis of the trainees is part-funded by the NHS Trust employing the trainees and part-funded by the trainees themselves.

The different training schools all endorse the requirements for personal analysis of the trainees but can have additional recommendations. Training schools have a committee that processes applications from senior psychoanalysts to select suitable analysts to carry out training analyses. They are generally very experienced clinicians and some of them are child psychotherapists in addition to being psychoanalysts.

In their Quality Assurance Framework for the Training of child psychotherapists (Association of Child Psychotherapists. 2016. London) the ACP provides a brief explanation of the reasons why personal analysis is an essential and central requirement. According to this document, personal analysis promotes the self-awareness that one needs, to be able to tolerate and contain the emotional states of others. It is also suggested that personal analysis helps clinicians become more resilient in their own lives and professional practices. In other

words, the ACP claims that personal analysis will help the child psychotherapist both in their professional development as a child psychotherapist and in their personal life.

In this paper, the training handbooks -where obtainable- and websites of all training institutions (in the UK and the ACP) were studied in order to identify the rationale regarding the importance of the training analysis as part of the training of child psychotherapists. There was only one handbook that included some reflection on the reasons behind the personal analysis requirement. In the handbook of the BPF, the requirement for personal therapy is explained in detail. Specifically, it is suggested that the personal analysis promotes the trainee's capacity to recognise, reflect on, contain and process their own feelings, anxieties and conflicts (IPCAPA training handbook 2016). Personal analysis is described in this handbook not only as a mandatory part of the training, but also an opportunity for personal development whereby the trainee gets the chance to experience first-hand being in the role of the patient. According to the IPCAPA training handbook, personal analysis will help the child psychotherapist to learn about their role, and be more able to observe and understand the workings of the mind. It is assumed that it will make the trainee more aware of their own anxieties and conflicts and more able to observe them in others. In terms of adult training, there are several professional associations that accredit psychotherapists in the UK. Apart from psychoanalytic training which requires trainees to be in analysis generally four to five times a week for several years, other associated professions also require their trainees to receive therapy. The British Association for Counselling & Psychotherapy (BACP) (BACP, 2002) requires its members to undergo a minimum of 40 hours of personal therapy that matches their specific theoretical model. The United Kingdom Council of Psychotherapy (UKCP, 2009) requires its members to undergo the same length and frequency of therapy as the one they are intending to offer their patients. Psychodynamic branches are usually required to have more than the minimum requirement. The British Psychological Society

(BPS) requires members of the counselling psychology division to undergo 40 hours of personal therapy as part of their training (Rizq and Target 2010). Clinical psychologists in the UK are not required to undergo personal therapy but are encouraged to attend for at least part of their training.

In this section the history and rationale behind the requirement for personal therapy in the training of psychotherapists was discussed. The relevant literature points to several benefits both for the personal and professional development of the trainee therapist. In the next section, the research from literature on the effects of personal therapy on the training of therapists will be presented.

Research and findings on the role of personal therapy in the training of therapists

In this section the findings of empirical studies on the role of personal analysis in the training of psychotherapists are reviewed. The section is organised in three parts: the first part entails research findings regarding the professional and personal advantages that therapists report in having therapy as a part of their training. The second part describes the difficulties and possible disadvantages that therapists associated with having personal therapy as part of their training. The third part concerns the links a few studies have made between therapists' personal analysis and patient treatment outcomes.

Personal analysis as a way to 'learn the trade'. The arguments put forth in the relevant literature regarding the usefulness of having personal therapy as part of therapy training are numerous. In their 2005 review of relevant empirical studies on the subject, Norcross and Connor found that personal therapy can be useful for the trainee therapist in several different ways, such as improving their emotional and mental state, providing support for professional difficulties, placing the trainee therapist in the patient's role and thus giving him or her a better understanding of therapist-patient dynamics, and providing the trainee therapist with the chance of observing and experiencing therapeutic technique in order to be able to adapt it and use it with their own patients.

Generally, there seems to be a high level of satisfaction in psychotherapists who have received personal therapy as part of their training. For example, Orlinsky, Norcross, Ronnestad and Wiseman (2005) designed a large study that examined the views and experience of over 5000 therapists from 14 different countries; they explored the percentage of therapists who sought personal therapy as part of their training, their demographic characteristics, and assessed the therapist's satisfaction with their personal therapy. Overall, it was found that the experience of having personal therapy was very positive, with 90 percent of the therapists reporting satisfaction. Similarly, Grimmer and Tribe (2001) reviewed a number of studies that suggested high rates of satisfaction of the therapists with their personal therapy. The areas of satisfaction were broken down in categories such as improved work function, improved relationships, as well as characterological changes. These findings illustrate the general opinion that therapists report finding personal therapy very helpful on both a personal and professional level. Large surveys, such as these reported above, can be very informative regarding the fact that many therapists find having psychotherapy as part of their training helpful, but cannot inform us regarding the ways in which psychotherapy can help a trainee become a therapist. It could also be reproached to those studies that they are

based on the opinion of the therapist and lack objectivity. To try and gain a more precise understanding of these processes, Rake and Paley (2009) designed a qualitative study, in which semi structured interviews were carried out with practising therapists who worked in the NHS, and all used psychotherapy in their work with patients with complex difficulties. All of the participants had had an experience of personal therapy. The responses to the interview were analysed using Interpretative Phenomenological Analysis. A key theme in this study, present in all the interviews, was that personal therapy was seen as an opportunity to learn to be a therapist. The opportunity to observe analytic techniques and have the experience of being a patient were also mentioned. However, the most important part of this learning opportunity was a much more personal and experiential sense of being in therapy. Being in therapy brought the trainees a deepened understanding of the importance they might have for their own patients, as their therapist became important to them. They gained insights that would have been impossible to learn in another manner. This experience also increased the care and the respect the therapists reported having for their patients because of their deeper understanding of being in the patient's place.

Another theme that was central in the Rake and Paley study (2009) was the impact the therapy had on self-knowledge. Several respondents mentioned the ability of the therapist not to panic and to tolerate strong feelings and emotions. This ability seemed to have had a strong bearing on the study participants, who thought this led them to better self-knowledge and self-acceptance. They also reported that this important self-knowledge helped them to become a better therapist to their own patients. There is also a mention of the genuine care and concern that was felt in the therapist's manner. This, in particular, seemed to have had a lasting influence on the study participants' way of practising therapy. Other themes that were of importance were the sense of personal robustness that came with the experience of therapy: the impression that one can survive even very negative and strong feelings and

emotions without collapsing. There was a sense from the response in the study that participants found this helpful when becoming therapists themselves. The confidence in the ability of not getting tangled up with patients was also important for the participants of this study. This study was very small as it had only eight participants who all worked in the same service, this make the generalisability of the study more difficult.

A study by Wiseman and Shefler (2001) also explored the impact of personal therapy on the professional and personal development of psychotherapists. This study presents particular interest for the case of child psychotherapy training because of the psychoanalytic orientation of the participants of the study. This study focused on experienced practitioners and the therapy they received as part of their training, but also later during their professional lives as a mean of personal and professional development. This qualitative, in depth study, presents an interesting description of the way in which personal and professional perspectives cannot be completely separated. For example, one of the participants explained in one of the interviews that personal issues that one works on during personal analysis are bound to be triggered while working with patients. Using analysis to talk and think about work with patients is then indistinguishable from working only on personal issues. In this study, there is also mention of the fact that some of the participants of the study were reluctant to begin psychotherapy. They had not identified personal issues they wanted to work on and did not feel they needed it. However, as soon as they began therapy, they recognised that they had issues that they needed to work on. This can constitute a valuable argument for making personal therapy mandatory. It is possible that some therapists would choose not to enter therapy if it was not mandatory, despite the fact that they might have needed it as an important part of their training. In other words, the trainees might not be the best judges of whether or not they need therapy. It is possible also that the choice to become a therapist might be partly fuelled by personal issues and needs (Shapiro, 1976). It can be ironic that

one of the things that might be achieved through having therapy is the ability to reflect on oneself, learning to ask for help and recognising one's difficulties and weaknesses.

Furthermore, Wiseman and Shefler (2001) argued that participants described sometimes modelling their therapist's manner, which was attributed to a very personal sense of admiration and fondness. This of course might lead to issues related to identification with, and potentially idealisation of the therapist. In this study there was a lot about imitation of the therapist which would not really be applicable in child psychotherapy work. As in previous studies, the participants reported increased self-knowledge and self-confidence as well as the increased ability to tune into the patient's experience. Moreover, participants in this study highlighted the increased ability to feel the needs of the patients at every moment during the session and reported a sense of flow in the sessions. Another interesting idea that was developed in this study was that of the therapist as a good mother, who helps the trainee therapist grow, develop and then move towards independence. Seeing the therapeutic relationship in the personal therapy as a way to scaffold the new therapist's work and personality might also be a justification for mandatory therapy in the training of therapists. This argument seems to be strengthened by the report the participants made about being more able to use supervision as a result of them having received therapy.

The costs of personal therapy. Despite evidence for the benefits of personal therapy in training, there are some less positive findings in some studies. More specifically, there is a suggestion that therapy in the early stages of training might lead to detrimental effects on the outcome of therapy, as the trainee might then become too preoccupied with their own difficulties and their own internal world, which might impede their therapeutic role (Garfield and Bergin 1971; Greenberg and Staller 1981). It is worth noting that for child psychotherapists, personal analysis has to begin one year before clinical work can begin. Similarly, Thorne and Dryden (1991) also mention the difficulties around the mandatory part of the therapy that could be detrimental to its efficacy. The emergence in the therapy of painful material could lead to the student not participating fully in some areas of the course.

Related to this, Macran and Shapiro (1998) wondered whether negative patient outcomes and negative consequences of having personal therapy during training might have to do more with the personality and personal issues of the trainee therapists, who might have come into the profession partly as a means to resolve their own issues. Macran and Shapiro (1998) described a substantial minority of aspiring therapists who enter the profession as a means of getting their conflicts resolved. On the other hand, one could argue that being interested in one's own mental health could actually be seen as a pre-requisite for becoming a therapist. It is then difficult to differentiate between the aspiring therapists who are interested in their own conflicts and aspire to better integration, and the ones who enter the profession, in order to resolve those conflicts. Some other negative personal outcomes reported in the literature, such as potential damage to marriage or other relationships, feeling that the therapist is the most important person in the life of the trainee and withdrawal from the outside world (Thorne and Dryden 1991), do not seem to be more prevalent or relevant in analysis as a part of training than in classic analysis.

Rizq and Target (2010) explored in a qualitative study the links between the attachment status of the trainee therapist and the outcomes of their personal therapy in the context of training. Twelve counselling psychologists were first interviewed with the Adult Attachment Interview (Cassidy & Shaver 1999), before being interviewed about their view on their personal therapy during training. In this study approximately sixty percent of the interviewed therapists were classified as securely attached, which leaves a high proportion of insecurely attached therapists. As this was a relatively small study, the authors did not seek to generalise the findings and there were no assumptions that the sample was representative of therapists. From this study, it appeared that securely attached trainee therapists are more likely to benefit from their personal therapy and are more able to then make use of it in the context of their own practice. Insecurely attached trainee therapists reported a more difficult relation with the therapist and were especially sensitive to power dynamics between the training analyst and the trainee therapist. This preoccupation with power imbalances in the relationship led to poorer therapy outcome. Even if the study is not easily generalizable, the idea that forty percent of trainee therapists are insecurely attached has implications for the way the profession is thought about. In Rizq and Target's study none of the participants were in psychodynamic training, and this might have a significant bearing on the result; in psychodynamic thinking part of the therapy happens on an unconscious or subconscious level and the patient might not always be aware that the therapy is working. Having a study based on trainee therapist opinion and recollections about their therapy carries the risk of subjectivity. Depending on the stage at which the therapy is at (or ended at) there might have been some difficult material in the relationship between the patient and the therapist. This material does not necessarily mean the therapy was not working, but that there was some significant work to be achieved on relationships. Therefore, the relationship with the therapist was there as a practice ground for other relationships

In the Rake and Paley study (2009) there are also interesting findings on the mandatory nature of the therapy, which was found to have a negative impact. Therapists seemed to find that generally therapy had a place in the training of therapists, but thought that the mandatory nature of it had a detrimental effect on its effectiveness. Some participants noted that the obligatory aspect of the therapy led them to minimize the value of it. The length of the mandatory therapy was questioned, especially when the therapy was difficult and found to have an unsettling effect on the therapist's own practice with patients.

Similarly, Wiseman and Shefler (2001) mentioned the difficulties of role switching between being a patient and being a therapist. One of the participants described dreading seeing his patients when he felt he was in a regressed state after a therapy session of his own. A similar argument was raised by Rake and Paley (2009) who reported an unsettling effect of having therapy at the same time as being a practising psychotherapist. Participants reported that during difficult times in therapy it was difficult for them to find the necessary emotional availability for their own patients. Some other negative findings were related to the general manner of the therapist. Some of the participants could vividly recall some comments that they judged negative made by their analysts, and still felt affected by these.

Patient outcomes and personal analysis in the training of the therapist. In the Handbook of Psychotherapy and Behaviour Change (2013), the evidence for the impact of personal psychotherapy in the training of therapists on the outcomes of the therapists' own patients is reviewed. The authors claim that it is difficult to directly link patient outcomes and personal psychotherapy attended by the therapist, as many different factors can influence patient's outcomes. Guy and Liaboe (1986) found that the therapist having personal therapy could be a way to alleviate or to prevent some of the negative effects inherent in the role of therapist, such as stress or mental disturbance, and to prevent burnout. Some studies such as MacDevitt (1990) and Linley and Joseph (2007) came to the conclusion that the therapist's well-being and good mental health had a positive impact on patients' outcomes. In the MacDevitt (1990) study this effect could be explained by a better awareness of countertransference dynamics. This finding is therefore very specific to psychodynamic trainings. In the Linley and Joseph (2007) study emphasis was given to the protective factors against burnout that personal therapy for the therapist could have. On the contrary, poor well-being and emotional health negatively influenced client outcomes. Therapist's mental health and well-being could be improved by the personal analysis they undergo during the training but the actual measurement of the impact of personal analysis on the therapist's well-being has not been researched in depth.

Sandel *et al* (2006) also pointed out that the area of the impact of personal therapy in training psychotherapists is under-researched. They have attempted to make links between the therapists attending therapy and the patient's outcomes. They compared patients' outcomes for a variety of therapists, including therapists who had had no personal therapy, therapists who had long analysis and therapists who had short term therapies. They found that psychotherapists with long personal analysis were heavily represented in the category of patients who had achieved the least change (as well as non-significant deterioration). The authors offered a

different interpretation of this finding. Psychotherapists with longer trainings and longer personal analysis might be matched with more difficult patients that would be deemed too difficult to manage by psychotherapists with shorter trainings and non-existent or shorter personal therapy. This is indeed often the case for child psychotherapists in NHS clinics who are mandated to treat complex patients with multiple traumas, sometimes after other treatments have been tried unsuccessfully. Another way the authors have interpreted the results is the question of the difference between psychoanalysis and psychotherapy. It is possible that the therapists who went through psychoanalysis in their trainings might adopt unwittingly some of the attitudes of their psychoanalyst (such as a very neutral stance), which might have a detrimental effect in psychotherapy. Along similar lines Grant & Sandell (2004) reported that therapists with classically psychoanalytic attitudes did less well with their patients than therapists who adopted a more flexible attitude. This difference might be even more pronounced between analysis and child psychotherapy. Child psychotherapy is based on child play, play being a way to uncover and understand the working of the unconscious mind, as free association is for adult therapist. Child and adolescent psychotherapists are mandated to have a classic analysis and are therefore employing a very different technique with their patient to the technique their analyst uses in their own analysis. The issue of adopting a classical psychoanalytic stance might not be such a problem for child psychotherapists as they are using a more flexible approach anyway. One older study by Guild (1969) found that therapists who had been through personal analysis had more efficient therapeutic relationships with their patients, but this was not directly linked to better patient outcome in the sense of symptom resolution. In a different study, Garfield and Bergin (1971) suggested that being involved in personal therapy while being in training might have a detrimental effect on patients because the therapists would be too preoccupied with their own issues. This finding was difficult to interpret, and the authors suggested carefulness and pointed out the need for further study.

In this section, the literature on the effects of personal therapy in the training of psychotherapists was presented. The majority of therapists reported that personal therapy was an important part of their training as well as a positive experience. The benefits of personal psychotherapy ranged from learning psychotherapeutic techniques to much more in depth benefits such as increased self-confidence, trust in the therapeutic process and ability to tolerate difficult states of mind in patients. In terms of the less positive effects of personal therapy in training, one of the findings was that trainees who undergo therapy at the same time as they see patients may pay less attention to their patient because they might be too preoccupied with their own state of mind. There were also reports of the effects of the therapy being mandatory. Some studies reported that this was a negative element making the student value the therapy less, whilst another study showed that trainees who might be reluctant to start therapy in the first place admitted later that they had benefitted from it. Links with patient outcomes were found to be very difficult to interpret and would require further research.

Conclusions

Personal analysis is described as an essential and central component of the training of child psychotherapists. From a review of some of the literature on the subject, there are some strong reasons to keep it. Personal analysis appears to be the only way to learn some of the key skills of the psychotherapist. Those skills must be learned by experience rather than by being taught, e.g. a sense of what it is to be a patient, and a strong trust that even very difficult and painful feelings can be tolerated. The mandatory part of the personal analysis appeared to be much more controversial as the lack of choice and the connection between the training school and the personal analysis can be a hindrance to the development of the therapeutic relationship between the trainee and their analyst. At the same time, if analysis was not mandatory it is possible some trainees would choose not to attend and they would

miss out on essential learning. One important finding was that some therapists realised they needed to have therapy, or at least could make good use of it, only when they had begun therapy.

This review focused mainly on research based on adult psychotherapy training, which has some significant differences from child psychotherapy training. Child psychotherapists might use their own analysis as a model for understanding and containing their patients' communications, but they generally will have to adapt their technique to the type of patients they are working with. As such, the argument about having therapy or analysis to learn the trade is not really relevant to child psychotherapists. This review of some of the literature on the role of analysis in the training of child psychotherapists highlighted the need for research on the processes through which personal analysis affects the professional development of child psychotherapists, as well as patient outcomes.

References

Anna Freud Centre (AFC), University College London (UCL), Independent Psychoanalytic Child and adolescent Psychotherapy Association (IPCAPA), British Psychotherapy Foundation (BPF). (2015-2016). *Doctorate in Child and Adolescent Psychotherapy Course Handbook*. London.

Association of child psychotherapists (ACP). (2016). *Quality Assurance Framework for the training of child psychotherapists*. London.

Balint, M. (1954). Analytic training and training analysis 1. *International Journal of Psycho-Anal*ysis, *35,* 157-162.

Bergin, M. & Garfield, L. (2004). *Bergin and Garfield's handbook of psychotherapy and behaviour change.* (5th ed. / [edited by] Michael J. Lambert. ed.). New York: Wiley.

Birkbeck University. (2013-2014). Graduate diploma and MSc in psychodynamic counselling *and psychotherapy with children and adolescents course handbook*. School of Social Science, History and Philosophy. London.

Birmingham Trust for Psychoanalytic Psychotherapy (BTPP). (2015-2016). *Clinical training in psychoanalytic psychotherapy with children and adolescents (and their parents)*. Course Handbook. Birmingham.

Bloomfield, O. H. D. (1985), Psychoanalytic supervision: An overview. *International Journal of psychoanalysis*, 66:401-409

Cassidy, J., & Shaver, P., (Eds). (1999) *Handbook of Attachment: Theory, Research, and Clinical Applications.* Guilford Press, NY.

Dryden, W. & Thorne, B. (1991). *Training and supervision for counselling in action.* edited by Windy Dryden and Brian Thorne. London: Sage.

Farrell, W. (1996). *Training and professional development in the context of Counselling psychology.* R. Woolfe & W. Dryden (Eds.), Handbook of counselling psychology. London: Sage.

Freud, A. (1938). *The problem of training analysis.* The writings of Anna Freud (pp. 407–421). New York: International Universities Press, 1968.

Freud, S. (1937). Analysis terminable and interminable. *International Journal of Psycho-Analysis*, 18:373-405.

Fromm-Reichmann, F. (1950). *Principles of intensive psychotherapy*. Chicago: University of Chicago Press.

Garfield, S. L., & Bergin, A. E. (1971). Personal therapy, outcome, and some therapists 'variables. *Psychotherapy: Theory, Research and Practice*, 8, 251-253.

Garfield, S. L., & Bergin, A. E. (2013). *The handbook of psychotherapy and behaviour change. Therapists' variables, 229-269.* New York: Wiley and Sons, Inc.

Grant, J., & Sandell, R. (2004). Close family or mere neighbours? Some empirical data on the differences between psychoanalysis and psychotherapy. In P. Richardson, H. Kachele & C. Renlund (Eds), *Research on psychoanalytic psychotherapy with adults*, 81-108. London: Karnac.

Grimmer, A., & Tribe, R. (2010). Counselling psychologists' perceptions of the impact of mandatory personal therapy on professional development--an exploratory study. DOI: 10.1080/09515070110101469

Guild, M. (1969). *Therapeutic effectiveness of analysed and unanalysed therapists*. (Unpublished doctoral dissertation). St. John's University, New York.

Guy, J. D., & Liaboe, G.P. (1986). The impact of conducting psychotherapy on psychotherapists' interpersonal functioning. *Professional Psychology: Research and Practice*, 17, 111-114.

Kernberg, O. F. (2014). The twilight of the training analysis system. *Psychoanalytic Review*, 101(2).

Linley, A & Joseph, S. (2007). Therapy Work and Therapists' Positive and Negative Well–Being. *Journal of social and clinical psychology*, 26(3), 385-403. DOI: /10.1521/jscp.2007.26.3.385

MacDevitt, J. W. (1987). Therapists' personal therapy and professional self-awareness. *Psychotherapy: Theory, Research, Practice, Training*, 24(4), 693-703. DOI: 10.1037/h0085769

Macran, S., & Shapiro, D. A. (1998). The role of personal therapy for therapists: A review. *British Journal of Medical Psychology*, *71*(1), 13–25. DOI: 10.1111/j.2044-8341.1998.tb01364.x

Masson, J. (1992). *Against therapy.* London: Fontana.

Nielsen, N. (1954). The dynamics of training analysis. *International Journal of*

Psycho-Analysis, 35:247–249.

Norcross, J., & Connor, K. (2005). *Psychotherapists entering personal therapy: Their Primary reasons and presenting problems*. J. Geller, J. Norcross, & D. Orlinsky (Eds.), The psychotherapist own psychotherapy: patient and clinician perspectives, 192-200. New York: Oxford University Press.

Orlinsky, D., Norcross. J., Ronnestad H., & Wiseman, H. (2005). *Outcomes and Impacts of the psychotherapist's own psychotherapy. A research review.* J. Geller, J. Norcross, & D. Orlinsky (Eds), The psychotherapist's own psychotherapy: patient and clinician perspectives. Oxford: Oxford university press.

Rake, C & Paley, G (2009) Personal therapy for psychotherapists: The impact on therapeutic practice. A qualitative study using interpretative phenomenological analysis, *Psychodynamic Practice*, 15(3), 275-294.

Rizq, R. (2011). *Personal therapy in psychotherapeutic training: Current research and future directions*. Journal of Contemporary Psychotherapy, 41(3), 175-185. DOI: 10.1007/s10879-010-9168-7

Rizq, R & Target, M (2010) *"We had a constant battle". The role of attachment status in counselling psychologists' experiences of personal therapy: Some results from a mixed-methods study*, Counselling Psychology Quarterly, 23:4, 343-369. DOI: 10.1080/09515070.2010.534327

Sandell, R., Carlsson, J., Schubert, J., Grant, J., Lazar, A., & Broberg, J. (2006). Therapists' therapies: The relation between training therapy and patient change in long-term psychotherapy and psychoanalysis. *Psychotherapy Research*, 16(3), 306–316. DOI:

10.1080/10503300500273110

Schlesinger, H. (1990). *Supervision and the training analysis: repetition or collaboration?* M. Meisels & E. Shapiro (Eds.), Tradition and innovation in psychoanalytic education (pp. 135–140). Hillsdale: Erlbaum

Shapiro, D. (1976). The analyst's own analysis. *Journal of the American Psychoanalytic Association*, *24*(1), 5–42. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/1262684

Tavistock and Portman NHS Foundation. (2015-2016). *Course handbook: professional doctorate in psychodynamic psychotherapy with children and adolescents (M80).* London: The Department of Education and Training (DET).

Wiseman, H., &Shefler, G. (2001). Experienced psychoanalytically oriented therapists' narrative accounts of their personal therapy: Impacts on professional and personal development. *Psychotherapy*, 38, 129-141.

A qualitative exploration of child psychotherapists` perspectives on the links between personal analysis during training and practice

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Abstract

Personal analysis is a central requirement for the training of UK child and adolescent psychotherapists and is part-funded by the National Health Service in the UK. Empirical research on the significance of therapy for the professional development of child psychotherapists is virtually non-existent. Some empirical literature supports the importance of personal psychotherapy for the training of adult psychotherapists, but the differences between adult and child psychotherapy make the findings of this literature tenuous and difficult to apply directly to child psychotherapy training. This study aims to explore this issue by studying qualified child psychotherapists'` views on the role that personal analysis has played on their clinical practice, with a particular focus on the ways in which it affected the relationships they formed with their patients.

Semi-structured interviews were conducted with six UK-based child and adolescent psychotherapists on their views about the role of personal analysis for their clinical practice during training and post-qualification. Interviews were audio recorded and analysed using thematic analysis.

Thematic analysis of the interview material points to three main themes that capture participants' views on the implications of their personal analysis during training for their clinical practice: the holistic experience of being a patient, the supportive aspect of analysis during training, and factors associated with the impact of the analysis being part of the training. In brief, it appears that personal analysis during training enabled participants to learn things they would not have been able to learn in any other way, however, the close links between the training schools and the analysts proved a more controversial topic.

Impact Statement

Personal analysis is described as a central and essential requirement in the training of Child and Adolescent Psychotherapists by the Association of Child Psychotherapists. There is some evidence also highlighted in this study that personal analysis plays an important part in the professional identity of child psychotherapists. More generally, there is a strong tradition of personal analysis as a central aspect of training in psychodynamically oriented psychotherapy training courses. However, there is no research to date on the effects of personal analysis on the professional development of child psychotherapists, on the process of training itself, or for patient outcomes.

This gap in the research literature was an important factor for conducting this study. The existing empirical literature supports the importance of personal psychotherapy for the training of adult psychotherapists, however, the differences between adult and child psychotherapy make the findings of this literature difficult to apply directly to child psychotherapy training and practice. This study aimed to explore this issue by studying qualified child psychotherapists` views on the role that personal analysis plays in their clinical practice, with a particular focus on the ways in which this experience affects the relationships they form with their patients. For child psychotherapists in training, personal analysis is part-funded by the National Health Service and NHS stakeholders are likely to value having proof of the usefulness of personal analysis as it may promote the outcome of psychotherapy.

An important finding of this study was that all participants stated they would keep the requirement for personal analysis in the training of child psychotherapists as it currently stands. The reasons they put forth were related to their sense of acquiring personal insight, insight into the process of therapy, and internalising good objects and feeling supported during their analysis, which they did not feel could have been achieved in any other way.

These findings support the notion that personal analysis is a crucial part of the training and provides learning of an important and unique kind.

Another key finding of the study was that contacts between the training schools and the trainees' analysts impose significant strain on the therapeutic relationship. This seemed to add to the already present power dynamic that usually exists between an analyst and their patient. This information could be fed back to training schools, with an aim to start a discussion about the transparency around such contacts and their usefulness.

Furthermore, research on the effect of therapist factors and their importance in the success of the therapy has shown some evidence that the personality, level of well-being and self-awareness in the therapist has a positive influence on patient outcomes. This study shows that personal analysis improves stress levels and self-awareness in trainee child psychotherapists, both of which are important factors for therapy outcome. These findings could be of interest to other training institutions for associated professions.

A qualitative exploration of child psychotherapists` perspectives on the links between personal analysis during training and practice

Personal analysis is an integral part of the psychodynamic child psychotherapist training and is mandatory for child psychotherapists who are registered with the Association of Child Psychotherapists (ACP) the professional body regulating child psychotherapy in the UK. Prospective trainees must attend personal analysis for a minimum of one year before they begin training and must remain in analysis for the whole duration, i.e. four years, of their training. Analysis is described as a central and essential requirement by the ACP but to date there is no published research that explores this subject in depth. Generally, there is a strong tradition of personal analysis during training in psychodynamically oriented trainings, but there is no current research on the effects of personal analysis either on the training itself or on patient outcomes for child psychotherapists. This is surprising considering that personal analysis is such a central requirement to the training. The fact that the trainees' analysis is part-funded by the NHS would also be expected to increase the need for research on this subject as the stakeholders might value having proof of the usefulness of personal analysis, especially as this impacts patient outcomes. Even though personal analysis is a requirement for becoming a child psychotherapist and has significant costs for both the NHS and for trainees themselves, it seems that this area of research has been neglected. In the next section, the historical roots and rationale behind the tradition of analysis as part of psychotherapy training are discussed, followed by a presentation of the empirical research on the impact of personal therapy on psychotherapists' professional development, work and personal life.

History – Origins of the training analysis

The tradition of having personal analysis as part of training comes from the training of psychoanalysts, where personal analysis is a mandatory and central part of training. The earliest writings about personal analysis in the training of analysts can be found in 'Analysis

terminable and interminable' (Freud, 1937). In this paper, Freud proposed a model in which the candidate analyst should have a short analysis carried out by a colleague. The analysis was expected to make the aspiring analyst aware of the presence and working of his own unconscious mind; this was known as the 'Demonstration Method'. According to Balint (1954), Ferenczi, in some unpublished letters to Freud argued that it was unacceptable that a patient should be better analysed than his analyst. This idea was met by Freud with considerable resistance, as he apparently argued that personal character was the work tool of the analyst and should only be tampered with, with extreme caution.

Traditionally, training analysis was also used as a means of selection of candidates for psychoanalytic training and was considered the main way to select the best clinicians. In the training of child psychotherapists, personal analysis has an element of selection to it as, when a candidate applies for training, their analyst is involved in the decision about them beginning training and qualifying. Training schools might also contact the analyst at any point during the training if there are concerns about the trainee. This makes for a strong link between the training schools and training analysts.

Empirical research

In terms of empirical research, there seems to be no published research to date on the impact of personal analysis on child psychotherapy training and practice. However, there is empirical research on the impact of personal therapy on the training of adult psychotherapists, psychoanalysts and counselling psychologists. This literature is reviewed below. It must be noted, however, that this area is considered under-researched (Sandel *et al* 2006).

Generally, there seems to be a high level of satisfaction in psychotherapists who have received personal therapy as part of their training (Grimmer & Tribe, 2001; Orlinsky, Shofield, Schroder & Kazantzis, 2011). Therapists report that having personal therapy as part of their training has had a positive influence on their practice and has helped them understand the dynamics between their patients and themselves better. A key finding in the literature is

that one of the most important things therapists learn from being in therapy themselves entails a personal and experiential sense of being in therapy. Being in therapy seems to bring therapists a deepened understanding of the importance they might have for their own patients, as their own therapist became important to them (e.g. Rake & Paley 2009).

Another finding regarding the benefits of therapy relates to increases in self-knowledge and the ability of the therapist to tolerate strong feelings and emotions and not panic in challenging clinical situations. Research also shows that it is difficult to separate therapy for personal reasons from therapy for professional reasons, as personal issues that one works on during personal analysis are bound to be triggered whilst working with patients (Rake & Paley, 2009; Wiseman & Shefler, 2001). Some studies that examined therapists' well-being found that functioning as a therapist can lead to some disturbance and stress and personal therapy can be a way to alleviate this. In these studies, therapists' stress was found to be associated with poorer therapy outcome (Guy & Liaboe 1986; Lambert & Bergin, 2004).

Research shows that therapists' positive qualities such as genuine care and concern has a positive influence on their patients' future practice. Therapists reported sometimes modelling their own therapist's manner out of a very personal sense of admiration and fondness. The authors further suggested that therapists function as a 'good mother', who helps the trainee therapist grow and then move towards independence (Rake & Paley, 2009).

On the other hand, there are some less positive findings regarding the effects of personal therapy in the training of therapists. The mandatory nature of personal therapy can have a detrimental effect, as some therapists noted that this led them to minimize the value of therapy (Thorne & Dryden 1991). This is in line with the issues discussed by Kernberg (2014) in which he criticises the training analysis system, and argues that trainee therapists often feel infantilized in the context of the power relationship with their own analyst . On the

other hand, one study found that although some participants were reluctant to begin psychotherapy as they did not feel they needed it, as soon as they began therapy they recognised that they had issues that they needed to work on (Wiseman & Schefler, 2001). A further issue was raised by other studies (Garfield & Bergin, 1971; Rake & Paley, 2009; Thorn & Dryden, 1991; Wiseman & Shefler, 2001), which reported that having therapy while seeing patients made some therapists feel more vulnerable as they might be in a regressed state. Those studies found that therapists found they sometimes had less mental space for their patients while being in therapy at the same time as providing it.

From a review of the relevant literature, there is evidence that personal therapy can be the best way to learn some of the key skills of the psychotherapist, which need to be learnt through feeling and experiencing rather than tuition. The sense of what it is to be a patient and a strong trust that even very difficult and painful feelings can be tolerated are amongst the things that can be learned primarily through having therapy oneself. The mandatory part of personal analysis appeared to be more controversial, as the lack of choice and the communication and connections with the training school can be a hindrance to the development of the therapeutic relationship between the trainee and their analyst. At the same time, it could be argued that if analysis was not mandatory, some trainees could miss out on essential learning, as there is some evidence that people sometimes discover the usefulness of therapy only whilst in therapy.

The above review focused on research on adult psychotherapy training, which has some significant differences from the practice of child psychotherapy. Child psychotherapists might use their own analysis as a model for understanding and containing communications, but they generally will have to adapt their technique considerably to the type of patients they work with. Child psychotherapists will often use play and creative materials in their sessions with children; they also often see the parents of their patient and liaise with the child's

network, and thus the boundaries of confidentiality are very different. Developmental needs and capacities are different in children and adolescents, the need to assess risk and to intervene is generally bigger, and of course the motivation to enter therapy is different for children and adolescents. It seems therefore important to explore and understand the particular links that exist between personal analysis during training and the practice of child psychotherapy. Attending analysis for at least five years is a heavy undertaking for trainees and it seems important to understand how it contributes to their professional development. This is of course in addition to the analysis being partly funded by the NHS which further points towards the need for research.

Method

Design

This study is a qualitative exploratory study. Six semi-structured interviews were conducted with qualified child and adolescent psychotherapists and analysed with thematic analysis.

Ethics

Before beginning the study, ethics approval was obtained from the UCL Ethics Committee (See appendix V). Consideration was given to the sensitive nature of the material that would be collected as one's impressions on analysis are highly personal. Recordings were password protected and destroyed after transcription had taken place. Transcriptions were kept securely on a password protected computer.

Participants

Six UK-based qualified Child and Adolescent Psychotherapists volunteered to participate in the study. All were registered with the ACP as full members. At the time of the study, they were practising child psychotherapy in different settings and were not training analysts themselves. All participants were female and had between one and 20 years post-qualification experience. The participants are briefly described below.

Larissa[1] had personal analysis for 6 years and continued her therapy for approximately a year after qualifying. She had 15 years' experience as a child and adolescent psychotherapist.

Eleanor had personal analysis for 6 years and had had intensive therapy prior to this during another training. She stopped analysis right after qualifying and had 15 years of experience as a child and adolescent psychotherapist.

[1] Pseudonyms are used to preserve participant anonymity.

Marina had personal analysis for about 8 years, continued after qualifying, and had 1 year of experience as a child and adolescent psychotherapist.

Elena had personal analysis for about 5 years and stopped after qualifying. She had 10 years of experience as a child and adolescent psychotherapist.

Catherine has had personal analysis for 8 years that she continued after completion of the training and had 3 years of experience as a child and adolescent psychotherapist.

Louise had analysis for 7 years, continued for approximately a year after qualifying, and had 20 years of experience as a child and adolescent psychotherapist

Procedure

Participants were recruited from the wider academic and professional network of the researcher. The main researcher asked colleagues and co-trainees to share information about the study to find interested participants. Participants were approached verbally or via email that informed them about the study and, if they showed interest in participating, they were provided with more information about the study (see information sheet and consent form, in Appendix B and C). Three participants were known to the main researcher in a professional capacity and three participants were contacts of contacts and not directly known by the main researcher. Participants were informed of their right to withdraw from the study at any time and without having to provide a reason. Five interviews were conducted at the participants' place of work and one in their home.

Interviews were semi-structured and each lasted approximately one hour. Semi-structured interviews were selected as they allow a free-flowing discussion where participants can emphasize any aspect of the subject they are particularly interested in (Silverman 2000). At the start of the interview, general questions were asked about the nature of the analysis (length, beginning and end in relation to the training). Participants were then asked about their perspective on the way their personal analysis had an impact on their practice and were

encouraged to provide examples. They were then asked about the impact of their analysis on the way they formed relationships with their patients. They were also asked to think about how the influence of the analysis had changed over time (throughout their training and after they had qualified) (for the full interview schedule see Appendix D).

Analysis

The interview transcripts were analysed thematically (Braun & Clarke 2006). The transcripts were arranged in a table and each sentence was assigned an initial meaning code (see Appendix A); this process was repeated with the initial codes categorised in wider meaning units or categories. This was repeated until no new higher-level categories emerged. Categories were grouped into themes, based on the participants' talk, the research question and the relevant literature. Two separate processes were used to minimise bias and subjectivity: -Samples of anonymised interviews were shared with the peer researcher group. The researchers were invited to code it and then the results were compared with the researcher's initial coding and discussed until code was agreed. –Research supervisor was asked to check the coding in relation to the data and then later was asked to check the themes in relation to the codes. This led to discussions and at times re-coding before the codes and then the themes could be agreed.

Results

The findings can be organised in three main themes. Figure 1 shows the three main themes (in yellow), the subthemes (in blue) and the different categories comprising the subthemes. Each theme will be discussed below.

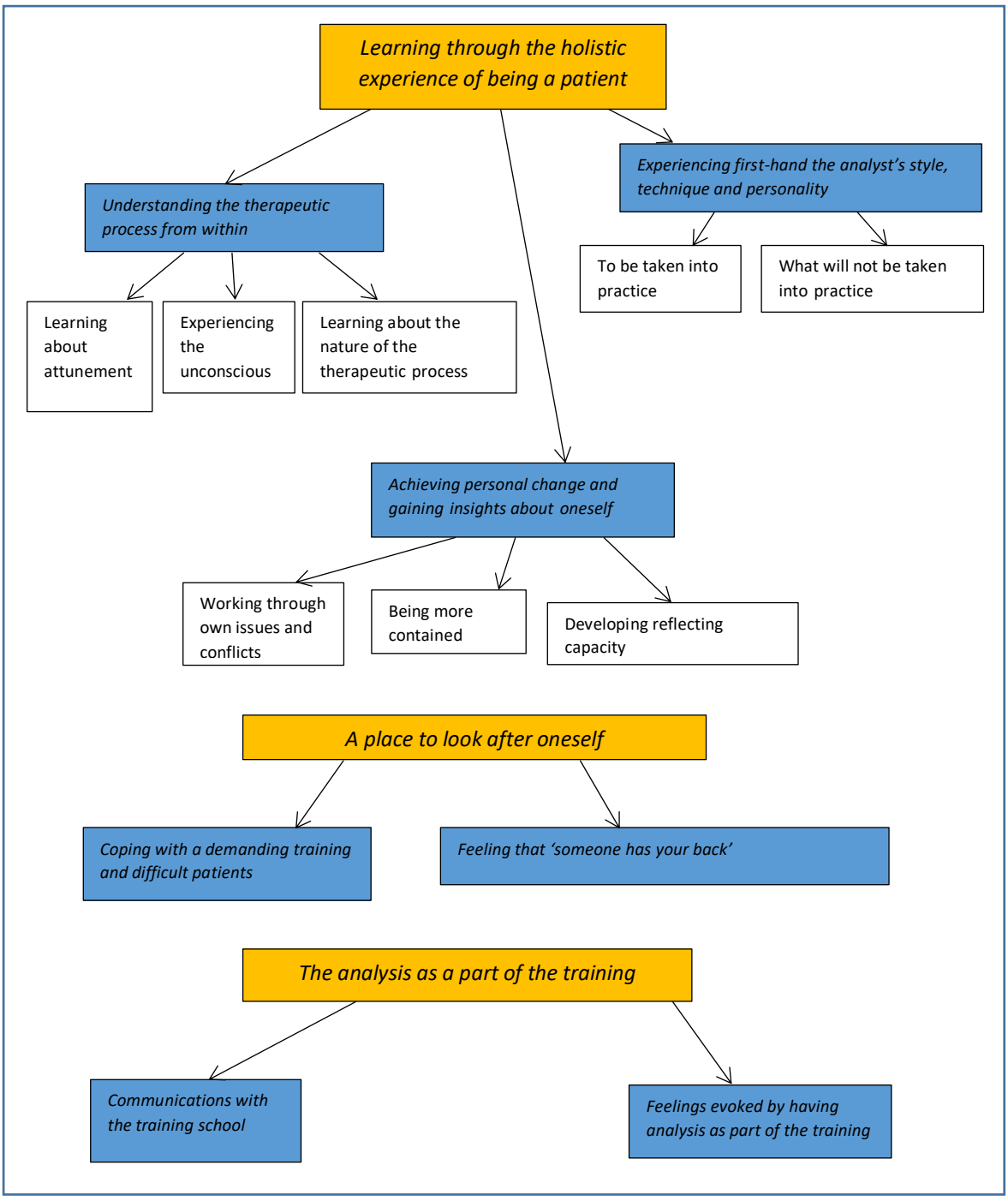

Figure 1: Summary of findings

Learning through the holistic experience of being a patient

The first theme relates to what has been learned by the trainee from the *holistic experience of being in therapy* and could arguably not have been learnt by other means, such as attending seminars, supervision or studying literature. This category contains the largest number of codes and it comprises three sub-themes: *Understanding the therapeutic process from within; Achieving personal change and gaining insights about oneself; Experiencing first-hand the analyst's style technique and personality*.

Understanding the therapeutic process from within. All participants conveyed the sense that having analysis had made them more aware of the fact that the therapeutic process was a complicated, delicate and highly personal process. This subtheme was deemed important, but participants sometimes reported finding it difficult to explain accurately as it pertained to a very personal experience. This difficulty of putting the experience into words highlights the fact that analysis is something to be experienced rather than something that can be learned solely theoretically. In relation to this the experience of attunement was mentioned by several participants, who described having someone following one's rhythm and ideas as a personally significant and formative experience. This aspect of the experience of being in therapy whilst training has not been described in the literature to date.

Louise, for example, talked about learning to be patient:

I think the other thing I learned about was process. I think I learned a great deal about how to be patient, how, you know, the, if, you know, it's like the toothpaste tube. If you hold it up long enough, it will come out, you know what I mean? It's, if you squeeze it, it'll come out but in a different consistency and if you hold it long enough, it comes out of its own accord, kind of thing. I just have a feeling, I learned a lot of that on the analysis couch, I think. Just the fact that, you know, it's a process.

The experience of *feeling understood* featured as an important point of learning for some of the interviewees. The importance of *unconscious communication* was highlighted by several of the interviewees as another important aspect of this learning. One participant mentioned how she often could tell that her analyst was preoccupied by something at the beginning of a session. This experience made her aware of the power of unconscious to unconscious communication, and as it was a difficult experience for her, led her to be very conscious of what she has in mind during her sessions with children. Another participant talked about how essential analysis was to her in understanding the therapeutic process:

> Larissa: *Um, I don't think I would have understood the process. Because I don't think until those, um, uh, you know that whole process of, you think you're absolutely fine, and then something happens that's, you know, and then you realise actually you're not fine at all, you're deeply distressed about something and you arrive in a state, and, you know, all of that. I wouldn't have believed that if it didn't happen to me actually.*

The intensity of the transference feelings was also mentioned in several interviews, and most participants reported this increased their sense of responsibility towards their own patients. One participant reported experiencing a very strong negative transference with her analyst and learning through this not to be scared of similar responses in her relationships with her own patients.

> Eleanor: *So I suppose one of the things it's done is it means I'm not really - I mean I've never been really frightened of negative transference when it's at me. I'm much more worried about if I'm working with a patient where they're really, really positive and*

> *idealising 'cause I think, I always think oh, I've only got one way to go and that's down.*

The experience of having been a patient, knowing what it was like and keeping it alive in one's mind while working with patients was described by several participants as one of the key achievements of their analysis.

> Louise: *And I think that's a profoundly important experience. I think we, quite appropriately, protect ourselves from the experience of being a patient as professionals and I think it's really important that we can, at least in our memories, go back to the experience, to the infantilising, to the disempowering, to the power, you know, to the establishment of a power relationship, all of those things.*

Getting an experience of dependency and regression was crucial for several of the participants for understanding the power they had over their own patients. Learning about the fact that everything in therapy is meaningful was also very important for several of the participants. Louise described this below:

> *I can always see how somebody might use even the most undermining, demoralising, you know, children running out of rooms, climbing, you know, all of that. It's all useful. It's not very pleasant but, you know. And so I think that's another thing, that everything is grist to the mill, everything is, is useful within the process.*

Achieving personal change and gaining insight . All participants referred to the importance of facing up to their own difficulties and, through this experience, realising the difficulties and resistances that might arise when one works through difficult material. Even though the motivation for having analysis differed between participants, personal change was an important theme in all interviews. The interview questions were geared towards the impact of analysis on practice, so participants were not particularly vocal on the impact of analysis on them personally, yet they were able to make links between how personal changes brought by analysis had an impact on their practice, as exemplified in the extract below.

> Catherine: *Like, you know, working through my adolescent, internal conflicts and my, if you like, infantile deficits, makes me probably better available to my patients' adolescents' conflicts and infantile deficits*.

Several participants talked about how they learned to recognize their own defences better and to be more comfortable with their own difficulties. Three participants reported not knowing they needed analysis before having it. Children, in particular, rarely admit or realise they feel any psychic pain at all, so it is especially difficult for them to acknowledge their need for psychotherapy. They are also often not involved in the decision of beginning therapy as parents or carers often make this decision for them. Personal analysis seems to have helped some of the participants to better understand and work with this form of resistance.

> Louise: *I was fortunate. I had two very loving parents, you know, (…) but there was so much else that I had mystified and I mean mystified not in terms of creating another, you know, another story and just making it comfortably inaccessible ((laughs)).*

One participant talked about how her analyst helped her making links between her own personal history and her practice when she talked about difficulties with her patients.

> Marina: *I would actually come out of the psychotherapy sessions feeling like I'd tormented and abused the child. And there was aspects of that experience that, yes, it was, it was, very useful to think about it in supervision but I think there was also something about just how unbearable it felt to me to be such a bad object for the child.*

Four participants, who also had supervisory roles, spoke about how they felt the difference between supervising child psychotherapists and other professionals, who have not gone through analysis. They described child psychotherapists as more able to take criticism, as they were more used to reflecting upon themselves and (at least during training) had a place to take the distress too. They conveyed a sense that child psychotherapists become more robust, as a result of having had analysis. Being more comfortable with strong feelings was also mentioned as a result of '*having put your life under the microscope*' (Louise). Two participants talked about the sense of having a little more control over oneself and of being more self-contained through analysis. This was most often described as a capacity to *reflect instead of acting out*. Unsurprisingly, half the participants mentioned the fact that analysis had helped them separate what belonged to them and what belonged to the patients. They also mentioned that analysis was helpful with identifying, tolerating and responding to negative and difficult projections. Elena, below, talked about how she thought she had achieved awareness rather than change in her personal relationships, and this helped her have more realistic expectations from her patients.

> Elena: *So, you know, so it definitely made me more aware, so the idea that, you know, it doesn't resolve it but it makes you more aware. So there was much less of, you know, how you often can, some people often blame the other person for if things don't work out or they go wrong and so the other person… I was actually able to see that it was a two-way thing, that I was, you know.*

Three interviewees also mentioned that having analysis has limits and that not everything could be resolved. This in time might have an influence on their expectations of what their patients might and might not achieve in therapy. Recognising one's difficulties as well as one's limitations as a therapist can be a painful subject, which some participants found difficult to talk about.

Experiencing first-hand the analyst's style, technique and personality. Being exposed to someone's therapeutic technique for many years and with an intensity of four times a week had an impact on all of the interviewees' technique with their own patients. In a very concrete manner, two participants talked about using their analyst as a role model for work with adolescents; they both described that this was done out of some anxiety and uncertainty about how to be with adolescent patients at the beginning of their training. No participants described using their analyst as a model for work with children and several of them talked about actually finding their own way with children and how they did not feel their analyst had influenced their way of being with children patients. This makes sense with the differences between psychoanalysis and child psychotherapy, which is often based on play and is often more active.

Marina: *I feel with younger patients I feel I've very much developed my own way of being with patients. Much more so than with older adolescents whereas I said, I felt more of, you know, a lot of the things that I've internalised in during the course of my analysis I feel they come out more clearly in the way I might articulate an idea. But with younger children it's, you're often communicating in ways that are not verbal or through play or in the displacement and, and maybe that's something that is missing in analysis when non-verbal communication is less present because you're not looking at each other.*

Aside from technique, participants described general characteristics of their analyst that they liked and decided to adopt in their practice. Larissa described the overarching feeling of kindness she experienced from her therapist:

Larissa: *It didn't mean that she wasn't difficult, and she, you know that it wasn't challenging, and I didn't feel frustrated, and I didn't get angry and upset about things. I didn't mean any of those things, but overarching there was, um, um, you know, whatever our differences were, and we were completely different in, well I don't know a huge amount about her personally, but you know, we were, you know, generations apart, and, you know, all of that, and had different sort of life experiences. You know, there was, um, I just had an overarching feeling of kindness. (...) And so, um, uh, you know, I'd hoped that I've internalised something of that in my work, and when it's not there, I think why it's not there…*

In Larissa's comment, the learning seems to have come from internalising something from the analyst rather than copying her technique. Another participant described a feeling of

warmth and humour from her analyst, which she decided to take into her practice not as a technique to be copied, but because this felt right. On the other hand, aspects of the therapy that did not feel helpful or were felt as too difficult were also discussed, and some of the participants reported deciding to make a conscious effort not to reproduce what they had felt was unhelpful or painful. Even if this came from a rather painful experience, participants still described these as important learning experiences and argued that they might not have realised the potential impact on patients, had they not experienced it themselves. For example, Elena talked about her analyst not being sensitive to cultural differences, something she chose to not repeat in her own practice:

> Elena: *There was something, you know that he really didn't understand some… It's not that he wasn't interested, but I think he, he almost had this idea that erm, you know, that the culture is almost, you know, that analysis can transcend culture? And that some of the cultural things, that you know, you need to challenge, that they're like excuses for things. And I know that his role as an analyst is obviously to challenge things and to challenge you, to try and challenge you, but I really did feel that he would often pathologise things, that for me were cultural, and that's just how it is, you know, and I've been very mindful in my work…*

Generally, the findings of this study highlighted the importance of the holistic experience of being a patient. This helped participants understand the importance they might have for their patients and gain a deeper understanding of the therapeutic process. Having analysis also promoted personal change and awareness as well as a higher ability to tolerate strong feelings in patients. Being directly exposed to one analyst's technique also had an influence on all participants whether this concerned aspects they wanted to take to their

practice or those they chose not to. There was a sense that the analyst was not really used as a role model for technique except out of anxiety with older adolescents, and participants reported finding their own way of being with younger patients.

A place to look after oneself

The second main theme that emerged relates to personal analysis as *a space to look after oneself* and receive support in the midst of demanding and challenging training. It comprises two subthemes, described in detail below.

Coping with a difficult training and difficult patients. Several participants mentioned the difficulties of the training and in particular the intensity of having to work intensively with very disturbed children. Five participants said that it was helpful to have a place to take the distress they felt at times in their placements, and mentioned that simply having analysis made their training journey more bearable. One participant talked about how analysis helped her focus on other aspects of her life:

> Catherine: *I think there's something about the rigour of it that's really - helps me at work now. It's not even so much with patients; it's more to do with life. Like, you know, I work, I work in a couple of different settings, the children, you know, the whole kind of, sort of, rigour of life is really, is much more easily bearable with analysis than without. (...) I have a space where I go every day, where I, I work that out, so I can go to work and I can work.*

Marina described how helpful it was to talk through important parts of the training such as the ending. One participant only described sometimes using her analysis to talk about patients

and several participants described actually never talking about their patients to their analyst. One reported this being the result of a difficult experience with her analyst but others did not specify a reason. However, they conveyed a sense that the analysis was for them, a place to look after themselves and talk about themselves.

"Feeling someone has your back". 'Someone having your back' was the way several of the participant described what felt good about having analysis. Louise talked about what she had noticed about working with a colleague, who had a different training and had not had analysis:

> Louise: *And I think that's because this particular individual, a good, you know, a good therapist, good practitioner but she has not had what you have had and what I've had, which is the sense of somebody's got her back. You know, somebody's had her back at times when it's been tough.*

The knowledge that the analyst had gone through the same process added to the sense of comfort and trust and connection felt in the relationship. There was also a sense of the analyst as a good object being internalised.

> Marina: (talking about her analyst) *But I think then it's something that I really appreciated during the analysis, uh, during the training, the fact that she that she knew where I was coming from, that she had gone through the same process.*

One participant explained how she had learned to look after herself emotionally through her analysis and she thought she carried this capacity with her after termination.

Elena explained that for her, analysis has a mental health safeguarding function as well. She explained:

> Elena: *It may not change you, it may not resolve things but you need somebody keeping an eye on you and on your emotional world while you're doing this work to make sure that you, you know, that you're, you're okay doing it but also that you're okay.*

The analysis as part of the training

The final theme is more descriptive and concerns the specifics of *having analysis as a mandatory part of training*; this includes views on the *communication between the training school and the analyst* at the times of selection and prior to qualification as well as perspectives on having *analysis as a mandatory part of the training*.

Communications with the training school . As already mentioned, communications between the training school and the trainee's analyst are part of the selection process. Before the applicant is accepted onto the training the analyst is contacted in writing and asked whether they have any objection to the applicant beginning the training. At the end of the training, they are contacted again and asked whether they have any objection to the trainee becoming a qualified child psychotherapist and working independently. This is an important difference from analysis that takes place outside training. All participants in the study talked about this aspect of their analysis and their feelings about it. For all, this aspect was difficult and anxiety provoking. Two participants described that their analyst was very transparent with them and talked them through the process, so they knew what would be written about them; they both said this made the process easier. On the other hand, two participants had a very difficult experience. Elena found out from the training school that her analyst had objected to her starting seeing patients in the first six months of her training. The fact that this

had not been explained or discussed with her before she began training was very difficult and strained the therapeutic relationship. Eleanor explained that her analyst expressed some doubts on Eleanor's suitability to work with children. For Eleanor those doubts felt unfounded and it was difficult to understand her analyst's position:

Eleanor: *I think it was not analytic and so I did feel that she behaved in a way that was, um, cruel I think, cruel.*

In the cases where the communication went badly between the training school and the analyst, it was very difficult for the therapeutic relationship to fully recover. It seems that uncertainty about the analyst's loyalty can be damaging.

One of the participants voiced the opinion that training schools should be able to do their selection without involving analysts. On the other hand, another voiced the view that being talked about by the training school and the analyst was a difficult experience but gave the trainee insight into what children might be feeling when discussed by therapists, parents and professionals, and this was something she kept in mind when discussing children or adolescent patients with professionals or parents.

> Larissa*: I think that's influenced my practice too in some way because I do think about how you, you know, how you reflect with youngsters about how they're doing. And actually what it tends then, you know, anxiety provoking and distressing, um, you know, moment that can be because you know, we are as therapists in terribly powerful positions, like our analysts are to us, and there is a power dynamic, you can't get away from it, you can't change that. And that, that can mark them forever if you. If you, if you don't think through the ramifications of that, I don't think it's necessarily a*

bad thing to have that experience, I think you can get something out of it. Um, and I think then, then you do integrate that into your practice.

However, even the participants who had a relatively good experience with this matter, still struggled with the change of role their analyst had to make when they had to comment on their suitability to train. Interestingly, the communication between the analyst and the training school at the end of the training was much less commented on. Two participants were not actually sure this had happened and had no recollection of the process. Others described that their confidence was higher at the time they finished training and they had built a better relationship with their analyst, thus being less anxious about the outcome.

Marina*: I think my confidence changed during the, the training. I realised I, you know, I was managing and I was developing and maybe by the end I was less worried about what her opinion would be or maybe more confident that her opinion was yes, she is and she can be a child psychotherapist.*

In conclusion, communication between the training schools and the analyst was a delicate topic and brought up strong feelings in all participants. It seems that when the communication was transparent and the trainees were feeling involved in the discussion, the difficult feelings could be worked through. In the cases where the trainee was not made aware by the analyst of what they had said to the training school, it was difficult for the relationship to recover.

Views regarding the mandatory nature of personal analysis. All participants, even the ones who had a difficult experience, said that they would keep the analysis requirement the same, and all agreed this was an important experience to have as part of the training. Only one participant mentioned the financial strain of having analysis prior to training before it

becomes part-funded. Two participants said that it was a strain at times to fit the intensive analysis in an already full schedule. Perhaps unsurprisingly, participants had very different ideas and desires regarding continuing or stopping analysis after the training or going back to analysis after completing training. This seemed to be more associated with their personal circumstances rather than their work as child psychotherapists. Participants also had different ideas regarding how separate their analysis was to the training. Two were adamant they never used the analysis to discuss cases and patients, and interestingly they both had had difficult experiences with their analyst at the beginning of training. One mentioned using analysis a little like supervision at times; this was facilitated by her knowledge that her analyst was also a child psychotherapist. This was not without challenges as it was both difficult when the analyst made links to her patient's own history and when she stepped out of role and discussed cases with her. Larissa talked eloquently about her experience of continuing analysis after the training:

> Larissa: *And actually probably I got more out of the time when I - when it wasn't part of the training, because there is always that anxiety as you're training because you're analyst has asked can you take your next patient, or are you eligible, are you, you know, fit for qualification, and so it kind of intrudes on an experience in a certain way, at different time-points.*

Two participants mentioned having some knowledge about their analyst from outside the training. There was a sense from several participants that the analysts did not know about the reality of working with the type of children seen in CAMHS today, such as levels of trauma experienced as well as the degree of flexibility required in the technique to be used with these patients; this made it more difficult to talk about patients because of the fear the analyst would disapprove of their technique.

> Marina: *I think my analyst is quite old school, classic, classical in her approach and, and the type of work that I was doing during my training required a level of adaptation of technique working with complex trauma and I think sometimes she expressed some negative opinions on how I would handle cases or sometimes she thought that, you know, the most important thing in a, in treating a child is holding this very firm analytic frame and o-, you know, obviously in working in the NHS with really traumatised patients entails a much messier approach at times.*

Discussion

The most important theme was learning through the holistic experience of being a patient. This theme comprised three subthemes, *understanding the process from within*, *achieving personal change and gaining insight about oneself* and lastly *experiencing first-hand the analyst's style technique and personality*. Another important theme was the analysis providing a place to look after oneself which includes *coping with a demanding training and difficult patients* and *'feeling someone has your back'*. The last theme was about having analysis as part of the training and subthemes were the *communications with the training school* and the *feelings evoked by having analysis as part of the training*.

The main theme's idea of understanding the therapeutic process from within is reminiscent of Freud's (1937) suggestion that analysis is a way for trainee therapists to acknowledge and begin to recognize the presence of the unconscious. Farrell (1996) also suggested that personal analysis helps the therapist fully understand the position of the patient. This subtheme was deemed important but participants sometimes reported finding it difficult to explain accurately, as it pertained to a very personal experience. This difficulty of putting the experience into words highlights the fact that analysis is something to be experienced rather than something that can be learned solely theoretically. The experiential

sense of being in therapy as an essential learning experience was also an important theme in the study by Rake and Paley (2009). In relation to this, the experience of *attunement* was mentioned by several participants, who described having someone following one's rhythm and ideas as a personally significant and formative experience. This aspect of the experience of being in therapy whilst training has not been described in the literature to date. Even if the theme of learning through the holistic experience of being a patient has been described previously in the literature and research, this study puts this theme at the heart of the experience of having analysis. This study also highlights that the experience of being a patient is transferable from having analysis as an adult to practicing child psychotherapy, as all participants described having internalised aspects from their analysis- aspects they were able to use in their own practice. Some specific aspects such as learning to tolerate negative transference may be particularly pertinent in work with children. In addition to facilitating learning, the experience of therapy also promoted a more ethical stance in therapists, especially in relation to recognizing the power of their position. This may be particularly pertinent in work with children as there is a power differential in their relationships with adults and as, in many cases, children do not choose therapy themselves.

In terms of *achieving personal change and gaining insights about oneself* several participants had reported not knowing they needed analysis before having it, and this has been reported in some studies (e.g. Wiseman & Shefler, 2001). This realisation is particularly helpful for therapists working with children as children rarely admit or realise feeling any psychic pain at all, so it is especially difficult for them to acknowledge their need for psychotherapy. They are also often not involved in the decision of beginning therapy as parents or carers often make this decision for them. Personal analysis seems to have helped some of the participants to better understand and work with this form of resistance. This idea makes for a strong argument to keep the analysis mandatory in the training of child

psychotherapists, not only because they might miss out otherwise but also because of the mandatory nature in itself can give them insight into the experience of being a child in therapy and this might be valuable in their work with children.

One of the strong features of analysis is the encounter of another thinking mind in the person of the analyst. Being exposed to their personality, their style but also the communication from their unconscious had a deep effect on the participants. In some of the interviewees' responses, the learning seems to have come from internalising something from the analyst rather than copying her technique. A participant described a feeling of warmth and humour from her analyst, which she decided to take into her practice not as a technique to be copied, but because this felt right. Similarly to Wiseman and Schefler (2001), participants reported sometimes modelling their therapist's manner out of a very personal sense of admiration and fondness. In this study the idea is not really of modelling but more of having internalised something that then gets integrated naturally into practice. This is an important difference between what was found in the literature and the findings of this study. This was highlighted by the difference between the reality of the job of a child psychotherapist and the job of child psychoanalyst. The roles are too different for role modelling but pertain to a more internal, powerful but subtle influence.

The second main theme that emerged relates to personal analysis as *a space to look after oneself* and receive support in the midst of demanding and challenging training. The observation that analysis may make the therapist more vulnerable because they are processing difficulties at the same time as seeing patients (Rake & Paley, 2009; Wiseman & Schefler, 2001) was not found in this study. This could be explained by the fact that child psychotherapists go through a long selection process and have had analysis for at least a year before beginning the training, so disturbing material might not come as a surprise. A lot of the trainees also see very disturbed children and young people and it is possible that the relief

found in being held by the analyst overrides the potential for disturbance. Being in touch with one's vulnerability while working with extremely vulnerable children is at the core of the child psychotherapy work and child psychotherapists might be expecting this level of disturbance in themselves as just a part of the learning and the process. Being in analysis was seen as a protective factor and an assurance of professional robustness. This finding was an important difference to existing literature and research.

The final theme concerns the specifics of *having analysis as a mandatory part of training***.** Communications between the training school and the trainees' analysts was a delicate subject. Kernberg (2014) has written extensively about the power relationship between training analysts and trainee patients and he argues vehemently against this practice. Unsurprisingly most participants found this communication difficult and anxiety provoking. This is very different to saying that this is bad practice or that there is no usefulness to it. Only one participant voiced that she thought it was detrimental to the analytic relationship. The idea voiced by another participant was that being talked about by the training school and the analyst gave child psychotherapists insight into the experience of children who routinely experience being talked about by their therapist with their parents or other members of their network such as schools or social services. This theme is also linked to the notion of a generational gap between training analysts and trainee child psychotherapists. This study brings some links between analysis in the training of child psychotherapists and professional development that were not found in any other study. Because training analysts are selected amongst senior analysts, they are often from a different generation. This creates another layer of complexity in the relationship, especially if the trainee feels the analyst would disapprove of their technique.

The aims of this study were to gain a deeper understanding of how child psychotherapists perceive the implications and influence of their personal analysis during

training on their professional practice. This study was very small-scale and this limits its generalizability. The main researcher is a child psychotherapist in training and as such was undergoing analysis whilst conducting this study. Those facts were known to the participants. This is likely to have had an influence and introduced bias on the way participants talked about their experience as well as in the way the material was analysed. Additional studies on the same theme could contribute to understanding the links between personal analysis and the practice of child psychotherapy as well as exploring the potential links to therapy outcome. It would also be interesting to conduct a study with trainees, as their views might be different to those of qualified child psychotherapists who have had the time to reflect upon their experience. Similarly, it would be interesting to have the point of view of training analysts. Therapist factors are known to be important for therapy process and outcome and that this therapist factor merits more research.

Conclusion

This study highlighted the importance of the holistic experience of being a patient for the professional development of child psychotherapists. This helped child psychotherapists in this study understand the importance they might have for their patients and gain a deeper understanding of the therapeutic process. Having analysis also promoted personal change and awareness as well as a higher ability to tolerate strong feelings in patients. Being directly exposed to one analyst's technique had an important influence on all participants, whether this concerned aspects they wanted to take to their practice or those they chose not to. Understanding that everything in therapy is meaningful and that small changes can have a big impact on patients was another aspect of learning through being oneself in therapy found in this study. The ability to reflect on oneself and think about one's practice, rather than act out, was an important gain of personal analysis during training. Initial communications between the training school and the analyst made it very difficult to establish or to keep a trusting

relationship, whereas for others it gave them insight into being discussed and spoken about as child psychotherapists do with their patients.

References

Association of Child Psychotherapists. (2016). *Quality Assurance framework for training of child psychotherapists* [Brochure]. London: np.

Balint, M. (1954). Analytic training and training analysis. *The International Journal of Psycho-Analysis*, *35*(2), 157–162.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology* 3(2), 77-101. DOI: 10.1191/1478088706qp063oa

Dryden, W. & Thorne, B. (1991). *Training and supervision for counselling in action.* edited by Windy Dryden and Brian Thorne. London: Sage.

Farrell, W. (1996). *Training and professional development in the context of Counselling psychology*. In R. Woolfe & W. Dryden (Eds.), Handbook of counselling psychology. London: Sage.

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

Garfield, S. L., & Bergin, A. E. (1971). Personal therapy, outcome and some therapist variables. *Psychotherapy: Theory, Research & Practice*, *8*(3), 251–253. DOI: 10.1037/h0086667

Grimmer, A., & Tribe, R. (2010). *Counselling psychologists' perceptions of the impact of mandatory personal therapy on professional development--an exploratory study*. DOI: 10.1080/09515070110101469

Guy, J. D., & Liaboe, G.P. (1986). The impact of conducting psychotherapy on

psychotherapists' interpersonal functioning. *Professional Psychology: Research and Practice*, 17, 111-114.

Kernberg, O. F. (2014). The twilight of the training analysis system. *Psychoanalytic Review*, 101(2), 151–74. DOI: /10.1521/prev.2014.101.2.151

Lambert, M., & Bergin, A., & Garfield, S. (2004). *Bergin and Garfield's handbook of psychotherapy and behaviour change*. New York: Wiley 5th edition.

Norcross, J. C. (2005). The psychotherapist's own psychotherapy: educating and developing psychologists. *The American Psychologist*, 60. DOI: 10.1037/0003-066X.60.8.840

Orlinsky, D. E., Schofield, M. J., Schroder, T., & Kazantzis, N. (2011). Utilization of personal therapy by psychotherapists: a practice-friendly review and a new study. *Journal of Clinical Psychology*, 67(8), 828–842. DOI: 10.1002/jclp.20821

Rake, C., & Paley, G. (2009). Personal therapy for psychotherapists: The impact on therapeutic practice. A qualitative study using interpretative phenomenological analysis. *Individuals, Groups and Organisations*, 15(3). DOI: 10.1080/14753630903024481

British Journal of Guidance & Counselling, 24. doi.org/10.1080/03069880801926418

Sandell, R., Carlsson, J., Schubert, J., Grant, J., Lazar, A., & Broberg, J. (2006). Therapists' therapies: The relation between training therapy and patient change in long-term psychotherapy and psychoanalysis. *Psychotherapy Research*, 16(3), 306–316. DOI: 10.1080/10503300500273110

Silverman, D. (2000). *Doing qualitative research: A practical handbook*. London: SAGE.

Wiseman, H., Shefler, G. (2001). Experienced psychoanalytically oriented therapists' narrative accounts of their personal therapy: Impacts on professional and personal development. *Psychotherapy*, 38, 129-141.

Appendix A: Coded Interview Sample

Interview 3

1	**C L**	Right (.) so to start with (.) I'm going to ask you a few questions about (.) erm (.) your (.) your analysis (.) like practical questions and then if you can tell me a bit more about your general impression about how your (.) your analysis (.) how you think it (.) erm (.) it influenced your (.) your practice. Sorry (.) I don't know why it doesn't go dark (.) okay. Erm (.) so how long were you in analysis before (.) before your training?	
2	**R 3**	**I just thought you were going to ask me that and I'm just trying to work it out. Before my training (.) probably about 18 month. Well you mean before the psychotherapy 'cause there's the (.) I did the (.) I did the pre (.) the pre- pre- pre- course in psychology.**	**Began 18 months before the training**

3		I mean before the main… Before the main training.	
4	**R 3**	**About 18 months. Possibly a bit longer.**	
5		And do you want to tell me about how long ago that (.) that was ((laughs))?	
6	**R 3**	**That's a bit frightening. Er (.) I think that was probably now 20 (.) more than 20 years ago.**	
7		Okay (.) okay.	
8	**R 3**	**I started the training (.) I think in '90 (.) about '95 (.) '96 (.) yeah.**	
9		Uhum (.) and how long were you in analysis for (.) altogether?	
10	**R 3**	**((Sighs)) I carried on for about another year (.) following qualification (.) but I did a five year training so (.) erm (.) so that would be say (.) say that's seven years. Say (.) so about eight and a half years (.) I think (.) probably.**	**Carried on for another year so about 8.5 years altogether**
11		Okay (.) okay.	

12	**R 3**	**I mean (.) it's a bit guesswork but ((over speaking)). Yes (.) yes.**	
13		But quite a significant…	
14	**R 3**	**For quite a significant period.**	
15		Yes (.) yes.	
16	**R**	**Yes (.) yes.**	
17		And at the time (.) I think it was (.) did you have to be in analysis five times a week?	
18	**R 3**	**Four.**	
19		Four (.) okay. Four times a week and (.) erm…	
20	**R 3**	**Yes (.) is it still four times a week?**	
21		Yeah (.) it's four times a week but (.) er (.) I don't know (.) someone told me that they had to do it five times. Erm…	

22	**R 3**	**I don't know (.) not for me.**	
23		Yeah (.) not for you. Where did you train?	
24	**R 3**	**At the Tavistock.**	
25		At the Tavistock. Erm (.) and generally (.) I mean (.) I can ask more precise questions after but (.) erm (.) how (.) how do you think that your (.) your analysis helped you become a therapist?	
26	**R 3**	**Hmm (.) well I mean (.) you know that's a (.) that's a multi-faceted question (.) clearly.** **I mean (.) the first thing that springs to my mind is the gain from the experience of being a patient.**	**Multi-faceted question** **Several ways in which personal analysis influences trainees** **The experience of being a patient**
27		Yeah.	

28	**R** **3**	**And I think that's a profoundly important experience. I think we (.) quite appropriately (.) protect ourselves from the experience of being a patient as professionals and I think it's really important that we can (.) at least in our memories (.) go back to the experience (.) to the infantilising (.) to the disempowering (.) to the power (.) you know (.) to the establishment of a power relationship (.) erm (.) all of those things.** **It's so important to remember that's what the experience is for somebody else.** **So there's that ((clears throat)) and then I think clearly what the analysis taught me was about demystification.**	**The experience of being a patient detailed:** **-Infantilising** **-disempowering** **-Establishment of a power relationship** **Importance of being able to bring back this experience when working with patients** **Demystification**
29		Yeah (.) of (.) of the analysis or…?	

30	**R 3**	**Well it's interesting. I (.) I remember when I wrote to apply to the Tavistock.**	
31		Uhum.	
32	**R 3**	**I had no anticipation that they would accept me because as everybody thinks (.) oh I (.) there must be other people better (.) you know what I mean?**	
33		Uhum (.) yeah.	
34	**R 3**	**All that self-doubt ((coughs)). Excuse me. And I (.) but I remember writing a statement (.) which described myself (.) which a lot of people did when they interviewed for the ((over speaking)) Birkbeck course as well (.) as having this kind of re (.) you know (.) perfectly straightforward (.) you know (.) cherished childhood and everything; which of course was true (.) you know.**	

		I was fortunate. I had two very loving parents (.) you know (.) and all of the things I wrote in that were true but there was so much else that I had mystified and I mean mystified not in terms of creating another (.) you know (.) another story. I don't mean (.) making into (.) into kind of legend (.) but I mean actually making it very misty and difficult to kind of (.) you know (.) to making it a real (.) and just making it comfortably inaccessible ((laughs)).	**Self-mystification** **Making things comfortably inaccessible**
35		Yeah (.) yeah.	
36	**R 3**	**And yet so much (.) and (.) but then yet of course (.) that was the material which determined a great deal of my emotional make up.**	**Uncovering of emotional make up** **Becoming more honest with oneself**
37		Uhum.	
38	**R 3**	**And so it was a very (.) I think it was (.) it gave me a experiential learning opportunity about how important demystification is and how difficult it is (.) and how**	**Demystification**

		resistant one can be and how easy it is (.) how many different strategies there are for avoiding going to those (.) painful places.	**Experiential learning opportunity about resistance/Being the patient**
		Erm (.) that's (.) so that's another aspect of it which (.) of course (.) sitting in the consulting room when I can kind of (.) when I have my own formulation coming (.) you know (.) and I'm sitting opposite a young person and I'm thinking why (.) why don't they want to come with me? You know (.) why don't (.) why is there so much (.) you know (.) why can't we get anywhere where I want to (.) you know (.) and actually I remember that; lying on the couch and feeling absolutely nothing because I didn't want to go there (.) you know. I'm sure it's a universal experience (.) you know. I mean (.) you need to feel what that feels like (.) really.	**First explanation about what was learned and then how this is applied with the patients: Bringing back to the mind those intense memories about resistance/feeling nothing/feeling empty** **Idea of a universal experience in therapy that can be apprehended only by experience**

39		Yeah (.) not want to go somewhere (.) you mean?	
40	**R 3**	**Well not even knowing you don't want to go there but the whole system (.) your psychological system…**	**Strong experiential learning about resistance/ useful when working with children**
41		Yeah (.) I see what you mean (.) yeah.	
42	**R 3**	**…you know (.) just blocks and you just lie there. I mean (.) I remember particularly in the later (.) later years of my things (.) just well in the middle years (.) probably (.) is actually thinking there's nothing. There's nothing. I can't (.) I don't even know where I want to go or where the analyst (.) you know (.) the fact is the analyst wants you to go somewhere (.) which isn't always entirely true but (.) erm (.) just that feeling of not (.) you know (.) just being completely out of touch (.) just dead in the middle (.) really (.) as a protection. And I see that in the consulting room all the time.**	**Experience of resistance** **Experience of feeling nothing in the analysis/Dead in the middle** **Idea that the analyst wants the patient to go 'somewhere'.**
43		Yeah (.) yeah. Yeah (.) with children and…	

44	**R 3**	**All. So that was very important. Erm (.) I think (.) I think the other thing I learned about was process. I think I learned a great deal about how to be patient (.) how (.) you know (.) the (.) if (.) you know (.) it's like the toothpaste tube. If you hold it up long enough (.) it will come out (.) you know what I mean? It's (.) if you squeeze it (.) it'll come out but in a different consistency and if you hold it long enough (.) it comes out of its own accord (.) kind of thing. I just have a feeling (.) I learned a lot of that on the ana (.) ana (.) analysis couch (.) I think. Just the fact that (.) you know (.) it's a process.** **And things have their time. I think the other thing I've probably learned (.) it's difficult after all these years (.) thinking what came then and what came later (.) but**	**Learning how to be patient (not a patient)** **Learning about the process** **Idea that things take time/therapy is a process that cannot be rushed** **Sense that everything is useful**

		anyway (.) ((clears throat)) (.) was the sense of how everything is useful.	
45		Okay (.) can you say a bit (.) a bit more about that?	
46	**R 3**	**Well you know (.) we (.) when we're training (.) I'm sure you identify with this (.) you're always thinking (.) am I doing it right? Am I (.) you know (.) can I do it better or (.) you know (.) there's a kind of (.) erm (.) there's a fantasy we have that we (.) we're kind of (.) there's a norm and (.) you know (.) I mean of course that (.) you know (.) that's a lifelong kind of paranoia that we all have (.) you know.** **But (.) but I think one of the things I have learned and I learned it there (.) on the couch as well as everywhere else (.) is that everything (.) you know whether it's the blockage (.) you know (.) for example when I was talking about that (.) or whether it's (.) you know (.) arriving late (.) missing**	**Help with insecurities about doing it right (via learning that everything is useful and things are a process)** **Learning to use any material (however frustrating) such as missed sessions as useful for the therapy** **(Essential?)**

		an analytic session; whether it's getting upset (.) whether it's those kind of aha moments (.) you know (.) erm (.) they are all useful.	
		The negative and the formative are really useful and so I don't (.) I mean (.) when I'm working with young people face to face (.) I sometimes lose that because you (.) you know (.) I mean I'm frustrated or they've complex transference issues or something.	**Negative experiences also meaningful and important** **Easy to lose sight of because of countertransference**
		But certainly in supervision (.) I can always see how somebody might use even the most undermining (.) demoralising (.) you know (.) children running out of rooms (.) climbing (.) you know (.) all of that. It's all useful ((laughs)). It's not very pleasant but (.) you know. And so I	**This is more apparent in supervision (as there is more distance)** **Note: Role of child psychotherapist as supervisor to other child psychotherapists or other**

		think that's another thing (.) that everything is grease to the mill (.) everything is (.) is useful within the process.	**therapists also informed by the learning done in analysis.** **Capacity to remember that even very negative transference/bad experiences in the therapy are useful/part of the process**
47		When you say…	
48	**R 3**	**It's the hole (.) it's the holistic view. It's a holistic view.**	**Holistic view**
49		Yeah (.) yes. When you say supervision (.) you mean like when you're supervising trainees or other?	
50	**R 3**	**Yes (.) I mean (.) now my role is very (.) pretty specialised here. I do a great deal of supervision and (.) and that's my (.) I do more of that than I do face to face work (.) so (.) erm (.) that's why I do (.) I carry on doing my learning through other people ((laughs)).**	**Capacity to keep on learning/ from other people's experiences**

51		Yeah (.) yeah but yeah (.) maybe it's easier (.) as you're saying to see all those things when you're (.) when you're not like yourself attacked with all those ((laughs)) (.) yeah.	
52	**R 3**	**No (.) it's much (.) it's a very different (.) I mean (.) you know supervision has its challenges but (.) erm (.) it's very different from being face to face. I mean (.) I think (.) really you know (.) we could be here for a week and I could carry on telling you things that I got from my analysis.** **Erm (.) clearly (.) you know the obviously (.) I mean (.) some self-knowledge (.) some. I still struggle ((laughs)) (.) as we all do. It's a lifelong struggle but I think (.) you know (.) I think it's quite interesting and it isn't (.) it isn't a kind of smug self-knowledge. It's a sense of being a little bit in control of oneself in a way that's comfortable (.) so that somebody else in the room can lose it.**	**Sense that a lot was learned from analysis** **Self-knowledge** **Sense of a little control in oneself to allow the patient**

		You know (.) it's (.) it's the feeling (.) it's the safety of being with somebody who's ((sighs)) just a bit self-contained.	**Giving patient a feeling of safety due to being self-contained**
53		Yeah (.) yes.	
54	**R 3**	**That's very important and that's partly what you get from analysis because it's not perfect. You know (.) we still (.) you know (.) we still (.) well you know (.) clearly we're not super human individuals who know everything (.) of course not.** **But ((clears throat)) (.) but I think (.) I think in lots of ways people who've had a really thorough analysis have an air of self-containment about (.) you know (.) that is useful. So I**	**Self-containment (as opposed to complete resolution of all internal conflicts)**

		mean (.) as I say (.) I could probably carry on talking about that.	
55		Yeah (.) yeah (.) yeah. No but that's really what it's about. I mean (.) I don't (.) erm (.) I can add more precise questions but it's really about your (.) your experience (.) really. So it's not really…	
56	**R 3**	**I think the difficulty (.) clearly (.) is that at this distance I haven't had analysis now. I have been back (.) not my (.) to my analyst but to other people at different times.** **That's the other thing. It opens you out (.) so that you can always go and ((over speaking)). Erm (.) it's become so integral to the way I work (.) to the way I live (.) really. I mean (.) you know (.) it's absolutely integral. It's a (.) it's a no going back. You know (.) once you (.) once you've opened up your mind to understanding yourself and**	**Went back to analysis (not to the same person)** **Able to seek help. Opened out** **Idea of opening your mind/to try and understand yourself**

		understanding your psyche (.) then I can't quite distinguish it from everything else.	
57		No of course (.) yes. Yeah. Yeah (.) because one of the questions that I ask sometimes is (.) erm (.) how do you think your practice could be different if you hadn't had analysis (.) but that may be (.) that might be difficult (.) really. I mean (.) if it's still part of it (.) really.	
58	**R 3**	**Well (.) except that I do (.) I do supervise people who haven't had analysis (.) so I cannot really answer for myself but I can answer from my experience (.) and I think they are more vulnerable.**	**Comparison to other therapists or practitioners who have not had analysis** **They are more vulnerable**
59		Vulnerable to…?	
60	**R 3**	**To the negative projections (.) to the counter-transference issues.**	**(people with no analysis) Vulnerable to negative projections/countertransference issues**
61		Yeah.	

62	**R 3**	**Erm (.) and the defences that will develop (.) inevitably. Erm (.) and also more vulnerable to the stress (.) more vulnerable to the pain. I mean (.) I (.) in supervision (.) you have to sometimes say some very painful things to people.** **Maybe (.) I don't know (.) maybe you've experienced but this but ((over speaking)). Of course (.) you know (.) there's (.) there's no benefit from supervision if you cannot expose yourself.**	**More defences/More vulnerable to stress/more vulnerable to pain** **Hard in supervision when having to say difficult things. Analysis makes you more solid? More able to hear things? Difficult things?** **Capacity to expose oneself/Benefit from supervision/benefit from criticism**
63		Yeah	
64	**R 3**	**And sometimes when you expose yourself (.) what you fear can happen (.) critical (.) you know (.) a critical voice or something (.) and that has to happen.**	**Being able to stand/benefit from criticism**

		Now obviously there's ways of doing that but I think the (.) I feel far (.) far more confident being strident and being honest with somebody who's in (.) I know has had an analytic experience or is still in analysis (.) than I do for those people who haven't because I don't know (.) number 1 that they've got some way to cope with the emotional experience that I'm asking them to go through and I (.) you can't do that in supervision. **Erm (.) and also I don't know whether they know how to be resilient to that kind of thing. So I (.) it makes quite a lot of difference (.) I think. I think it's a great deal about resilience (.) really.**	**Analysis gives you a way to deal with emotional experience of being criticised/asked to change the way you are working** **Learning to be resilient**
65		Do you have an example (.) previous example in (.) in mind of…?	

66	**R 3**	**Well I have one supervisee who did a different training. She's a good practitioner but she did a different training and because of the role (.) my role as her line (.) you know I'm not (.) I'm not her manager but I'm her clinical lead. So I've had to ask her to stretch her competencies to try things which she doesn't feel particularly confident in.** **With some reassurance that I'm there to help her and to (.) you know (.) but of course in order to help her (.) I have to also point out where she has kind of screwed up or (.) you know (.) I think made a wrong decision or made a (.) a faulty judgement or (.) you know (.) whatever (.) or something I might think differently about (.) and it's been rocky.**	**Being able to take criticism without being too affected/destroyed/damaged** **Having somewhere to take the distress to. Or the capacity to deal with the distress.**

		It's been very rocky because if she comes out of the supervision feeling in any way distressed (.) she's got nowhere to take it. I mean (.) if other people could assess her (.) she brings the distress to me. I mean (.) we have a trusting relationship but if the distress comes (.) you know (.) comes as a result of something that's come up with our supervision (.) she doesn't have anywhere else to go.	**A place to take the distress**
67		Yeah.	
68	**R 3**	**And (.) and it makes me feel like I'm walking on eggshells (.) you know (.) so it's very difficult and sometimes in (.) you know (.) and inevitably when you're working honestly and closely with other people (.) you get angry with each other. I mean (.) that's inevitable.**	**More difficult to work with people who have not had analysis/more fragile/difficult to bring in difficult feelings such as anger.**
69		Yeah ((laughs)).	
70	**R 3**	**I can't (.) I can't do that with (.) with this particular individual because I don't know (.) I have absolutely no**	**More difficult to work with**

		confidence that she could cope with that (.) whereas (.) you know (.) other people I work with (.) who I know are kind of looking after themselves…	**Capacity to look after one self emotionally**
71		Yeah (.) yeah.	
72	**R 3**	**…you know (.) erm (.) if that's the case (.) that's the case (.) you know ((laughs)).**	**Capacity to look after one self emotionally that is evident to others/solidity**
73		Yeah (.) they (.) hopefully they can take it or take some of it and (.) yes.	
74	**R 3**	**Yes. It doesn't mean it doesn't have its consequences.**	**Criticism still have consequences but not same vulnerability**
75		Yeah (.) yeah (.) yes.	
76	**R 3**	**But I don't feel as though (.) you know (.) I don't feel the same vulnerability.**	**Not the same vulnerability**
77		Hmm (.) yeah.	

78	**R 3**	**And I think that's because this particular individual (.) a good (.) you know (.) a good therapist (.) good practitioner but she has not had what you have had and what I've had (.) which is the sense of somebody's got her back. You know (.) somebody's had her back at times when it's been tough.**	**The sense that somebody has got your back**
79		Hmm.	
80	**R 3**	**So she doesn't know what that feels like to be…**	
81		Yeah (.) yes.	
82	**R 3**	**You know (.) when you have that moment when you think I just can't (.) you know (.) it's all too much and then you go to analysis and you (.) you lay on the couch and you (.) you work it out.**	**A place to take things when it is too much/can't hold it in anymore**
83		Yeah (.) yes.	

84	**R 3**	**You know (.) I mean literally kind of holding your back ((laughs)).**	**A holding place**
85		Hmm (.) yeah (.) but I guess that's how it works with the training. I mean (.) the intensive supervisors (.) they know that their trainees going to analysis (.) so hopefully they can be quite frank in the (.) in the supervision and what they expect.	
86	**R 3**	**You have to be (.) you have to be. You have to be because what we are (.) what (.) as a service supervisor (.) that's another role of course (.) a service supervisor (.) what we are giving you is (.) well giving you (.) you're developing with that support (.) is a very powerful tool and it is not to be taken lightly. You know (.) if we (.) if by the end of you training (.) you are (.) you have a great deal of power knowing about (.) knowing and working with the unconsciousness. It's a powerful experience and it has to be**	**Idea of being given a powerful tool -the ability to work with the unconscious-** **Powerful experience**

		taken with respect and if you can't do it (.) you can't (.) it's (.) then you shouldn't be doing it ((laughs)) (.) you know.	
87		Yeah (.) yeah.	
88	**R 3**	**That's (.) you know (.) you're messing with other people's heads.**	**Power given to you/could be dangerous**
89		Yes (.) that's true (.) yeah. Yeah. So I guess it brings also a bit of (.) erm (.) theme of safeguarding aspect of analysis (.) that (.) erm (.) I mean (.) there is something about the trainee getting upset or hurt but there is also the power that they have with (.) with children and the (.) with very vulnerable people (.) I think.	**Safeguarding aspect, for the trainee and for the children that the trainee works with**
90	**R 3**	**But just thinking back to the (.) if you don't mind going back that far.**	
91		Yeah (.) yeah.	
92	**R 3**	**Cause I mean (.) ((over speaking)) the course and (.) and very often people say on that course (.) 'Oh my God (.) I**	

		never knew that you'd tear me apart and then have to put me back together again.'	**Torn apart and put back together. Difficulties of the training/the analysis helps getting through it.**
93		Yeah (.) yeah.	
94	**R 3**	**And (.) and of course we try and tell people that when they come into the course but it's such a powerful (.) has such a powerful impact on everybody.**	**Powerful impact of the course (Birkbeck course)**
95		Yeah (.) yes. Yeah.	
96	**R 3**	**That's a huge responsibility (.) to change people's minds like that (.) and I think the analysis (.) that's why (.) you know (.) the Birkbeck course is so emphatic that you cannot do it without the analytic or therapeutic support.**	**Course works with the analytic support otherwise so much could not be asked from the trainees**
97		Yeah.	
98	**R 3**	**Because you would (.) you know (.) everybody has a moment of crisis during those three years (.) don't they?**	**(still talking about Birkbeck course)**

			Course works with the analytic support otherwise so much could not be asked from the trainees
99		Yeah (.) yeah that's true (.) yes.	
100	**R 3**	**And that's important. That's important. It's part of it ((laughs)).**	
101		Yeah (.) yeah. Yeah (.) and we were very much encouraged to (.) erm (.) even go twice a week. I mean (.) it was a very important part of it (.) yeah.	
102	**R 3**	**Yes (.) and that's because the people who set up the course and the people like myself who carried the course through knew what this relationship that you're asking about (.) how important it is.**	

		And (.) and (.) you know (.) you can learn the skills but you can't learn how to do the whole things without having had the experience of being on the couch (.) really.	**Experiential learning/you can learn skills/techniques etc. but not the experience of being on the couch**
103		Yeah (.) yeah (.) and what about relationships (.) how you think analysis helps people like forming (.) forming relationships with their patients?	
104	**R 3**	**Well there are different relationships. I think analysis examines one's personal relationships in such a way that an awful lot of them come a cropper. I know that. With my (.) certainly in my year (.) my training year (.) there were quite a lot of relationship breakdowns and…**	**Rigour of analysis** **Examining relationships**
105		Really? Oh.	
106	**R 3**	**Yeah 'cause it (.) everything's (.) you know (.) everything's under the microscope. Er (.) but relationship with your patients (.) yes (.) yes (.) and I think that comes back to my first point (.) is that (.) you know (.) I remember noticing**	**Under the microscope/looking at things in a lot of detail**

		for it (.) just as a (.) as a (.) as a kind of graphic example (.) the pattern of the carpet thing that was in my therapist's consultant (.) you know there's always some kind of carpet or some painting.	**Learning about how every small detail might be important**
		Something to be able just to lose yourself in. I can remember that pattern now (.) in detail. I can lose myself and (.) and I know that I might think to myself now (.) in the morning (.) oh I'm just seeing two patient (.) you know (.) duh-duh-duh-duh-duh (.) doesn't really matter.	**Even with analysis going back to thinking it does not matter/ bringing back memories of analysis to see that it does matter**
		They will notice whether I change my earrings (.) whether (.) you know (.) 'cause they're not on the couch here. Some of them are but mostly not. I mean (.) you know (.) you know how (.) the kind of things we don't normally notice (.)	**Small things and changes do matter. Analysis as a way to learn about the importance of those small things/**

		which is how carefully people look at each other (.) how carefully people take in each other. **You know (.) how my demeanour (.) you know (.) one child (.) this was years go. This was in Lambeth (.) erm (.) always said to me (.) 'Oh you're always nodding (.)' and I said (.) 'Oh am I?' And he said (.) 'Yes (.) you always nod your head (.)' and since then I've been aware of that. I do ((laughs)).** **I think it's my way of reassuring people (.) I nod my head. And just (.) you know (.) I've never noticed. But I mean (.) that's (.) just knowing (.) because I know how intently I notice (.) you know (.) where things were in the room (.) whether they smelled different (.) whether I (.) you know (.)**	**Paying attention to analyst consulting room or analyst demeanour make therapist more aware of the effect heirs might have on their patients.** **Learned the importance of changes (even small changes) from the analysis and can understand their meaning for patients.**

		and so I know that when my patients come (.) those things are very important. **The environment is important (.) the tone of her voice was important for me. I had a female therapist. ((Clears throat)) Everything.** **So I know how important (.) yes sometimes when you're working with children and young people (.) it's hard to recognise how significant you are.**	**More examples about all things that matter such as changes in the tone of the voice of the analyst** **Analysis gives you an ideas of how significant you are for your patients**
107		Yes (.) that's true.	
108	**R 3**	**It's too uncomfortable.**	**Feeling of being very significant could be uncomfortable**
109		Yeah (.) yeah.	
110	**R 3**	**Having knowledge that you're actually rather important and it's easier to think that actually she only comes once a**	**Learning about how important you are/can be/ to your patient even if hard to believe at times**

		week for 50 minutes. What difference (.) you know (.) if I'm not here (.) if I'm ill (.) actually it makes a heck of a lot of difference.	
111		Yeah (.) yes. As you were saying (.) it's really through the experience of being a patient (.) only that you can understand that really (.) yeah.	
112	**R 3**	**Yeah (.) I think so.**	
113	**R 3**	Hmm (.) because it's true that sometimes that in meetings with like social workers when we say (.) 'Oh we're having a break in the therapy (.) they don't necessary understand that (.) erm (.) it matters. They think…	
114	**R 3**	**Hmm (.) and (.) and it's in classic things like (.) erm (.) teachers. You know (.) not telling the children who's going to be their teacher until the last day of term (.) you know (.) or not telling them that their teacher's leaving or (.) you**	

		know (.) and you think no ((laughs)) (.) you know (.) they need to be able to get (.) be angry with you that you're going or what have you.	**Learning to give people the chance to be angry with you if you let them down (only works if you recognise you are important to them)**
115		Yeah (.) yes. Yeah.	
116	**R 3**	**Well that's another thing (.) I mean (.) you've mentioned it and I've just thought of it (.) relating it to my own experience (.) just learning about breaks and endings (.) you know.**	**Learning about breaks and endings**
117		Yeah (.) yeah.	
118	**R 3**	**That how disoriented one can become when your patterns changed or your times change or you see (.) you know (.) I think once I (.) I would always see my analyst at kind of seven in the morning or something and then one day (.) I saw them at five o'clock in the afternoon. I couldn't use that time at all.**	**Learning about how change/breaks and endings have a profound effect. Could not believe it if never experienced.** **Change can have very strong effect**
119		Really?	

120	**R 3**	**Absolutely hopeless. It was a waste (.) well it wasn't a waste of time (.) but (.) you know (.) it was so interesting. It was just (.) you know (.) didn't work ((laughs)). And yet (.) you know (.) you (.) I would (.) I was surprised. I was surprised. So I mean (.) just knowing how those things feel (.) stays with you.**	**Learning from experience the importance of change/the impact small changes can have**
121		And that's something after that you (.) yeah (.) you could use with your (.) with your patients.	
122	**R 3**	**Well because (.) you know (.) a lot of the time we protect ourselves from these things (.) you know. It's (.) it's (.) you know (.) I (.) we've got a training day next Wednesday (.) so I had to say to my patient this morning (.) you know (.) that well (.) what would happen (.) you know (.) reminded here that we wouldn't be here next week. And it's very easy (.) I mean (.) just not to think that it matters to her at all…**	**Example to illustrate how easy it is to forget the importance**
123		Yeah.	

124	**R 3**	**…because her reaction is…**	
125		Yeah (.) that's true (.) that's true.	
126	**R 3**	**…((mumbles)) but (.) actually (.) she's furious. She's absolutely furious and ended up sticking pictures of herself all over the wall (.) you know.**	**Help to understand strong reaction of child to break**
127		((Laughs)) Yeah.	
128	**R 3**	**And that's one week (.) you know.** **So yeah (.) just rem (.) you know (.) we protect ourselves from those feelings 'cause they (.) I mean (.) particularly ending cases. Wow (.) isn't it difficult (.) how you (.) have you (.) you've had to end cases?** **It's bad (.) isn't it?**	**Even with analysis need to protect ourselves from the pain of ending/tendency to forget how important it is**
129		The two year intensive actually (.) so ((laughs)) yeah (.) that was (.) that was very tough (.) really. I almost (.) I find it hard	

		to think about it now. I mean (.) I'm glad I don't have - I'm not writing my paper on it but yeah.	
130	**R 3**	**Hmm.**	
131		Yeah. So how is it to end then your (.) your next (.) because you ended it after (.) so you sort of didn't have this experience during your training.	
132	**R 3**	**No I didn't (.) no. I (.) I was anxious to end it (.) erm (.) for lots of reasons. Like lots of people (.) the financial reasons and everything else. And I wasn't particularly touched by the analyst ((laughs)) either. I don't think (.) we didn't gel terribly well (.) kind of not (.) you know it wasn't (.) I know a number of people have a kind of place in their heart for their particular (.) for their analyst. I have it for analysis but not for my analyst. She was the instrument.**	**Ended about one year after the training. Not particularly fond of analyst but still valued the process** **Importance of the process rather than the person**

		And I think that was (.) I think (.) I appreciate that (.) actually. I appreciate what she did. It was a (.) it was her (.) it was her (.) the way she did it (.) her method. Erm (.) so I was actually quite anxious to finish.	**Anxious to finish**
		I also felt (.) I felt I had moved on and I felt that I (.) not (.) this is not a criticism of my analyst but I felt I wanted to move on as well. I didn't (.) you know (.) I couldn't bring myself not to be (.) to shift my self-image in analysis. You know (.) I was still the student. I was still the trainee. I was (.) you know (.) still the (.) and actually I wasn't. I was a practitioner and (.) you know (.) I moved (.) I mean (.) I was still in analysis when I moved from my first job to my second job.	**Difficult to shift self-image in analysis (from the trainee to the professional)**

		So erm (.) I think probably (.) maybe it happened around about the same time but (.) you know (.) it wasn't (.) I couldn't do the shift.	
133		A bit like you can never feel a grown up in your parents' house or something like this.	
134	**R 3**	**Exactly.**	
135		Yeah.	
136	**R 3**	**Exactly (.) and I felt I needed to (.) I needed to have that independence (.) really. You know (.) to see (.) you know (.) to (.) to (.) to internalise it I suppose (.) really.**	**Need to separate from analyst to have independent practice/independent work identity** **Need to internalise analyst rather than**
137		But I find it really interesting what you're saying about the (.) erm (.) being attached to the analysis but not especially to the analyst because (.) erm (.) you know some people will say things like oh (.) it really depends on the right person and sometimes as a trainer (.) I worry whether I'm the right person	

		for all of my cases (.) but sometimes maybe it doesn't matter that much. Maybe (.) you know (.) you can give an experience of something (.) even though (.) you know (.) they're not extremely well matched for whatever reason.	
138	**R 3**	**No it's not about match. It shouldn't be. It's a working (.) it's a working (.) it's a working match.**	**Not about match/not about personality match/idea of a moving relationship**
139		((Laughs)) Yeah.	
140	**R 3**	**You know (.) I didn't (.) I don't particularly think (.) you know (.) I'm not (.) I'm not concerned whether she liked me or didn't like me or whether I was boring or (.) I mean (.) I did worry at the time. You know (.) we always worry we're a bit of a bore you know (.) we might (.) our lives are not interesting ((laughs)).**	**Not too concerned about being liked or not by the analyst**
141		Yeah (.) yeah.	

142	**R 3**	**Or I internal lives are not that exciting. Erm (.) but I don't (.) it's not stayed with me. I mean (.) really (.) you know (.) it was (.) it was very (.) very much the process (.) very (.) and she was the instrument of that process. And that was okay. I mean (.) maybe it isn't okay for everybody but that was okay for me.**	**Not too concerned about being liked or not by the analyst/ liberating idea as less pressure not trying to be liked?** **Analysis as a process**
143		And are there (.) I don't know (.) concrete things you can remember (.) you think you've taken from it (.) that you do with your (.) or did (.) I don't know (.) at some point with your (.) your patients?	
144	**R 3**	**Erm (.) ((pause)) I think I learned to shut up. She was very quiet. She wasn't (.) I mean (.) she wasn't (.) you know (.) Kleinian and silent (.) that kind of thing (.) but erm (.) but she was very quiet and I'm not; and I'm busy (.) busy (.) busy (.) talk (.) talk (.) talk (.) talk (.) talk (.) talk (.) you know (.) and actually she taught me to be quiet (.) and she**	**Learning from analyst as role model, the benefits of being quiet/of being patient?**

		taught me why and she taught me (.) I mean (.) the process and she taught me the benefit of staying with things or waiting for things. And I think that's helped me with patients. I can wait.	
145		Hmm. That's good (.) yeah.	
146	**R 3**	**And I can wait without impatience because waiting and waiting patiently are very different.**	**Learning to be patient**
147		Yeah (.) that's true (.) yeah (.) and why do you think it's important?	
148	**R 3**	**Well just a very small example this morning. I have a little girl who comes to see me. Erm (.) and she finds that emotional (.) that kind of emotional examination quite difficult. She wants to do it but she finds it very difficult (.) so she's avoiding (.) she avoids it (.) any which way. So this morning (.) we just (.) you know there was clearly (.) she was clearly need to communicate something but I had no**	**Example of applied patience** **Learning to go at the patient's rhythm/ let them bring what they need to bring**

		idea what it was. I could have asked her all sorts of questions but I didn't and about halfway through the session (.) she said (.) 'I'm feeling really sad today.' And I said (.) 'Oh (.) I was thinking that you were feeling something. I wasn't sure what it was but it fell like (.) you know (.) something.' And I didn't say why. I didn't say (.) 'Tell me (.)' you know (.) I didn't (.) nothing like that. I just said (.) acknowledged that I could (.) that it was there and then I said (.) no and then she said (.) 'I can't tell you what it is but I'm going to write it down (.)' and she sat at a different table from me (.) doing that thing that children do (.) you know (.) all this. **'Don't look (.) don't look (.)' and I said to her (.) 'Well you know (.) that's why I'm here (.) to look (.) to listen (.) to think but I'm not (.) you know (.) so if you don't mind I will**	

		look (.) but not what you're writing. Just looking at you (.)' you know (.) and she said okay. And she wrote and she wrote and she wrote (.) and she held it up and she said (.) 'Don't read it (.) I just want to show you how neat it is (.)' and I said (.) 'It looks very neat and it looks like it's really thought about.' **And then (.) and she said (.) 'Yeah (.) but don't read it.' I said (.) I'm not reading it (.)' and she carried on (.) she carried on (.) she carried on. She wrote about half a page and then she brought it over to the table and she still found it painful. So she (.) you know (.) then I (.) you know obviously my (.) my curiosity was (.) what had she written (.) you know (.) but I actually just (.) she put it on the table (.) folded it over and I said (.) 'Now when should I read it?'**	

		And she said (.) 'No not quite yet (.)' and I said that's fine. She said (.) 'I'm going to read (.) I'm going to write the next bit.' So she went back to the table and started writing and then said (.) 'You can read the first bit now.' **So it's that kind of feeling of being able to just take me out of the (.) you know (.) it's entirely hers and I'm just doing whatever it is that's needed.** **And that takes time (.) it takes time to learn how to do that…**	**Learning to give the child a different experience to the usual adults around**

		…because you know (.) it's so (.) your children are so used to being directed and enquired upon (.) and I think they expect you (.) you know (.) she's expecting me to want to read it (.) you know.	
149		Yeah (.) yeah.	
150	**R 3**	**What reassures her (.) to allow her to bring her feelings (.) is that she can do it at her own pace and to (.) you know (.) so there's a little example.**	**Going at the patient's own pace/learning to be patient**
151		Yeah (.) it's very interesting (.) yeah (.) because sometimes it's curiosity that's not about the child.	
152	**R 3**	**Exactly (.) exactly correct. That's exactly (.) it's about our (.) you know (.) managing (.) managing ourselves to really be child-sensitive (.) I suppose.**	**Managing your own curiosity (and other feelings) to make it about the child (and not about you)**
153		Yeah. What do you think about the (.) would you keep the requirement the same if you (.) if you were the one changing the rules for the (.) for the training?	

154	**R 3**	**I think there's so much to think about with the training (.) it's difficult. Oh ((sighs)) ideally yes (.) of course (.) I think I would but reality (.) I mean (.) I (.) I'm worried about who can afford (.) you know (.) with funding (.) with the training being trained (.) I think I'm really (.) really worried about who's going to be able to afford to come into child psychotherapy.**	**Would keep the requirement the same. Worried about future changes to funding**
155		Yeah (.) yeah. It's it now confirmed that it will change?	
156	**R 3**	**No (.) no.**	
157		The funding is a worry (.) that they are (.) yeah.	
158	**R 3**	**No (.) but there is (.) there's a real threat hanging over it and they've already changed the nursing training and (.) you know. I mean (.) we're fighting it but…**	**Analysis as a great contribution to the training**

		I certainly (.) I think it's (.) it's one of the (.) one of the great contributions to the training. That's why child psychotherapists are so bloody good at their job ((laughs)) (.) and there's an awful lot of people in (.) working in our field (.) that are not that great. They're okay (.) they do (.) they don't (.) you know (.) but I think it was Trudy Klauber who said to me not (.) not (.) not responding to a child's distress is a (.) you know (.) can be quite abusive. **You know (.) if a child comes into (.) into the clinic (.) into a clinic and is expressing (.) and it's not being picked up and it's not being responded to (.) that's really bad (.) and the thing is that an awful lot of therapists don't.** **I'm not slagging off every (.) you know (.) as you say there something about child psychotherapists and I think the**	**Importance of capacity to be attuned** **Importance of being able to be attuned to pick up what the child is communicating (whatever way they might do it)** **Analysis as a way to get the courage to to work with very entrenched difficulties + depressing parts**

		analysis is part of it (.) that gives them the courage to work with the very (.) very (.) very entrenched and difficult and depressing parts.	
159		Yes (.) yeah. Maybe with some children that would otherwise go through the next or (.) you know (.) or…	
160	**R 3**	**Well they bounce around (.) don't they?**	
161		Yeah (.) yeah.	
162	**R 3**	**I don't know how it works where you are but (.) erm (.) here (.) the children that come to V (.) myself and A are (.) you know (.) they've tried everything else.**	**Sometimes child psychotherapy is the last resort because of special ability to being attuned to the child even if**
163		Is that they kind of referral that you get? So what (.) like they've tried like a bit of CBT or…?	
164	**R 3**	**Usually they've tried CBT (.) maybe some family therapy (.) counselling (.) you know (.) all sorts. I mean (.) they are the very (.) the very difficult cases.**	**Reality that good training is needed as child psychotherapists working with the difficult cases**

165		I guess it's a little bit different in care then because sometimes (.) because we (.) we already have this criteria of being looked after (.) maybe sometimes it's their first actually experience of therapy and because there are a lot of trainees (.) they get the chance to have child psychotherapy as the first thing (.) really. Uhum. But yeah (.) well I've heard a little bit about the rest of the ((laughs)) (.) the rest of those professionally	
166	**R 3**	**Hmm. Is that useful?**	
167		Yeah (.) no it was very (.) very useful. Yeah. Good (.) I'm going to stop this.	

Appendix B: Consent form

Anna Freud Centre/University College London

Consent Form

Title of Study:

A qualitative exploration of child psychotherapists' perspectives on the links between their personal analysis during training and their own practice

Principal Researcher:

Evrinomy Avdi

Researcher:

Coralie Lasvergnas

Your participation in this study is completely voluntary and confidential. You may withdraw from the study at any time, without any consequence. Even upon completion of the study, you may still choose to have your information fully discarded. All audio files will be password-protected and all paper files will be kept in a locked cabinet. Audio files will be destroyed after they have been transcribed and all transcripts will be anonymised.

If you have any complaints about the research or researcher, please discuss them with the Researcher. If these problems are not resolved, please discuss them with the Research supervisor, Evrinomy Avdi, The Anna Freud Centre, 21 Maresfield Gardens, London NW3 5SD. Tel: 020 7794 2313. If you wish to complain about the conduct of the research, you may email the Chair of the UCL Committee for the Ethics of Non-NHS Human Research (gradschool:ucl.ac.uk) or send a letter to: The Graduate School, North Cloisters, Wilkins Building, UCL, Gower Street, London WC1E 6BT.

I, _____, understand that if I decide at any time during the research that I no longer want to participate in this project, I can notify the researcher(s) involved to withdraw from it immediately and without any consequence.

I consent to the processing of my personal information for the purposes of this research study. I understand that such information will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 1998.

Participant's Statement

I agree that the research project named above has been explained to me to my satisfaction and I agree to take part in the study. I have read both the notes written above and the Information Sheet provided, and understand what the research study involves.

Signed: _____ Date:

_____

Researcher's Statement

I_____ confirm that I have carefully explained the purpose of the study to the participant and outlined any reasonably foreseeable risks or benefits.

Signed: _____ Date: _____

Appendix C: Information Sheet

A qualitative exploration of child psychotherapists' perspectives on the links between their personal analysis during training and their own practice

This project is being conducted by Coralie Lasvergnas, under the supervision of Evrinomy Avdi

Aims of the Project

This project aims to explore the way in which child psychotherapists regard the links between their personal psychoanalysis during their training and their own clinical practice following qualification. This study is conducted as part of the researcher's Doctorate in Child and Adolescent Psychoanalytic Psychotherapy at UCL, the Anna Freud Centre and the British Psychotherapy Foundation. The focus of the interviews will be on how the child psychotherapists think their own personal psychoanalysis influences their practice of child psychotherapy and the relationships they develop with their own patients. It is hoped that this study will deepen our understanding of the role of personal analysis in clinical practice.

What are we asking you to do?

If you would like to participate then you can proceed to sign the consent form and return it to us via email. Once it is received, we will contact you to arrange a meeting for the

interview. There will be one interview per participant. The interview will last approximately one hour and will take place at a place that is convenient for you.

Who will carry out the interview?

I, Coralie Lasvergnas, Child and adolescent Psychotherapy trainee, will be carrying out the interview.

Access to the information you provide:

My research supervisor, Evrinomy Avdi, and I will have access to the information you provide but this will be kept on password-protected audio files and once transcribed, paper copies will be placed in a locked cabinet to ensure confidentiality. Audio files will be destroyed after transcription has taken place. Your name or personal details will not appear in the paper files.

What to do if you change your mind:

You are free at any point, before, during, or after the study to withdraw participation with absolutely no consequences. Your participation is entirely voluntary. In addition, after the interview is complete and the data is collected, you are still able to request that your information not be used in our study.

Will there be any feedback about the findings?

After the study is completed, general feedback will be available at your request.

Where the study will take place:

The study will take place at the Anna Freud Centre.

Who to speak to if a problem arises:

If you feel uncomfortable discussing a problem or issue with the researcher, please contact the research supervisor, Evrinomy Avdi (contact details below).

Who are the people involved with this project:

Researcher: Coralie Lasvergnas

Location: UCL & the Anna Freud Centre for Children and families

Supervisor: Dr Evrinomy Avdi

Occupation: Research Tutor (PsychD)

Location: The Anna Freud Centre for Children and families

How to contact the researchers for more information:

Researcher: Coralie Lasvergnas

Email: coralie.lasvergnas@gmail.com

Principal Supervisor: Evrinomy Avdi

Email: Evrinomy.Avdi@annafreud.org

Thank you for taking the time to read this information sheet, we look forward to hearing from you soon to answer any further questions you may have.

Appendix D: Interview schedule draft

A qualitative exploration of child psychotherapists' perspectives on the links between their personal analysis during training and their own practice

Areas to explore:

Characteristics of the analysis

Possible questions to ask:

How long before the training did you start your analysis?

How long were you in analysis for?

How long after the training did you end?

At the time, how did you feel about having to go to analysis as a part of your training?

Perspectives on the way analysis influenced the interviewees' practice during and after their training

Possible questions to ask:

What aspects of your practice do you think were influenced by your personal analysis?

How did this evolve over time? Was it different during your training and after you qualified?

Ask for examples for each of the aspects mentioned by the interviewee

Possible themes (Might add prompts if needed)

Language (the way the therapist speaks to their patients)

Boundaries of the sessions

General non-verbal attitude of the therapist (smile etc.)

Therapeutic technique (interpretations etc.)

Learning about mental health

Might add some questions if the conversation is not flowing such as:

How do you think your practice might be different if you had not had analysis during your training?

How did the experience of being a patient shape your clinical practice?

Perspectives on the way the interviewees' form relationships with their patients

Possible questions to ask:

How do you think your personal analysis during your training impacted the way you form relationships with your patients?

How did this evolve over time? Was it different during your training and after you qualified?

Ask for examples for the different aspects mentioned by the interviewee

Possible themes (might add prompts if needed)

Personal changes that influence way to relate

Using the analyst as a role model

Learning from the experience of having been a patient

Question about how the interviewee thinks personal analysis shaped their practice in comparison with other aspects of the training

Possible questions to ask:

How much do you think your personal analysis shaped your clinical practice, in comparison to other elements of the training (such as supervision or seminars)?

Can you give some examples? Can you explain your thinking?

Questions to conclude/general views

What is your current view on the personal analysis requirement in the training? Would you make it different in any way?

How would you explain this requirement to a prospective trainee?

Appendix E: Ethical Approval

UCL RESEARCH ETHICS COMMITTEE

ACADEMIC SERVICES

30th January 2017

Dr Evrinomy Avdi

The Anna Freud Centre

UCL

Dear Dr Avdi

Notification of Ethical Approval

Re: Ethics Application 0389/017: A qualitative exploration of child psychotherapists' perspectives on the links between their personal analysis during training and their own practice. Further to your satisfactory response to my comments, I am pleased to confirm in my capacity as interim Chair of the UCL Research Ethics Committee that I have ethically approved your study until 30th January 2018. Approval is subject to the following conditions:

Notification of Amendments to the Research

You must seek Chair's approval for proposed amendments (to include extensions to the duration of the project) to the research for which this approval has been given. Ethical approval is specific to this project and must not be treated as applicable to research of a similar nature. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing the 'Amendment Approval Request Form':

http://ethics.grad.ucl.ac.uk/responsibilities.php

Adverse Event Reporting – Serious and Non-Serious

It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator (ethics@ucl.ac.uk) immediately the incident occurs. Where the adverse incident is unexpected and serious, the Chair or Vice-Chair will decide whether the study should be terminated pending the opinion of an independent expert. For non-serious adverse events the Chair or Vice-Chair of the Ethics Committee should again be notified via the Ethics Committee Administrator within ten days of the incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol.

The Chair or Vice-Chair will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Final Report

At the end of the data collection element of your research we ask that you submit a very brief report (1-2 paragraphs will suffice) which includes in particular issues relating to the ethical implications of the research i.e. issues obtaining consent, participants withdrawing from the research, confidentiality, protection of participants from physical and mental harm etc.

Academic Services, 1-19 Torrington Place (9th Floor),

University College London

Tel: +44 (0)20 3108 8216

Email: ethics@ucl.ac.uk

http://ethics.grad.ucl.ac.uk/

Yours sincerely

Professor Michael Heinrich

Interim Chair, UCL Research Ethics Committee

A reflective commentary on conducting a qualitative research project as part of the clinical doctorate in psychoanalytic child and adolescent psychotherapy

Word Count: 3905

WNHB6

A reflective commentary on conducting a qualitative research project as part of the clinical doctorate in psychoanalytic child and adolescent psychotherapy

My main motivation for entering training in Child and Adolescent Psychotherapy was the clinical part. At the start of the training the research part was not my main interest. I saw the research part of the course as a way to further my clinical learning by exploring a subject that would be close to my clinical placement in a CAMHS clinic for looked after children. I was offered the choice to design my own project or to join an existing project at the Anna Freud Centre. From the beginning of working on the research part or the training I had been warned that having chosen to work on my own project rather than on one of the projects on offer at the Anna Freud Centre would be difficult in terms of time commitment. The difficulties did not come from where I was expecting them and along the way I also realised that students who had joined existing projects on offer at the Anna Freud Centre had also difficulties of their own that were no less challenging than the ones I had faced. Despite the difficulties, choosing and designing my own project with the help of my supervisors was right for me, because I do not think I could have had the same amount of enthusiasm, pleasure and interest had I joined an existing project. Having a choice was important to me and at times the process of training can be infantilising so it was important for me to preserve a sense of agency. Having a choice regarding the topic motivated me to work quite hard, especially in terms of quantity at the same time as holding a full-time job placement and meeting the course academic and clinical requirements.

Choosing the subject

Defining the subject was without a doubt the most difficult part of the whole process. Having decided that I would design my own project filled me with a great sense of urgency. I was worried at the idea of being left behind without a topic. Working on my own project had the consequence that I was placed in a group with two other students working on their own

projects. Unfortunately, those two students rapidly stopped working on their projects and I found myself receiving individual supervision but not working with a group of other students. Being separated from others also gave me unrealistic expectations about what the others were up to and I had a sense that they were all much further along the way than I was. At the time, I had the sense that the subject I would choose had to be somehow linked with my placement in a child and adolescent mental health service. As the clinical demands of the course increased I could not imagine how I could do a study that involved recruiting participants outside my work if only for practical reasons. I also thought I would benefit from the expertise and help of my service supervisor and work colleagues if I chose a subject closely related to work with looked after children in CAMHS.

Moving away from looked after children

The subject I had envisaged was around the idea of working with looked after children and the experience of it. I had begun my clinical placement and liked the work but with hindsight I also felt hit frontally by the level of distress and disturbance found in the children and young people attending the clinic. My idea at the time was to research specifically the counter-transference reactions brought on by working with looked after children and think about concepts such as secondary trauma. Perhaps at the time I was looking at discovering whether other professionals were also as affected as I was by the work and how they managed their distress. I think it is difficult to distinguish between a topic that is close to someone's interest and one that might prove too disturbing because the researcher cannot put himself at a distance from it.

My intention was to interview staff members from my clinic. I thought this would be both relevant and practical and seemed appropriate. This idea was challenged when conducting the first small piece of service-based research: the audit. I had not thought about the difficulties of conducting research in one's team and how difficult it is to be both a team

member and also a researcher. Particularly at a time when as a trainee child psychotherapist I was trying hard to integrate and be a member of the team. Much later in the training, I found out that another trainee in the same placement as me would do her research on secondary trauma. She had decided to interview staff members but only after she would be finished with her placement herself. I could understand only too well her concern about being too close. Instinctively, without talking to each other we had thought about the research element of the course as a way to help us make sense of the clinical part of the course. I am not sure whether this was intended when the course was designed. However, it felt important but difficult to find the optimal distance between a researcher stance and a more personal one. When I think I know exactly what a patient is feeling because I have felt this way myself, I usually make a point to proceed with even more caution than usual as there is a greater chance that I am attributing some of my feelings to them. I believe that feeling too involved can lead to projecting more of one's own feelings onto the patient or in the case of research, onto a topic. Those mixed feelings about finding a topic that would relate to looked after children led me to question this idea and were not helpful in defining a subject. In addition to my concerns about clinicians' reactions to participating in the study, there was there also a practical consideration that it would be very long (probably too long for the purpose of this course) to obtain ethical approval from the NHS for asking staff members to talk about their cases.

In a brainstorming discussion with one of my academic supervisors and another student a new idea emerged. This idea was still centred on clinicians' experience but this time not linked to looked after children and secondary trauma. The new idea was to try and understand the impact of personal analysis on child psychotherapists. In the brainstorming session we talked about possibly interviewing child psychotherapists in training and also maybe training analysts. This seemed to be an important question because of the specificity of the analysis required for the child and adolescent psychotherapy training. Trainees need to

be in analysis three times a week for a year before beginning the training and then four times a week for the four years that the training lasts (this requirement varies slightly for the different training schools but no less than three times a week is required for registration with the Association of Child Psychotherapists). The analysis is part-funded by the NHS and is a significant cost for the trainees but also for the taxpayers. The academic supervisor did not have the knowledge of published research on this subject. There was also the fact that this question is asked to me often by friends or relatives: why does one need intensive analysis to become a psychotherapist, what is the function of it? I had thought about it but had never researched the subject. The question of the difficulty of taking one's analyst as a role model was also on my mind. The link between having analysis and then becoming a psychoanalyst is more straightforward than the link between having analysis and becoming a child psychotherapist. Child psychotherapy is play-based and quite active so usually very different to analysis.

Searching the literature

I found that there was no published research on the links between analysis and child psychotherapy training. I could find brief theoretical statements on the importance of analysis on the ACP framework and in the handbooks from the various training schools, which I obtained from the schools themselves. In these handbooks there was no reference to research but references were made to psychoanalytic theorists. This made me wonder more generally about the need for integrating research in the child psychotherapy training. Analysis is a central part of the training and I find it important that as such it could be researched in the same way as treatment modalities or patient outcomes. The fact that analysis in the training of child psychotherapists has not been researched resonated with some of the literature that deplored a lack of transparency in the training system.

Researching the literature on the effects of personal therapy in the training of adult psychotherapists was somewhat unsatisfactory and brought to light the differences between being a therapist for adults and a therapist for children. The daily realities of the job of a child psychotherapist are very different from those of a psychoanalyst, especially when working in a NHS CAMHS team. As a trainee, I tend to see very disturbed children and a large part of the work consists of containing the children and helping them manage their intense anxieties or aggression, sometimes on a physical level. There is of course some thinking and reflection that takes place but I find that a lot of the thinking has to be done after sessions and sometimes in supervision. The actual sessions can be very lively and the time for reflecting is often quite limited.

Road Bumps

I had already spent a significant amount of time researching and summarising the literature when I mentioned my research subject to my progress advisor, who is linked with the clinical part of the course rather than the newer research component. I had been spending the past year defining it and beginning to work on it and I had assumed the clinical side of the course knew about it. I also assumed they would have no view about it and would leave the research to the research side of the course. It was made clear to me that there was a strong concern about me interviewing trainees about their analysis and also training analysts. This concern was escalated and my placement supervisor, placement consultant and even my analyst were contacted by the school about those concerns about the appropriateness of my subject. For me of course I was concerned about finding myself without a research topic again, after the long process of defining one that felt appropriate to me. Several suggestions were offered to me. It was suggested that I finished the literature review piece of work and then joined one of the pre-established research groups of students and completely change subject. There was also a suggestion that I could join students from the year below for the

research. These solutions did not appeal as I felt I would be falling behind. The crisis resolved more easily than I would have predicted with the suggestion from my other academic supervisor to continue on the same topic and simply modify it slightly. Together, we refined the subject and decided to focus on the role of analysis in the professional development of child psychotherapists rather than on their more personal experience of it. She acted as a link with the clinical side of the course who accepted my decision.

Having had time to reflect on the concerns of the training school I can now understand them better. Because this subject had emerged from a discussion with one of my academic supervisors, who also was the academic head of the course, it had not occurred to me to worry about the subject and how acceptable it was to the training school. What I was told by my progress advisor about the concerns was around the idea that I could not be objective about researching analysis while going through it at the same time. There was also the concern that I might not fully benefit from my analysis if I was researching other people's. Analysis is meant to be understood from within. Ironically, this was one of the main findings of the study. However, looking at analysis from the outside might not necessarily prevent fully experiencing it. Again, it might be a question of finding the right balance between being too emotionally involved in a topic and having the insight that comes with having experienced a process oneself. There might also have been a worry about the potential findings of the study. This was a small scale qualitative study and its generalisability is limited but still, if all participants had found having analysis unhelpful or detrimental to their training this might have led to uncomfortable questioning of the training as it is at the moment.

This incident generally made me reflect on the unpleasant feeling of being powerless. This made me think of the looked after children I work with and how they might experience decisions being made for them and being talked about. For a lot of the children it is difficult

to assume positive intent from the adults around them when they are not happy with the decision being made.

My supervisor and I thought it would be better, and less controversial, to interview qualified child psychotherapists rather than trainees and to abandon the idea of interviewing training analysts. I had made the choice to look at analysis through the lenses of research but I did not feel comfortable asking other trainees to do the same especially against the advice of the training school. With the support of my research supervisor, the training school accepted my decision. I believe that those difficulties also highlight the difficulties about being both a clinician and a researcher. As a clinician I had feelings and beliefs about my own profession and lacked the neutrality of a researcher.

Conducting the study

The intense relief of having a topic for my research made me work quite fast. Monthly meetings with the rest of the student group did not give me a clear sense of how advanced people were in their research. There was a lot of work to be done in the third year because I needed to obtain UCL ethical approval before I could begin the study. Approval was obtained without further delay.

I began looking for participants. The freedom of this was a little exhilarating. The criteria were very open. Participants had to be ACP registered child psychotherapists and they had to be working as child psychotherapists in any capacity. I aimed for six participants. Quite easily I found six willing participants within my extended professional network. Two of them were from my clinic. Conducting the interviews was the most enjoyable part of the project. The questions were very open and each participant was left free to take the interview in any particular direction they chose. Each participant talked about their analysis in a way that was specific to them. Some of them talked about very personal feelings and some of them talked more about theory and technique. I realised, while doing the interviews, that

there had been truth in the training school's concerns around my curiosity about other people's analysis. The idea that analysis is to be understood from within is difficult as it is also a big part of the training and an important commitment, emotionally, financially but also practically. I was struck by the shared feeling of worry about doing analysis right and making the right amount of progress. This worry had been one of the things that had led me to this very topic. At this time, I can say that having a little more insight into other people's analysis greatly benefitted my own. Simply knowing that the worry about not doing analysis well enough was shared by other people enabled me to relax enough to actually be in the analysis rather than worry about it. The interview material made me reflect on the expectations that I have on both my analysis but also the therapy I provide to children. What do we hope to achieve as child psychotherapists? Change? Awareness? What are reasonable expectations to have for one's patients? This reflection was shared by several of the interviewees and it seems that having analysis helped them think about this question.

I had never conducted interviews before and this felt like a cross between a formal conversation and clinical work. I was acutely aware that participants were doing me a favour by talking about personal experiences. With some of them, it felt quite intimate, especially the participants I had known only in professional circumstances, sometimes in a supervisory role with me. I was aware the material was confidential and felt respectful of that. Being face to face in a room reminded me of clinical work but the fact that the person in front of me was not expecting a response or a solution from me made the atmosphere more relaxed. I audio recorded the interviews and this also contributed to feeling more relaxed. I could be present but also at times let my mind wander about something that had been said without fearing that I would miss what the person would say next.

Transcribing the interviews was very time consuming and frustrating at times but I had a great sense of moving forward. This occupied all my free time for a period of time but

somehow I did not resent it and was fairly interested. After the transcription was completed, I had a sense of knowing the interviews very well. Some parts of them I can still hear in my head now. There were some puzzling aspects such as sentences or ideas I thought I had understood during the interviews and then later I was not so sure of having really grasped what the person meant. Some phrases heard too many times seemed to lose their meaning. I did not overly worry about this and thought that qualitative research does include the researcher's interpretation of what has been said and I could not chase perfect understanding in human communication because it simply did not exist. Again, this was very much in link with my clinical work: in child psychotherapy a lot depends on the therapists' interpretation. Using one's feelings and intuition about the clinical material is one of the keys aspects of being a child psychotherapist. The same sense of moving forward was with me when I began coding the transcripts. There was a lot to do: arranging the transcripts into tables, trying different concrete ways to code was time consuming but fairly entertaining. I was always eager to meet my supervisor who would tell me about the next step. The decision to use thematic analysis was suggested by my supervisor. It could be applied to the material but in addition to that it was very in line with the skills I was developing as a child psychotherapist. Finding themes in the play of children is something I do as part of my daily work in the clinic. Finding themes in the words of the participants felt like a very similar process with the difference that I did not have a raging child in front of me. I could take my time with the material and let my thoughts mature. In some way this could be compared to having a supervisory role, as some of the participants talked about during the interviews.

The coding stage was quite difficult as it required making decisions and interpretation about the meaning of what the interviewees had said. In particular it was about making decisions about what would be included in the paper, what was important, what mattered. The progress slowed down because things took longer simply because they required more

thought and processing. Fortunately, some of the thinking had been done while transcribing and coding even though at times it had felt like a bit of an automatic task. I had to change the shape of results a few times. My supervisor suggested making a diagram. This again was very helpful and was a way to integrate some doing into the exercise of thinking. This made it easier and clearer for me. This process was quite different to clinical thinking because I had to eliminate material that I thought was important and meaningful because it did not fit with or answer the research question.

The conference and writing up a short summary

The paper was in the final stages when I had to pause and leave it for some time in order to prepare a fifteen minute oral presentation to present at a psychotherapy research conference. At the time this felt difficult, because I wanted to finish writing the paper. Surprisingly, writing this short summary was incredibly helpful for finishing writing my actual paper. It helped me make decisions about what was most important and what was secondary. Generally, it gave me more clarity about what I had learned from the literature review, from the study and made me think about what could be learned by others from it. This came at the right time when I was so immersed in the study that it was very hard to take a step back and see it as a whole. Going to the conference and rehearsing presentations together with other students was a nice way to reconnect with the group and to have a shared experience. The conference itself was an interesting and rich experience but it also made me a little dizzy seeing how many very small research studies (like) mine were out there and how much work it would be to put them all together. It was only some weeks later that I felt I had properly taken in some of the information, similar to clinical work where a multitude of information make sense only after having had time for reflection and supervision.

Conclusion

Conducting this piece of research has been a very enriching experience and I have learned things (including things about myself) I probably would not have if I had not been given the opportunity to do this piece of research. At the beginning of the training, research was not my main interest and if it had not been mandatory I might not have done it considering all the other requirements of the training. My outlook on research has changed a lot through this training. I am more aware of the importance of research in child psychotherapy and it also does not appear to me as something completely separate to clinical practice. In fact I found many similarities between conducting clinical work. The analytic skills and the sense of working with my feelings and intuition was similar to clinical work except for the sense of working under attack. I will not be afraid if future jobs include auditing or researching, in fact I might initiate it myself. As a side process, my analyst had been ill and back for some months before telling me she could not carry on working because of illness and treatment. As such this was a difficult and painful experience, but I can say that having heard the participants of the study talking about how painful it could feel to finish analysis I felt that my experience could be shared.