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ABSTRACT

The global rise in adolescent self-harm and suicidal behaviours has intensified the demand for mental health services in the UK. This has further strained already underfunded and understaffed resources, resulting in longer waiting times and increased emergency department visits among teenagers. To address the overwhelming need for effective community-based emergency support, a brief psychodynamic crisis therapeutic intervention was developed within a CAMHS adolescent crisis team, inspired by child psychotherapist Ruth Schmidt Neven's work on time-limited psychotherapy with adolescents and their families. This 12-session intervention offers both individual therapy for the adolescent and sessions for their parents, along with regular family reviews. Two psychotherapists work closely together on each case – one with the young person, the other with the parents. The brief model views crises as opportunities for deeper understanding, moving beyond diagnostic and symptom-centred approaches, as well as standard risk management and safety-planning strategies, and underlines the centrality of parent involvement in adolescent crisis work. This paper outlines the intervention's theoretical foundation, guiding principles, and practical design, and presents preliminary findings from a pilot study of 22 cases, run over two and a half years. Early results suggest broad potential for this psychodynamic crisis approach in various adolescent crises, and merit further investigation.

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Introduction: presenting the pilot project

This paper describes our experience of a two-and-a-half-year pilot project, which we conducted as part of our work in the adolescent team at Enfield CAMHS (Service for Adolescents and Families in Enfield, SAFE), in London, UK.[1] The project introduced a brief psychodynamic intervention for young people and their parents experiencing a crisis, consisting of up to 12 sessions.

For the purposes of this paper, we refer to crises as those involving suicidality or moderate to severe self-harm. Often, such crises lead teenagers to visit the emergency department (Bommersbach et al., 2024; Poyraz Fındık et al., 2022). There are many

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other forms of crises, of course; but here we specifically focus on crises related to suicidality and self-harm, to give a taste of our day-to-day work in our clinic.

An applied psychoanalytic approach

Our intervention is grounded in psychoanalytic concepts, with observation, transference, and countertransference as central pillars (Lia, 2017; Luborsky & Barrett, 2006; Sandler et al., 1970). We have also been influenced by systemic ideas, which highlight the interactive and interdependent nature of family dynamics (Hanna, 2018; Massey, 1986; Selvini et al., 1980; Sexton & Stanton, 2016).

We have opted for using the term 'psychodynamic' when referring to our therapeutic work with adolescents and their families in our clinic. While our work draws on psychoanalytic principles, it adopts an applied way of working that fits a CAMHS[2] context, joining others before us who have adapted psychoanalytic ideas across varied settings (Axelrod et al., 2018; Esman, 1998; Lemma & Patrick, 2010; Rowan, 2003; Schmidt Neven, 2017).

This pilot project emerged from our effort to continue offering psychodynamic treatment to adolescents (aged 13–18) and their parents who attend in crises. We believe in the value of this approach as part of the adolescent crisis service offer, as we hope to show in this paper.

Background

This time-limited model for crisis was borne out of our experiences as ACP[3]-trained psychoanalytic child psychotherapists within an adolescent team. The therapeutic approach we developed over time reflects adjustments we made to our previous practice. In this section, we explain these adaptations, the rationale behind them, how they were implemented in our clinic, and offer ideas about contexts where we believe this therapeutic approach might be suitable for young people and families.

This way of working did not stem from theoretical or clinical ideas alone. Instead, it was a direct response to the practical challenges we faced in recent years within our NHS adolescent crisis team, made worse by the destabilising effects of the Covid-19 pandemic (Bouter et al., 2023; Panchal et al., 2023; Wolf & Schmitz, 2024) and years of economic austerity measures in the UK (Cummins, 2018; Hunter, 2018). These issues, combined, deeply affected adolescents, their families, and the NHS as a whole; so, it became clear to us that we needed to think 'outside the box' and try new approaches in our work.

As psychoanalytic child and adolescent psychotherapists working in a crisis team, we were already grappling with some key questions: could we balance our heavy caseloads with the wish to contribute meaningfully in the midst of the broader NHS staffing and funding crisis? Could we provide something valuable to our service while staying true to our psychoanalytic background?

A crisis as an opportunity

Through this pilot project, which started at the tail-end of the pandemic, we answered these questions in the affirmative. Despite the pain and turmoil involved, we came to see that

a family crisis, especially in high-risk situations involving self-harm or suicidal ideation, represents a unique opportunity to uncover meaning for both the young person and their parents, by allowing critical themes to be articulated in the moment when defences against psychic pain are lowered and thus awareness is temporarily more open about what is going on under the surface. This offers space to potentially reduce risk relatively quickly (Campbell & Hale, 2017; Schmidt Neven, 2017; Yakeley, 2018).

Throughout the project, we gained a deeper appreciation of the role that child and adolescent psychoanalytic psychotherapists can play in crisis teams. Rather than viewing a crisis in the adolescent and their family as a negative event, or a set of symptoms to be managed, we could seek practical ways to integrate our therapeutic approach into crisis work. This identified the point of crisis as an opportunity to elicit a developmental shift in the family, with parents actively participating in the changes – one of the major findings we adopted from Schmidt-Neven's work (2010, 2017). As such, our goal became to rethink the 'crisis work' we were already doing, moving towards an in-depth psychodynamic approach grounded in observation, use of transference and countertransference phenomena, and the collaboration of two psychotherapists on each case.

Positioning this intervention

The work that we describe here is best initiated early in the journey of a crisis, regardless of how big or small the manifestations of the crisis appear. As such, it aligns with the typical NHS adolescent crisis pathway, aiming for a first appointment within two weeks of referral, and could be considered as one of the frontline options for families in crisis. The intervention, we believe, offers a viable alternative going beyond the prevailing risk management strategies, which often rely on rigid safety planning, detached from therapeutic understanding.

This brief psychodynamic intervention aligns with the NICE guidelines on self-harm (2022), which emphasise the value of a holistic psychosocial assessment. Before a detailed discussion of our pilot project, including its context, structure, and initial findings, we want to start with some thoughts about the wider societal crisis within which these current problems in adolescence are occurring, and how we think we can work with them psychoanalytically in the NHS. From there, we will discuss some recent literature on brief psychotherapy work, followed by a detailed examination of three main pillars central to the brief psychodynamic psychotherapy intervention, which we summarise as:

(1) The general usefulness of time-limited psychodynamic work in crisis;
(2) The active involvement of parents in adolescent crisis work;
(3) The close collaboration of two therapists in crisis work.

The wider context

In this section we refer to the existing gap in knowledge around psychotherapeutic crisis work as a frontline option in NHS CAMHS crisis services, in the context of the increasing rates of psychological difficulties in adolescence.

The adolescent mental health crisis

Reflecting the broader vulnerability of adolescents to mental health challenges, the World Health Organization (WHO, 2021) estimates that approximately 14% of teenagers worldwide suffer from emotional disorders, with depression, anxiety, and behavioural issues being the most prevalent. The number of young people needing emergency care has surged, with a 29% increase in contacts with mental health services in England between December 2019 and April 2021 (Edwards et al., 2024). These developments underline the pressing need for expanded crisis interventions to address these difficulties proactively before they escalate further. However, there's an ongoing debate on the best ways to 'spot' and prevent the progression of suicidality (Garland & Zigler, 1993; Gibbons, 2023, 2024).

Data from NHS Digital (2020) also show a steady growth in these problems among children aged 5–19, with one in six impacted in some way, up from one in nine in 2017. Suicide tragically ranks as the fourth leading cause of death among 15–19-year-olds worldwide (WHO, 2021), making its prevention an international imperative (WHO, 2014).

In previous decades, teenagers' crises more often centred on externalising behaviours, such as drunk driving, drug use, or other forms of risk-taking – along the lines of Holden Caulfield in 'Catcher in the Rye' by Salinger (1951); or Bruce Springsteen's 1975 anthem 'Born to run'. But things have changed. Since around 2010, there has been a striking expansion in internalising difficulties, such as anxiety and depression (Haidt, 2024). Today's struggling teenagers, when presenting to crisis teams, typically may be self-harming or considering suicide.

As this growing crisis progresses, stretched services and high demand have led to lengthy waiting times for children and young people needing help, compounded by ongoing issues in social care and education (Salisbury et al., 2023). The House of Commons Health and Social Care Committee (2021) has warned that the delays in support may be causing manageable problems to escalate into crises due to waiting lists and high thresholds for accessing care in the NHS.

When considering how to respond to this, we need to keep in mind that adolescence is often the time that mental illness emerges (Jones, 2013; Ormel et al., 2015), making it crucial to distinguish between prodromal signs of severe, long-term mental illness and transient difficulties (Kelleher et al., 2012; Lång et al., 2022). In the case of self-harm in adolescents, Uh et al. (2021) have shown that most young people presenting in crisis do not develop entrenched mental health problems, a hopeful idea to keep in mind.

It is particularly within this field – crisis presentations that most likely will not lead to longstanding issues – that our psychodynamic psychotherapy intervention for adolescents and their families finds its place.

The need for urgent mental health support for adolescents

Despite the stated need for urgent interventions, we don't know enough about what works and what does not in the context of today's mental health crisis, when it comes to therapeutic crisis interventions (Washburn et al., 2012). The formalised risk reduction approach is what is mainly explored in the literature

(Edwards et al., 2024; Glenn et al., 2015), but we need more contextualised, in depth, clinically informed ideas, given that adolescent mental health has become a top policy priority in the UK and internationally (NHS England, 2019; WHO, 2021).

Within the limited existing literature on time-limited adolescent-parent therapy for risk, we note: a family-based crisis intervention in the emergency department (Ginnis et al., 2015; Wharff et al., 2012, 2019); an ultra-brief acute crisis model based on Interpersonal Psychotherapy (IPT) (Adini-Spigelman et al., 2024; Haruvi Catalan et al., 2020); and an integrated model combining individual and family therapy, working on emotional regulation, school attendance problems, and relapse prevention (Wijana et al., 2021). Another intervention combines parent training with cognitive-behavioural therapy for teenagers over 8–10 sessions (Dekel et al., 2021). Time-limited psychodynamic models do exist, such as those based on mentalization ideas (Rossouw, 2013; Rossouw & Fonagy, 2012), Stephen Briggs' short-term therapy for adolescents (Briggs et al., 2019), and short-term psychoanalytic therapy (STPP) for young people with depression (Goodyer et al., 2011), offering helpful insights that we've drawn on.

Despite the evidence on how useful psychodynamic psychotherapy can be for understanding and addressing self-harm and suicidal ideation (Briggs et al., 2019; De Maat et al., 2013; Fonagy et al., 2015), specific ideas in this field remain limited, with a paucity of evidence, both in the form of case studies and in the empirical field. A gap thus exists in specific psychodynamic crisis interventions that consider both the centrality of parents' support in understanding and addressing the adolescent's problems, but also the wider sociocultural environment in which adolescents grow up and the ways it shapes their subjectivity and family experiences, as well as their friendship and wider cultural interactions. All this comes into the material the therapist listens out for in the room.

Addressing this gap is critical since child and adolescent psychotherapy is a core profession within multidisciplinary NHS CAMHS; a solid evidence base is essential for continuing our work in crisis contexts, which forms a substantial portion of CAMHS daily responsibilities. Psychoanalysis has continuously evolved (Shedler, 2023), and it's within this framework of change and growth that we built this therapeutic intervention for adolescents and families in crisis.

We now turn to the foundational assumptions of our project.

The foundational principles of the pilot project

In this section, we outline the key values and principles (see Figure 1) underpinning our pilot project, highlighting its distinctive elements compared to other models and its areas of alignment. By keeping these principles in mind and adopting some or all of them in their practice, we believe clinicians can offer better quality care to families in crisis. This is why we start with these principles before outlining the sequence of appointments and detailing the 'logistics' of this way of working. These values and principles are at the heart of our psychotherapy intervention, shaping its overall structure and approach.

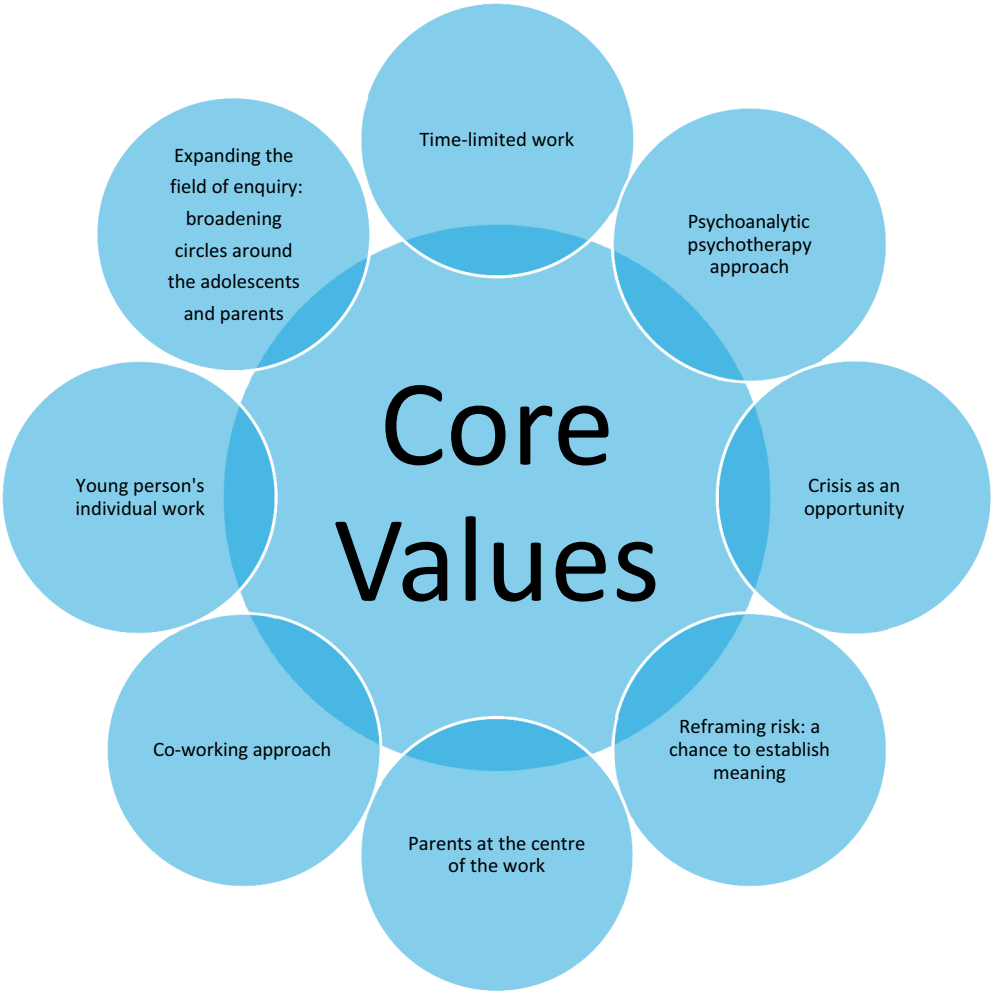

Figure 1. Core values of our model.

Time-limited psychodynamic psychotherapy for adolescents in crisis

While certain adolescents need long-term psychotherapy, not all require such extensive treatment; nor do they always *want it or expect it* when coming to clinics like ours. As Peta Mees (2015) points out, a detailed assessment or a few short encounters is often all that proves possible when a family comes to CAMHS. This can be for several reasons, some related to the family and others related to service limitations, including limitations in education, social services and NHS provision.

Beyond issues of capacity and engagement, it's also the case that brief psychotherapy can be a developmentally suitable option for young people (Edlund & Carlberg, 2016; Gatta et al., 2019) and it has been shown to be helpful for those self-harming or experiencing suicidal thoughts (Briggs et al., 2019; Catty, 2021).

The main theoretical framework we have adopted – viewing *adolescent crises as opportunities for therapeutic engagement* (Schmidt Neven, 2017) – represents

a significant shift from the conventional NHS divide, where crisis work and psychotherapy often operate in silos. This is particularly the case with psychoanalytic psychotherapy approaches, which tend to be excluded from preventative and frontline services and are regarded as follow-on options when other interventions (presumed to be better suited) have been exhausted.

However, psychoanalytic training equips clinicians to create and maintain a reflective space and sustain critical thinking even in the face of emotional turmoil – qualities that are essential in crisis work; this is a resource, we believe, that is under-utilised in the NHS context, and we hope this paper can contribute towards a different way of thinking about this.

By intentionally merging these two fields, risk support and therapy, we not only promote the integration of therapy into crisis work, but also argue for a redefinition of the role of adolescent crisis intervention itself. Instead of viewing crises as moments to be quickly stabilised and left behind, we see them as critical junctures in a developmental journey. They allow us a rare opportunity to gain access to underlying issues in real-time. This can potentially have a powerful impact on the family and adolescent's developmental trajectory, going beyond symptom management.

Crisis as an opportunity

The term 'crisis' is commonly understood as 'an extremely difficult or dangerous point in a situation' or 'a time of great disagreement, confusion, or suffering'.[4] However, the meaning of 'crisis' is not straightforward and varies across disciplines and contexts (Abdelrahman, 2022; Dafermos, 2024; Freeden, 2017). We take up an alternative meaning of the concept, rooted in its Ancient Greek etymology, viewing crisis as a 'turning point' (Dafermos, 2024), where the outcome is critical but still uncertain:

> According to the Hippocratic treatise 'On Affections', crisis 'occurs in diseases whenever the diseases increase in intensity or go away or change into another disease or end altogether. (Dafermos, 2024, citing; Starn, 1971, p. 4)

Borrowing from Vygotsky's perspective on crisis, as presented by Dafermos (2018, 2024), we understand it as 'not only something negative or positive itself but a critical moment of a dynamic, contradictory, developmental process' (Dafermos, 2024):

> The crisis was defined by Vygotsky as a situation of the contradictory co-existence between the destruction of old, previous, concepts on the one hand and the emergence of new concepts on the other. The old concepts have been hopelessly compromised, while the new concepts have not yet been created. (ibid)

Ultimately, a crisis signals that *something meaningful needs to be heard and addressed*. And something needs to change.

Adolescence as a period of crisis, change and transition

Adolescence is a critical phase marked by many changes (Bleiberg, 1988; Blos, 1967; A. Freud, 1958), involving the gradual 'shedding of family dependencies' and 'loosening of infantile object ties' (Blos, 1967), a journey marked by back-and-forths. It is also a time of significant vulnerability, including mental health

challenges such as suicide and self-harm, which as we've mentioned have sharply increased over the past two decades (Haidt, 2024; Sharma & Fowler, 2018). Contemporary adolescence has become further complicated by shifts in attitudes towards mental wellbeing, with young people increasingly engaging with psychiatric diagnoses, moving from stigmatisation to heightened awareness and strong interest (Acheson & Papadima, 2023). While these shifts have benefits, they also bring unintended, complex consequences (Foulkes, 2022; Foulkes & Andrews, 2023). The immersive nature of online life adds another layer of complexity, contributing to the rise in emotional and behavioural difficulties (Fowler & Vinson, 2020; Haidt, 2024; Nesi et al., 2020).

All this has a direct impact in the way adolescents interact with us as clinicians as well as how they engage with their families and friends. When we encounter the adolescent in the room, talking to us during a crisis, we must consider all these factors: what do they have in mind when they refer to a 'breakdown', how would they describe it? What does suicidality look like in detail? What do they think is the meaning of the self-harm, what does it offer them? For example, does it occur in isolated moments of very low mood? Is it a coping mechanism? Does it happen within a friendship group? Does it lead to family clashes? And how does this occur in the context of their online and offline experiences?

Viewing a crisis in adolescence through this lens reframes it as a transformative, meaningful process that pushes towards change: it's not yet clear when a crisis is happening what this change will be. We can think of the crisis as a temporary deviation from the developmental path, where for a period of time various possibilities are open. The goal is to help the adolescent and family move back to ordinary development, avoiding further escalation into crisis.

Relational, psychodynamic risk management

Traditional risk assessments often use structured questionnaires and safety plans created with the family and network. While these aim to capture a comprehensive picture of risk, they can easily become standardised, with compartmentalised risk stratification (e.g., low, medium, high risk). Moreover, procedures that don't focus on continuity of care, and often alternate between practitioners, fail to build on previous therapeutic progress.

Safety planning, as described by the Royal College of Psychiatrists (2020), typically involves practical problem solving, such as identifying coping strategies and reducing access to lethal means. In our own project, we have focused instead on the current NICE guidelines on self-harm and risk, which invite clinicians to 'focus … on the person's needs and how to support their immediate and long-term psychological and physical safety' (NICE, 2022).

Suicide and self-harm, in any case, can be challenging or impossible to fully understand and prevent when it comes to the individual level – as each case is different and the causes are multifactorial; but prevention becomes more feasible on a population level (Gibbons, 2023). Risk-taking can be better understood as 'acting out behaviours' (ibid), expressing something (or a number of things) beneath the surface.

In our pilot project, we have focused on the adolescent's narrative and their family relationships to achieve effective risk reduction, rather than relying on a structured risk assessment approach. Anderson (2000) offered a psychoanalytic perspective on understanding and working with risk in adolescence that we have kept in mind, while De Kernier (2012) emphasises the 'latent meaning of the suicidal gesture'. Lybbert et al. (2019) explain that even brief therapeutic encounters should 'promote the exploration and development of meaning … relative to behaviours and factors related to suicidality'.

Two key psychoanalytic principles: the distinctiveness of each family, and the importance of the obvious

We adopt two key principles from our psychoanalytic tradition. First, we focus on the simple fact that each patient and family are different, rather than being preoccupied with surface symptoms and risks. It can be hard to stay with this, given the anxiety risk evokes and the emphasis on diagnostic explanations. But, as many psychoanalysts and systemic clinicians have demonstrated, paying attention to the nuances of a narrative can bring substantial relief, including not just individual aspects but also contemporary sociocultural elements, all of which come together into the young person and parents' narrative and meaning making. Bion's words come to mind:

> The most important assistance that a psychoanalyst is ever likely to get is not from his analyst, or supervisor, or teacher, or the books that he can read, but from his patient. The patient—and only the patient—knows what it feels like to be him or her … . That is why it is so important that we should be able to hear, see, smell, even feel what information the patient is trying to convey. He is the only one who knows the facts. (1977/2005 CWB Vol. IX pp. 103)

The second principle is the importance of the *obvious or common-sense*. These common-sense elements, often hiding in plain sight, can be overshadowed by loud symptoms and conflict, and acting out behaviours. Bion stressed this idea:

> One is usually so busy looking for something out of the ordinary that one ignores the obvious as if it were of no importance. (1973/2005 CWB Vol. VII p. 67)

Inspired by this, we deliberately steered away from viewing crises solely through a mental illness lens, instead focusing on discussions devoid of professional jargon (Shedler, 2023). Wondering simply, 'what's going on' or 'what might this mean', can bring relief and can, surprisingly, represent a radical departure from the current norm.

The central involvement of parents

Ruth Schmidt Neven (2010, 2017) emphasises the critical role parents play in therapy with adolescents. She has long critiqued the artificial and excessive, as she sees it, psychoanalytic focus on adolescent independence, often at the expense of thinking about togetherness and attachment as they occur during these years. Others, amongst them psychoanalysts Novick and Novick (2013) and child psychotherapist Deborah

Marks (2020), have also stressed the importance of involving parents much more directly in therapy with adolescents.

Adolescents, of course, *are* moving towards greater independence and *do* need separate spaces. However, as Schmidt Neven reminds us, separating adolescents from their parents at this critical juncture is premature. Adolescence may provide the last window of opportunity for therapy involving both parents and the adolescent together to understand the crisis in the context of earlier developmental experiences.

Involving parents at the heart of crisis work with adolescents, we have found, enriches the therapeutic work and makes it more possible to move beyond something merely supportive, to something exploratory that has a chance to lead to lasting change. For example, on numerous occasions we found that parents were able to help by identifying elements that their son or daughter could not at first articulate in moments of high anxiety. The parents did this through having access, it seemed to us, to their own version of countertransference, which the crisis and the adolescent's behaviour evoked in them. What surprised us was how open adolescents were to these moments, perhaps because during crises defences break down to some degree, offering more access to previously unseen personality and family issues: this is true both for parents and for the adolescents themselves (Campbell & Hale, 2017; Yakeley, 2018).

The active involvement of parents thus enables therapists and parents to build an awareness of what might be going on, which may have become obscured by the anxiety of the crisis. By becoming familiar with previously unknown details of their child's struggles which may also relate to their own experiences, parents can become more able to respond. In turn, this increased openness can help adolescents feel more secure, enabling them to move towards independence with greater confidence.

Parents often feel shocked and unsure of how to react when they discover their teenager is self-harming or expressing suicidal thoughts. They may fear making the situation worse and, as a result, may refrain from setting ordinary boundaries. Others may become angry, not understanding why their child feels and behaves the way they do or may perceive these actions as an attack on them, becoming confrontational or controlling in response. Frequently, parents share that *they* also struggled as teenagers, yet they add, they 'just had to get on with it: why can't their teenager do the same?' It's easy to lose sight of what it is like to be a teenager amid the emotional turmoil of a crisis.

Through close work with parents, we have observed that crises often de-escalate when the young person feels that something has been heard. Primarily, that they have understood something about themselves; but importantly, that their parents have recognised this as well.

This understanding can happen even in situations when the parents and adolescent continue not to see eye to eye on what all this means. This is where the therapists can help in the 'translation' process. For example, a young person may view their self-harm as indicative of an underlying disorder, while the parent may see it as 'doing it for attention'. The critical point here is the mutual effort to appreciate each other's perspective, which often has cultural as well as personal roots. A parent from a traditional, stricter background may struggle to understand the fluid way today's adolescents slip in and out of diagnostic language and may equally feel unclear on whether this language indicates something serious or not. This can lead to either

dismissing the problem altogether or panicking about it. Similarly, an adolescent who feels stuck in their internal self-attack or rumination and expresses it in intense, diagnostic-heavy or risk-laden language may not realise how their words impact their parents.

Expanding the field of inquiry: broadening circles around the adolescent and parents

To understand a crisis in the context of the young person's life and make a meaningful difference within a short period, going beyond the symptoms, close collaboration with schools and other agencies is essential, widening the teenager's safety net. This perspective is well-established in CAMHS work, recognising that teenagers are embedded within interconnected systems, as described in Urie Bronfenbrenner's Ecological Systems Theory (Bronfenbrenner, 1979).

Sometimes, a positive relationship with a keyworker can make all the difference; other times, complications may arise: a 'good teacher' can become idealised, while a 'bad parent' can become demonised. We integrate these circles of support into our work, considering both the home and school-based spheres. We see this as a broader application of Bion's container/contained environment (Cartwright, 2014), like Russian Matryoshka dolls with different levels of holding for the teenager at the centre. Bronfenbrenner described this as 'a set of concentric circles representing nested systems[5] (Gerrard, 2012).

Schmidt Neven (2017) highlights that widening the field of enquiry around the young person is an essential part of the therapeutic endeavour at times of crisis; she uses the term 'leverage' to evaluate where and how positive change can be effected in the system to support the adolescent.

In contrast with other similar models, we place special emphasis on the particular sociocultural context in which adolescents live today. This includes their daily experiences, the diagnostic ways they interpret their psychological symptoms, their friendships both online and offline, and the ways they care for and impact each other's mental health within peer groups. All this comes into their experience of themselves. Recognising these factors is crucial for addressing risk, as peer group dynamics can significantly impact teenagers and family life, often without the parents' awareness. Schmidt Neven highlights this, stating:

> The individually lived life cannot be separated from the relational, family, systemic and wider organisational, social and political environment … Predominantly pathology-driven diagnosis associated with these problems has not led to hoped-for outcomes with respect to improvements in child and family mental health. In fact we can argue that narrow pathology-centred diagnosis not only compromises the child and young person, but also the ability of professionals to offer meaningful treatment and care. (2017, p. 6)

Two therapists working together

As mentioned earlier, this project emerged when we, as therapists in a crisis team, felt the need to pull together and support each other amidst the influx of referrals and the Covid-19 crisis. Typically, our team would assign one clinician to manage a case at the assessment stage, with additional resources (e.g., psychiatric input) sought later if

necessary. In our project, however, we opted for collaboration between two clinicians from the outset.

The benefits of co-working in crisis are threefold. First, it creates a containing framework for therapists, which is vital when addressing self-harm or suicidal ideation. In such cases, meaning often emerges through actions rather than words or is revealed through powerful countertransference. Jointly conducting reviews with the adolescent and parents allows contemplation on what is observed, fostering the sharing of perspectives within the family and the therapy dyad.

Second, the adage 'two minds are better than one' applies particularly well in managing risk and crisis given the intense emotions these situations evoke for families and therapists alike. Joint efforts can accelerate shifts in understanding and lead to better outcomes. Having two therapists for each case helps identify blind spots, considering the tendency for splitting that can occur when there is heightened emotion. Further, liaison with external networks is inherently time-consuming for a single psychotherapist to manage alone, but co-working allows tasks to be shared, providing more robust and safer care.

Third, co-working helps avoid over-identification with either the young person or the parents, allowing therapists to maintain a balanced perspective. This ensures that family dynamics are understood from multiple perspectives.

Finally, the peer support and supervision we offer each other enriches and deepens the therapy. When under pressure, we can easily neglect the time needed to discuss the work with colleagues. However, we stress the importance of protecting this time for regular meetings, to process what is taking place.

A psychoanalytic psychotherapy perspective

The framework we present broadens the scope of enquiry across two dimensions. Horizontally, it extends beyond the parents to include wider support circles surrounding the young person. Vertically, within the adolescent's intrapsychic dynamics, a psychodynamic perspective ventures beneath observable behaviour to uncover unconscious forces that drive symptoms. By exploring defences, identifying anxieties, and revealing underlying patterns, we gain a deeper understanding of the crisis at hand, which is necessary to successfully address it. We take it as a given that what we see on the surface is not always what drives the problem (Shedler, 2023).

Central to the psychodynamic approach is that we expect resistance to change, along with an investment in symptoms, negativity, and acting out behaviours, even though on the surface the stated purpose of those who come to therapy is to change. We don't assume that teenagers and parents will automatically *want this change* or for that matter that they want to be safe and reduce the risk, and this needs to be understood and respected. The investment in what's familiar – even if dysfunctional – is a longstanding psychoanalytic insight:

> no one who has any experience of the rifts which so often divide a family will, if he is an analyst, be surprised to find that the patient's relatives sometimes betray less interest in his recovery than in his remaining as he is. When, as so often, neurosis is related to conflicts

> between members of a family, the healthy party will not hesitate long in choosing between his own interest and the sick party's recovery. (S. Freud, 1917)

A psychodynamic lens allows the exploration of unstated death wishes, suicidal fantasies, projective processes that may play a role in risk, and the fluid boundary between thought and action. It could be, for example, that the passive self-destructive wish of a parent who's incapacitated by depression or addiction may get acted out through loud, risky behaviour on the part of the adolescent. And vice versa (sometimes the parent may be the risky one!) Keeping these possibilities in mind is crucial when considering how to approach a family in crisis, and how to gradually build sufficient trust to point out these patterns when they emerge.

A time-limited but flexible therapy

Contrary to the misconception that short-term psychotherapy is 'second best' when compared to the 'gold standard' of long-term therapy, Schmidt Neven argues that it is a valuable and fitting approach, matching the young person's natural trajectory of growth. Brief therapy is especially well suited to risky situations where events move quickly, and where understanding and containment are needed within a short timeframe.

In some of the brief psychoanalytic approaches on which we've drawn (e.g., Bronstein & Flanders, 1998; Searle et al., 2011; Winnicott, 2018) the common thread is attention to the uniqueness of each family while ensuring the young person feels heard in their distress, whether expressed through self-harm, parasuicidal actions, or delinquent behaviour. There is a strong element of individualising the treatment to each case in these ways of working. In this spirit, our intervention, while specifying an approximate number of 12 sessions including both parent and adolescent meetings, holds a firm position of flexibility, as we are not aiming to produce a manualised way of working. Sometimes we see families for just a few sessions, while other times for more than 12 sessions.

Interestingly, by looking at the numbers of what was actually offered over the two and half years, we noticed that the average number of sessions offered was indeed 12, hence suggesting this number as a benchmark to start from, rather than something to stick rigidly to.

We now move onto the practical details of the time-limited psychodynamic crisis therapy we have piloted.

The two-year pilot project

While we cannot comment on the specifics of cases, in this section we will offer an overview of the pilot project and will then present a composite example. The overview with which we start includes information on:

- Sources of referrals.
- Reasons prompting referrals.
- Demographics of the cases.

- Common overarching themes observed.
- How we formulate the presenting problems.
- Any observed reductions in the risk of self-harm or suicidality.

Context and demographics

The project has run over two and a half years in a London specialist CAMHS clinic that offers community-based, rapid support to adolescents aged 13 to 18 in need of urgent care. This often includes young people who have harmed themselves or are at risk of suicide. Referrals frequently follow visits to the Emergency Department, sometimes after a suicide attempt, or they may be referred by their General Practitioner (GP), school or social worker. SAFE also offers specialist assessment and treatment for teenagers experiencing complex or severe difficulties, such as emerging psychosis, or where there is ongoing risk.

The group running the project

Referrals to our clinic typically belong to two categories: those experiencing temporary crises linked to age-specific concerns, and those dealing with acute versions of longstanding problems. Our multidisciplinary team, which includes psychiatrists, psychologists, nurses, systemic family therapists, and psychoanalytically trained child and adolescent psychotherapists, aims to respond promptly to referrals and assess adolescents and their families within two weeks.

The pilot project has involved the cohesive effort of a closed group of professionals at the clinic. The group includes child and adolescent psychoanalytic psychotherapists, both qualified and in training, as well as assistant psychologists who have supported the work. Together and over time, we have worked towards defining the framework, aims, goals, and key principles of the treatment. This has involved dedicating time to review relevant literature and presenting our evolving work to the wider CAMHS team.

The first steps of the intervention

When starting each intervention, we first need to ensure that it aligns with the presenting problems of the family. For example, in cases where parent participation hasn't proven possible (which can be for a variety of reasons) we don't proceed with offering this intervention and other members of the wider team work with the family.

Before the first meeting, all young people complete the RCADS forms,[4] as is standard in our team. We ensure that all families are seen within two weeks of referral and then continue with the brief therapy aimed at risk reduction, without any intervening waiting time. The vast majority of referrals in our team, including in this intervention, involve female adolescents, mirroring the broader pattern of referrals to teams like ours where young women constitute the bulk of referrals.[6] The families we have seen spanned a wide range of socioeconomic backgrounds, encompassing both disadvantaged families and some on the other end of the economic spectrum. In addition to the crises these families faced, a recurring theme that came up involved

the *disconnect* between adolescents and parents. Both parties usually felt misunderstood, with parents experiencing fear and uncertainty about how to care for their adolescent during the crisis, which often involved language and behaviour they could not comprehend and follow. Some parents felt 'paralysed' by the stress of the situation, leading them to refrain from setting regular boundaries out of fear of further escalation. Other parents, on the opposite end, imposed strict measures, such as removing bedroom doors or closely monitoring their adolescent's every move. Our work aimed to address these relational difficulties, facilitating a gradual easing of tensions.

As we have outlined earlier in this paper, one psychotherapist primarily works with the young person, while the other focuses on the parents and broader network liaison. We aim for approximately 12 sessions, but with an emphasis on flexibility depending on what fits for each family. Sometimes this may mean spreading out the sessions over a much longer period; other times we have opted for different combinations of individual adolescent sessions, parent sessions and joint reviews. We have had a few cases, for example, where the two therapists did almost all the work together with both adolescent and parent(s), because that was deemed clinically most helpful.

First appointment

In the first appointment, the two therapists introduce the framework. After spending about 15 minutes jointly as a group, one therapist then meets separately with the adolescent, while the other remains with the parents or carers.

After this first meeting, each therapist independently notes their observations, feelings, and thoughts. To help with this, we use a grid based on the Milan Family Therapy Group's structure (Selvini et al., 1980), which focuses on creating a provisional working hypothesis at the outset of the work. This allows us to craft a psychodynamic formulation that is adapted and reconsidered over time. Specifically, each therapist writes:

> Sentence A: 'I have a hunch that … '. (explaining the presence of the problem or symptom)
> Sentence B: 'And therefore, I am interested in finding out more about … ' (identifying avenues of enquiry)

Within two days of the first meeting, the two therapists meet to share their thoughts and formulate a unified plan. Individual sessions for the adolescent are then scheduled weekly at first to build momentum; they either continue weekly or shift to fortnightly intervals to ensure continuity. In parallel, sessions with the parents are offered (a minimum of four, but usually more). Sometimes, again in the spirit of flexibility, we have opted for a larger number of joint meetings rather than separating the adolescent and parents. Ongoing liaison with the school or other relevant networks is maintained throughout.

Midway review

Around the sixth session mark, a review meeting is scheduled with the young person, parents, and the two therapists, followed by a discussion between the two therapists. This stage involves revisiting and potentially reformulating our initial working hypotheses, built on the progress so far and our observations. In this and all similar phases of the therapy, we actively use the emotions and reactions we have in appointments, recognising that in cases where acting out and projective processes are prominent, much of the formulation work hinges on carefully noting our countertransference and learning from it.

Final sessions and review

Next, there are approximately six more sessions, concluding with a closing review where the parents, young person, and two therapists come together again. At this point, we consider whether to end the work, or whether further support is needed for the young person and/or their family. This decision will have been discussed in advance with both the adolescent and the parents or carers. While sometimes further work is offered, such as ongoing parent support, family therapy, group therapy, or individual longer-term psychotherapy, often the 12 sessions prove to be enough. We have found in this way of working that risk levels can diminish within a short period of time.

A composite case example[7]

Case overview

> Melissa, aged 15, was referred by her GP for self-harm through cutting. The self-harm had started after she failed an exam for which she had prepared extensively.
>
> Melissa, we were told, had a sibling with profound disabilities and when she would become angry with her parents for (inevitably) focusing more of their time on her sister, she told them she felt depressed, couldn't see the point of it all, and wanted to die.
>
> Her school and parents were alarmed by the escalation in Melissa's behaviour, the deterioration in her mood, and the overall sense of things being stuck. It seemed that Melissa was dealing with multiple stressors simultaneously; as a result, there had been frequent trips to A&E and repeated calls to the crisis line whenever she expressed suicidal thoughts or after incidents of self-harm. At first, these contacts provided relief for Melissa, but over time, their usefulness waned, and her frustration with her parents and school grew. She felt that no-one and nothing could help.

Therapists' initial reflections

Following the first meeting, the two therapists involved in Melissa's case documented their initial hunches and expressed what they were curious about.

Parent therapist's reflections

Hunches

The mother seems eager to fix everything at once, likely because of the guilt she feels about possibly contributing to Melissa's self-harm.

It could be that her guilt stems from resentment towards Melissa for 'creating problems' when her sister 'has it so much harder'.

Both parents were brought up in traditional middle eastern families where mental health isn't talked about: it's a taboo. I have a hunch that Melissa's parents struggle to understand the mental health-oriented language she uses. They swing between feeling panicked at the risk, and frustrated with her when she talks about feeling suicidal.

I have a hunch there might be an unconscious attack on Melissa by the parents, due to the confusion they feel, which perhaps Melissa internalises as anger towards herself.

What am I curious about?

I am curious to hear about the parents' background, the function of guilt within the family, and Melissa's relationship with her sibling.

Adolescent therapist's reflections

Hunches

Melissa seems to struggle with expressing her feelings and appears suspicious of me.

I suspect she harbours strong feelings of anger about being side-lined – sometimes directing this anger outward, other times inward.

There are frequent miscommunications with friends and family.

She is particularly furious with her mother for prioritising her sibling and feels disconnected from her.

What am I curious about?

I'm curious about Melissa's place in the family, particularly with a sibling who has disabilities and requires a lot of attention.

I'm interested in her relationship with her parents. How do they talk about mental health?

I am curious to understand how the family communicate thoughts and feelings.

When the two therapists met to discuss the first appointment, they shared their thoughts about the session, their working hypotheses, and what they were curious about. The therapist working with Melissa reported a feeling of heaviness at times, with moments of blankness, or disconnect. The therapist working with the parents noticed an intense wish to provide immediate solutions, coupled with a feeling of being ineffective. Following this discussion, the two therapists together planned next steps.

As the work progressed, one day Melissa's school called to say they were considering sending her to A&E: she had told a member of staff that she felt suicidal. It occurred to us,

while listening, that if this went ahead, it would be the third visit to the hospital in a month. If it was necessary, it should happen of course: but what was going on?

Melissa's therapist spoke to her on the phone and asked how she was doing. Melissa expressed that she couldn't see the point in living. The therapist enquired about what might have led to these feelings, asking Melissa to just talk about the events leading up to this moment of despair, even if she didn't know how they were connected. Melissa at first didn't know what to say; but later in the conversation she mentioned a small argument with her mother that morning. Initially, Melissa rejected any connection between the argument and her suicidality. However, after thinking together about the details of the argument, she eventually came to see she had felt sad and angry since the morning. She paused and added – 'In truth, I don't want to die but I feel so stuck. No one understands how I feel, and my parents get frustrated with me: they understand nothing about mental health'.

What she wanted, she said, was for someone to just listen and understand, but that felt impossible; she also wanted the feelings to go away. She didn't really know what to do.

Subsequent sessions were held jointly with Melissa and her parents, allowing the therapists and family to explore family communication and the underlying meaning of Melissa's suicidal language and self-harm. Rather than immediately contacting the crisis line whenever Melissa struggled, her parents started sitting with her and simply listened to what she was saying, sometimes going through the day's events.

Over time, the parents grew in their ability to view the self-harm and suicidality as a communication of distress, which helped contain their own responses as well as Melissa's. Although further difficulties arose, the self-harm and crisis calls ceased. Melissa and her parents spoke on several occasions about feeling better connected as they now had a narrative that helped them understand each other's perspective to some degree.

The case was closed after 12 sessions, which was a joint decision.

Preliminary findings and clinical implications

In this section, we share some thoughts about the efficacy of this brief therapy and identify the types of clinical presentations where it might be most useful. After the first year of running the project, one of the co-authors conducted a qualitative service evaluation looking at clinicians' reflections on the project up to that point. Findings from the service evaluation, as well as findings from our continued observations and learning from the pilot project, indicated a number of themes which we will summarise in this section.

At the time of finalising this paper, we have offered this brief psychotherapy to 22 adolescents and their parents. In some cases, it was determined that this treatment was not appropriate due to factors such as the nature of the family's trauma and loss, or that the parents chose not to engage. From the cases where we proceeded, all the young people were self-harming, either through cutting or through deliberately mismanaging serious health conditions. The majority also expressed suicidal thoughts, and a considerable number had taken an overdose.

One of the primary aims when we first started working this way was to find effective but also clinically meaningful ways to reduce risk by establishing the driving forces behind a crisis. At the end of the two and a half years, in all cases, we observed a clear reduction in risk following this intervention. While this was a pilot study, the conclusions indicate a positive outcome based on the clinical observation of far fewer incidents of self-harming behaviours and visits to A&E in these cases.

More meaningfully, we also observed a noticeable shift in how the young person and parents understood their situation and communicated their problems to each other. We see this improved understanding and communication as the most critical outcome, as it was generally coupled with an increased sense of self-efficacy and confidence in the parents, when it came to making sense of and responding to the crisis.

The findings from the pilot project may be considered aligned with those of the *practitioner research model* of translational research that has the potential to create immediate application to the practical field circumstances (See: Translational Research: American Institutes of Health NIH. Rubio et al., 2010).

Key findings

- Based on the service evaluation, exploring the experiences of the clinicians involved in the project, the reality of working within a pressured service landscape came up as a main overarching theme, echoing in a way the crisis faced by families coming to the service.
- The case for the value of time-limited psychodynamic work in crisis, for adolescents and their families, emerged as a strong central theme in the service evaluation.
- We were reminded, as a central finding, of something we knew but that was illustrated vividly in the project: that the crises presented by adolescents are diverse, each with different traits; we cannot generalise them and treat them all in the same way, so each crisis (and thus each family) needs its own approach. This point may seem obvious, until we pause to remember the unifying, repetitive approach structured risk assessments and safety plans take, and the way they rely on certain assumptions that in many cases may prove untrue.
- Understanding and normalising the adolescent process, particularly the changes and transitions it involves, and avoiding pathologising and premature fixing of the problems observed, leads to better outcomes for the adolescent and parents.
- Including parents leads to far better outcomes, as shown clearly in the service evaluation and subsequent work. It helps the young person feel better understood, it contextualises the crisis symptoms within a framework that expands beyond the individual teenager, it offers scaffolding for parents' sense of authority. And most importantly it creates a unique opportunity for a therapeutic intervention that can have long lasting effects in the parent-adolescent relationship, as the young person moves towards adulthood.
- Establishing links with critical networks broadens the help available to the adolescent for a supportive therapeutic scaffold, leading to better outcomes.
- When two therapists co-work on cases involving self-harm and suicidality, a more intensive approach to brief work is enabled, avoiding the risk of splitting. It also provides

better containment for the therapists themselves to recognise and articulate what is being enacted.
- Central to understanding the meaning of the crisis within a fairly short period of time was attention to the immediacy of the relationship between the therapist and adolescent, and the therapist and parent/carer working together in open dialogue.

Questions for future research

(1) Exploring the thoughts and feelings of adolescents and their parents, how meaning is made by them, is an invaluable dimension of this work. Our goal has always been to move beyond symptoms and uncover some of the previously unconscious elements driving a crisis, making a fuller picture of what's happening possible. Involving the young person and their parents in shaping future steps, both in research and clinical directions, would help us understand what aspects work particularly well for them, delineating the different priorities of patients and clinicians and shedding light on whether our own perceptions of the work 'fit' for families too. This could transform the project into an action research forum, which is our initial hope for a next step.

(2) Advocates of time-limited therapy, particularly for adolescents with complex vulnerabilities referred to CAMHS (Abbass et al., 2013; Schmidt Neven, 2017; Trowell et al., 2007), recognise its potential to help adolescents 'confront [the] specific developmental tasks, thereby enabling the developmental process to proceed' (Laufer, 1975, p. 525). Despite its potential, this way of working presents its own challenges, such as negotiating the end of treatment and timing it well – a common issue in all brief psychotherapy (Della Rosa & Midgley, 2017). Issues specific to short-term therapy have started to be researched (e.g., Briggs et al., 2015, p. 314). Continued exploration by psychoanalytic psychotherapists working with children and young people in crisis is needed, to better establish when and how brief models can be effective and when they might not be indicated.

(3) By adopting a phenomenological perspective and exploring how people attribute meaning to what happens to them, we can also consider broader sociocultural shifts and how they impact adolescents. This might include the influence of social media on adolescents' everyday life and relationships; the erosion of parental authority and the confusions many parents feel as to how to respond to the different world their children inhabit; the higher percentage of self-harm among girls; or the distinct meanings of overdosing and suicide attempts in different social groups, as well as gender differences in these particular areas.

(4) Another area we would like to develop and research, and which would be a promising avenue for psychoanalytic clinicians in other CAMHS teams, is whether this way of working can apply to other types of crisis, beyond suicidality and self-harm. This intervention stands in the area of overlap between the individual, often unconscious reality of each adolescent we see, and the concentric circles around them, including family, friendship group, parents, wider society, and the internet.

(5) Further, this is a pragmatic intervention, created in the context of the realities of working at CAMHS, and could be applied as one of the frontline services for a wider

range of crises without relying on formal diagnosis. While we consult with schools about safety planning, we don't create written crisis plans, except if a family explicitly requests this. Instead, we rely on clinical engagement, continuity of care, interest in the psychodynamics of the individual and the family, and a belief that symptoms have a meaning and tell a story.

Conclusion

Looking back on the past two and a half years, we have grown increasingly confident in the applicability and potential of brief psychodynamic crisis work for adolescents and their parents. This work has proven helpful in most of the cases, provided the main principles are kept in mind, the parents are closely involved, and the emphasis is placed on uncovering meaning rather than on reducing symptoms. We concentrate on engagement, the active involvement of parents and the broader network, and verbally agreed-upon plans to monitor risk – all grounded in meaning and trust.

We believe, based on the pilot project, that this method of working with adolescents in crisis can be manageable and straightforward to implement, working well in the context of strained NHS services. It is also therapeutically effective. By centring the work on understanding the underlying meanings behind the crisis, involving parents as key partners, and fostering trust through continuity and consistency over a period of time, we have observed promising positive outcomes.

Notes

1. The views and opinions expressed in this paper are those of the authors and do not necessarily reflect the official policy or position of the NHS or the team within which the authors work.
2. Children and Adolescents' Mental Health Services within the NHS (National Health Service) in the UK.
3. Association of Child Psychotherapists, the regulatory body in the UK for psychoanalytic child and adolescent psychotherapists.
4. https://dictionary.cambridge.org/dictionary/english/crisis
5. 'Bronfenbrenner's model begins by recognizing that young people's personal experiences and development are shaped by their interactions with the people around them; that is, they react to and act on their immediate environment of familial and peer relationships (microlevel). These interpersonal relationships are also influenced by neighbourhood and community dynamics and exposure to institutions and policies (mesolevel). These, in turn, are nested within the organizational, political, historical, cultural (for example, values, norms and beliefs) and physical environments (macrolevel) whose interplay directly or indirectly affects the adolescent's mental health and well-being. A high court ruling (policy environment) could have direct or indirect effects on the community, household and personal well-being of a young person seeking asylum. The socioecological framework encompasses the dynamic relationships of an individual with the social environment' (Collins et al., 2024).
6. It's beyond the scope of this paper to explore the reasons for this striking gender disparity, but it's something that is reflected widely across the relevant literature of referrals to CAMHS adolescent services and particularly in crisis services.
7. This is not based on any of the existing – past or present – cases we have worked with. To create it, we have combined some overarching themes that occur repeatedly in this type of work.

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Patient anonymisation statement

Potentially personally identifying information presented in this article that relates directly or indirectly to an individual, or individuals, has been changed to disguise and safeguard the confidentiality, privacy and data protection rights of those concerned, in accordance with the journal's anonymisation policy.

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