Original Manuscript

Adolescents' Experiences of Brief Psychosocial Intervention for Depression: an Interpretative Phenomenological Analysis of Good Outcome Cases

Abstract

Background: Brief Psychosocial Intervention (BPI) is a treatment for adolescent depression that has recently demonstrated clinical effectiveness in a controlled trial (Goodyer et al., 2017). The aim of this study is to explore experiences of adolescents with major depression receiving BPI treatment in the context of good treatment outcomes. **Method**: A sub-sample of five interviews from a larger study of adolescents' experiences of BPI was purposively selected, focusing on good-outcome cases. Interviews were analysed using Interpretative Phenomenological Analysis to provide a richer understanding of participants' experiences of overcoming depression in the BPI group. **Results**: Four central themes were identified: 'Being heard and feeling safe', 'Collaborative working enhancing therapy', 'Gaining a different perspective on one's self and relationships' and 'A positive therapeutic relationship'. **Conclusions**: BPI is a novel approach with promising clinical effectiveness. Utilising adolescents' experiences has revealed potential psychological mechanisms of good treatment response to BPI. Overall implications for clinical practice with depressed adolescents are discussed.

Word Count: 5,637

Keywords

Depression, Adolescents, Brief Psychosocial Intervention, BPI, Interpretative Phenomenological Analysis, IPA, Qualitative, Experiences.

Introduction

Adolescence is a challenging time marked with rapid changes in physical, emotional and social maturation and development (World Health Organization, 2018). For some young people, this can lead to more significant depressive experiences, which can have an impact on their long-term well-being. Young people experiencing depressive episodes in their adolescence have a significant risk of symptom relapse, diagnostic recurrence, academic underperformance and other psychiatric outcomes, such as substance misuse and interpersonal conflicts in adulthood (Boyd, Butler & Benton, 2018, Rudolph & Klein, 2009).

Current evidence suggests that the majority of adults with major depression have had their first depressive episode before the age of 15 (Kessler et al., 2005). The National Institute for Health and Clinical Excellence (NICE) in the UK recommends moderate-to-severe depression to be treated by a psychological therapy alone or when necessary, in combination with medication (NICE, 2005).

Brief Psychosocial Intervention (BPI, Kelvin, Dubicka, Wilkinson & Goodyer, 2010) is a manualized treatment designed for use with depressed adolescents in Child and Adolescent Mental Health Services (CAMHS) in the UK. Structured care is delivered, through carefully considered individualised formulation of the young person's presentation and life circumstances. The aims of BPI are to gain an understanding of

mental states, building trust in others to form and/or rebuild relationships with family and friends, managing risks and problem-solving. The stance of BPI should be collaborative, actively seeking to enhance strengths and resilience in order to overcome challenges the young person faces with those close to them, be that at home, school and/or wider social groups, including online.

A randomized controlled trial (ADAPT; Goodyer et al., 2007) carried out in CAMHS clinics for adolescents with moderate-to-severe depression suggested that an earlier version of BPI, known as Specialist Clinical Care (SCC, Kelvin, Wilkinson & Goodyer, 2009), when combined with Fluoxetine, was of equal effectiveness to SCC combined with both Fluoxetine and Cognitive Behavioural Therapy (CBT) in reducing depressive symptoms at 28 weeks of treatment. This result indicated that SCC could potentially be a useful form of psychological treatment, although its clinical effectiveness without fluoxetine needs further evaluation.

SCC was therefore re-formulated and manualised as Brief Psychosocial Intervention (BPI) and tested, as the reference treatment in the Improving Mood with Psychoanalytic and Cognitive Therapies study (IMPACT; Goodyer et al., 2017). In this randomized controlled trial, the effectiveness and cost-effectiveness of two existing specialist psychological treatments, Short Term Psychoanalytic Psychotherapy (STPP) and Cognitive Behavioural Therapy (CBT) were compared to each other and to BPI. As this was a pragmatic trial, anti-depressant medication could be offered alongside any of the treatment arms, in line with UK treatment guidelines. 465 adolescents aged 11-17 years, who met the criteria for moderate-

severe depression in NHS specialist CAMHS were randomised to the three arms of the study (for full details, see Goodyer et al., 2017).

The BPI treatment manualised for this study emerged from the treatment as usual in the earlier ADAPT trial. The intervention is a treatment based on re-structuring and codification of the principles and practises found in the domains of skilled assessment, listening, information giving, advising, problem solving, safety, caring and explaining about adolescent depression. In the BPI arm, up to 12 sessions were offered to participants, plus up to four sessions with family or carers. These sessions were offered in the CAMHS clinic, in a similar way to the other treatment arms. Liaison with external agencies and personnel e.g. teachers, social care and peer group were commonly undertaken. Professionals following the BPI manual addressed relevant triggers and causal factors and provided support to parents, problem-solving schemes and advice on mental and physical well-being. Personalised psychoeducation was included to allow adolescents to discover themselves and recognise the attributes of the disorder in their lives. The collaborative stance in BPI aimed at providing care to the clients by effective listening, offering problem-solving strategies and encouraging adolescents to reconnect their interpersonal relationships in order to help diminish feelings of isolation that may have accompanied their depression. Emphasis was placed on the importance of psychoeducation about depression, and action oriented, goal-focused and interpersonal activities as therapeutic strategies. Specific advice was to be given on improving and maintaining mental and physical hygiene, engaging in pleasurable activities, engaging and maintaining schoolwork and peer relations and diminishing solitariness.

BPI therapists in this study were drawn from a range of professional backgrounds including mental health nursing, clinical psychology, psychiatry and mental health social work. The majority (>80%) of therapists were however psychiatrists in specialist CAMHS training as well as consultants. All those delivering BPI had basic training in the approach: reading of the manual; attendance at a BPI training day; continued access to the BPI manual and ongoing supervision fitting in with usual local CAMHS NHS supervisory structures. The regional leads for BPI met and problem solved supervisory issues in relation to BPI on a regular basis across the IMPACT study period.

The findings of the IMPACT study provided new and positive data about BPI. Overall, all psychological interventions in this study were associated with a reduction of 49-52% of depressive symptoms at 86 weeks (approximately one year after the end of treatment). There were no superiority effects of CBT and STPP over the BPI condition reported at 36, 52 or 86 weeks and the three interventions did not have a significant difference in their cost-effectiveness during the trial. Hence, the study advocated BPI, along with CBT and STPP, as an additional choice for treating adolescents with depression in UK.

Whilst these quantitative findings are important, there is also a need to explore how young people experience therapy, including their understanding about what contributed to meaningful change (Midgley, Ansaldo and Target, 2014). Results from qualitative studies about client experiences in therapy can be used to help refine therapeutic techniques and increase the effectiveness of treatments (Elliott, 2008).

Consequently, understanding an individual's lived experiences can provide essential information for developing and improving intervention services for other adolescents with depression (McCann, Lubman & Clark, 2012).

Given its novelty, there is an absence of qualitative literature about experiences of adolescents who have received BPI for treating depression. The current study aims to address the gap by exploring the therapeutic experience of adolescents with depression, who received BPI and had good outcomes, as part of the IMPACT study (Goodyer et al., 2017). The current study aims to explore adolescents' experiences, with the intention of better understanding the mechanisms that may have led to positive changes in the BPI treatment arm.

Method

The is a qualitative study and data was analysed using Interpretative Phenomenological Analysis (IPA; Smith, Flowers & Larkin, 2009). IPA's inductive approach is appropriate when the focus of a study is a relatively unexamined aspect of personal experience and where the aim is to understand participants' experiences of process and change in-depth (Smith & Osborn, 2015).

Setting

The current study examined data from the IMPACT-My Experience study (IMPACT-ME, Midgley, Ansaldo & Target, 2014), a qualitative study "nested" within the IMPACT trial (Goodyer et al., 2017). IMPACT-ME was a longitudinal study, wherein semi-structured interviews were carried out with a sub-group of the participants from

the IMPACT study at three time-points; baseline (T1), after therapy ended (T2), and one year after the end of therapy (T3). (for full details, see Midgley et al., 2014).

Participants and Sampling

For this study, five adolescents with depression (2 females, 3 males) aged 14-18 years were sampled purposively from the IMPACT-ME dataset (Midgley et al., 2014). A sample size of five participants is in line with Smith et al.'s (2009) recommendations to have 4-6 participants in IPA to enable in-depth and thorough within-case and cross-case analysis.

The aim was to explore how BPI works, from the perspective of adolescents, when the approach is most effective. Out of the 42 BPI cases in the IMPACT-ME study, five participants were identified. Participants were selected based on the following criteria: (a) they were in the BPI treatment arm; (b) had a successful treatment outcome, as measured by a shift from the clinical range (27 or above) to the non-clinical range on the primary outcome measure: Moods and Feelings Questionnaire (MFQ), together with a decline of approximately 50% (or more) in depressive symptom sum scores on the same measure between baseline and end of treatment; and (c) had been interviewed as part of the IMPACT-ME study at the end of therapy, so that qualitative data was available. None of the five participants were on anti-depressant medication before or during their participation in the IMPACT study.

Participant	Gender	Age at time of interview	Comorbidity at baseline	MFQ Scores at baseline (T1)	MFQ scores at 36 weeks (T2)
'Jim'	Male	14	-	29	16
'Matt'	Male	17	Psychosis	42	2
'Peter'	Male	18	-	40	14
'Stacey'	Female	15	-	54	2
'Emily'	Female	15	-	59	23

Table 1. This table illustrates the characteristics of each participant. The participants were given pseudonyms for the purpose of this study.

Data Collection

A semi-structured interview schedule was developed to explore adolescents' experiences of overcoming depression after undergoing psychological therapy (T2; Midgley et al., 2014). Interviews examined the adolescent's views on how things had changed (or not) since they had been referred to CAMHS; their experiences of therapy; and their own understanding of what had contributed to any change, both within and beyond therapy. The interviews also invited the adolescents to tell their own 'story' of therapy, including some exploration of their relationship with their therapist(s).

Data Analysis

Qualitative data analysis was carried out in line with guidance on IPA (Smith et al., 2009) First, audio-recorded interviews were transcribed, and each transcript was read several times by the first author. During this process of multiple readings, notes including exploratory comments were made in the transcripts to gain a general understanding of the participant's experiences of overcoming depression. Second, after close examination of the individual transcripts, the notes made were transformed into emerging themes, where the aim was to formulate precise phrases that reflected the data on a more sophisticated level of abstraction. Third, the emerging themes were grouped together on the basis of their conceptual similarities and the clusters formed post this, were each given a descriptive label. These were discussed with the research team. In practice, the analysis looked at convergence and divergence across cases, wherein the themes were compiled for each transcript individually first, before seeking cross-case connections and forming clusters across transcripts. Consequently, themes that were not salient to the research or that did not apply to a minimum number of four participants, were excluded. Fourth, the themes were further analysed and arranged to present the final list of superordinate themes and sub-themes that represented the shared experiences of the participants.

Ethical Considerations

No ethical approval was sought for this study as, The Cambridgeshire-2 Research Ethics Committee, Addenbrookes, Cambridge, UK gave ethics approval to the IMPACT-ME study in 2014, where this study draws its data from. All adolescents and

families involved had given informed consent, identifying details have been changed, and pseudonyms were given to each participant to preserve their anonymity.

Results

Adolescents' experiences of therapy in the BPI condition was captured by four overarching themes, presented in Figure 1. This section describes each of the themes and provides data to support the analytic interpretations.

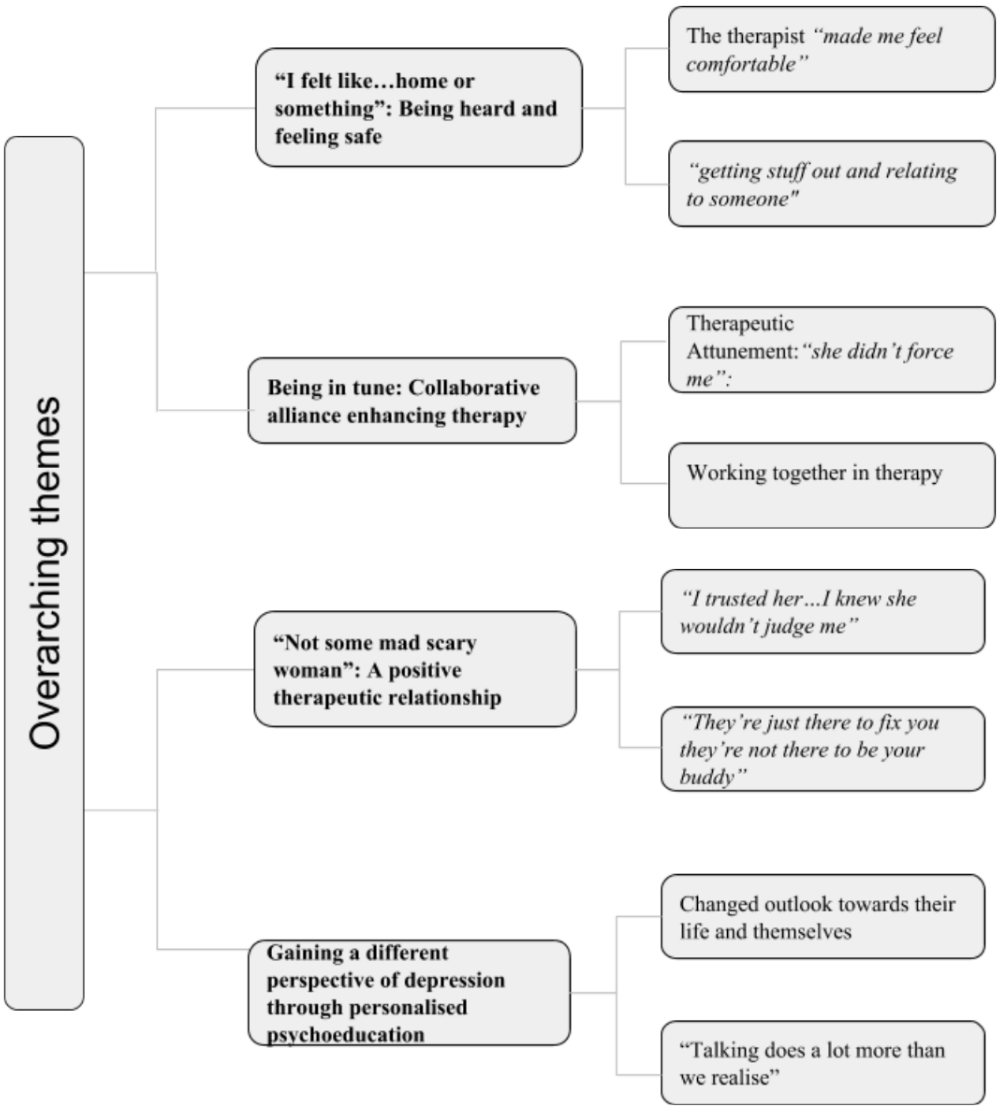

Figure 1. An overview of the overarching themes accompanied by their respective subthemes.

Theme I: "I felt like…home or something": Being heard and feeling safe.

The foundation of adolescents feeling "*at home"* was facilitated by their therapists, who provided an environment for them to feel comfortable and heard. For participants to talk about their difficult feelings and experiences, it was important for them to have a therapist who was genuine, easy-going and exhibited a relaxed body language.

In therapy, Emily felt that she was provided with a time and setting dedicated to her. The therapist gave Emily the opportunity to share her feelings about depression and how it impacted her daily life. It was extremely important for her to be given a 'space' where she was the centre of attention and her difficult feelings were addressed, without judgement.

> **Emily:** *I think just releasing things that you've locked away for a long, long time. And being able to say things and explain how you feel without...people judging you or getting angry themselves. Just feeling comfortable talking about it and not worrying what other people might think of what you're saying.*

Peter had previously had an unsuccessful therapeutic experience with another service, where he found therapy to be boring, and felt that it made him feel more anxious and distressed. Therefore, he found the interactive and relaxed session content rewarding in this context and had a positive experience with the current therapist:

> **Peter:** *Basically she tried to make it like live and you wouldn't think it's counselling, you'd think it's something else.*

Jim had felt isolated and misunderstood in various contexts during his experience of depression. However, when he was in therapy, he experienced feeling accepted by his therapist and was encouraged to think about himself constructively and talk freely. For Jim, feeling heard by his therapist and having someone valuing his experiences and emotions enabled him to feel accepted.

Stacey's experience of the therapist's caring nature also evoked feelings of safety in her during therapy and encouraged her to engage in the therapeutic work. This was an important feature for Stacey as her experience of depression led her to feeling a general loss of interest in things around her:

> **Stacey:** *Cos you can relate to them more and talk more freely to them, if you know what I mean.*

Theme II: Being in tune: Collaborative working enhancing therapy

In four out of five cases, there was a theme of adolescents engaging and sharing freely as a result of feeling they had a collaborative relationship with their therapist. The collaborative work involved therapists being mindful of the pace and intensity of each session.

Stacey reported feeling like she was not forced to answer questions that made her uncomfortable. Likewise, Peter experienced a similar notion of attunement with his therapist:

> **Peter:** *Yeah if you say you don't want to talk about something... they would be like 'oh you don't have to answer the question but in the first one [his previous therapy] you have to answer it.*

Stacey and Peter recognized and valued the therapist's attempts to be attuned with their feelings in therapy. This allowed them to trust their therapist and consequently, engage in collaborative work by gradually opening up more in sessions.

Matt's symptoms of depression included feelings of apathy. In therapy, Matt and his therapist worked together by thinking together of ways to cope with difficult situations. Matt's therapist encouraged him to persevere even when changes weren't immedietly obvious.

> **Matt:** *She'll be like "well how about you do this and see what it feels like" and you're like "alright then". You'll do it and you'd be like "nothing changed". She's like "well let's talk about this for a while, but keep at that". Then after like 5 weeks, you go "what's this?" she's like "well it means you're getting better" and then you're like "Oh! That's good".*

Compared to other participants, Jim was less talkative when describing his experience of therapy. However, throughout his interview, Jim acknowledged a significant change in his life post-therapy (e.g. *"my mum started being a bit nicer*") but was unable to articulate what brought about the positive changes in his life, and often responded vaguely by saying: *"I dunno".*

Theme III: "I'm ok who I am": Gaining a different perspective on one's self and relationships

Through exploration with their therapists, four out of five participants described feeling empowered to develop a different outlook on their depressive symptoms and experiences. The participants spoke of how they were prompted to view and experience their relationships with others and themselves differently (i.e. not through the lens of the illness), which provided them with greater confidence for the future. Stacey learned that it was possible to experience being depressed and still have someone (her therapist and family) who accepted her for who she was. As a result, Stacey experienced increased confidence and self-esteem, and gained a better sense of herself.

Matt experienced *"feeling something"* after working towards engaging better with his peers, which involved the ability to criticise, as well as, care:

> **Matt:** *I got into tonnes more arguments with my friends now but it's good thing cause...it means that you're having care towards your relationships. It's like if I've planned something and everyone bailed I'd just been like [tsk noise], but now I'd be like "you dickheads*

> *what's up what you doing?" But that's a GOOD thing although it causes like stress and you're a bit like GRRR, but that's the thing that's not apathy and that's the misconception that people get it- that if you're sad some days people might be like "Oh, relapsing or something?" But then I'd go to them and say that they are feeling something which is the point!*

Additionally, participants learned different coping strategies for the future by means of talking things through. Peter learned to link his low mood with unhelpful patterns of behaviour, and see how a more positive mental state helped those patterns to improve. He learned to value and incorporate these new ways of thinking in his life. Through therapy, Emily learned how to regulate her feelings by talking to loved ones around her. Additionally, she described how talking in therapy helped to free herself from distressing feelings and emotions that had previously felt unmanageable:

> **Emily*:*** *It really, really helped because at first I was like "oh what does talking do? talking doesn't do anything, talking just makes you upset" but I realised that talking does a lot more than we realise and that it does help you let go of things that you're worried about and stuff.*

Theme IV: "Not some mad scary woman": A positive therapeutic relationship

Building and maintaining a positive therapeutic relationship was seen as the most essential component in this form of treatment, as adolescents felt they had the

opportunity to experience a relationship that made them feel validated and hopeful.

Peter had come to therapy with preconceived notions of the therapist being uninterested and judgemental, partly due to previous experiences of counselling. However, in this therapy he felt "*safer*" to talk to his therapist. Similarly, Jim and Emily built a trusting relationship with their therapists. This helped Emily to share her intimate feelings more willingly:

> **Emily:** *I trusted her, I still do trust her. I knew that she wouldn't judge me for what I'd say. So yeah, she was nice.*

While most participants appreciated having their relationship being friendly and relaxed, Matt liked that his therapist stayed true to her role as a professional:

> **Matt:** *I mean she seems like she wanted to fix stuff, but it was like she knew what she was doing, she knew why she was doing it, so like you don't have any of this fakeness around her.*

Stacey appreciated that her therapist was "*not some mad scary woman",* but instead was someone who was there to talk to her and help her understand her difficulties better.

> **Stacey:** *When I sat down with her, yeah she was just like a normal person, just talked to you and like how you're feeling and stuff.*

This relatability with her therapist allowed Stacey to experience a trusting relationship with her therapist and made her feel more at ease in therapy.

Discussion

This study aimed to explore adolescents' experiences of overcoming depression following a good-outcome from BPI treatment. Using the inductive approach in IPA, four central themes were identified from 5 naratives: 1) Being heard and feeling safe; 2) Collaborative working enhancing the therapy; 3) Gaining a different perspective on one's self and relationships; and 4) A positive therapeutic relationship. Results indicated that adolescents' experiences in BPI were representative of their successful quantitative scores in the IMPACT study (Goodyer et al., 2017).

The first theme supports previous qualitative studies that emphasize that a safe space in therapy provides an environment to adaptively converse with the therapist (McCann, Lubman & Clark, 2012; Bury, Raval & Lyon, 2007). The therapists in these good-outcome cases of BPI maintained a non-judgmental stance which evoked a sense of safety for the adolescents to engage in therapy. It is possible that this safe environment leads directly to the notion of trust in their therapist and improved confidence in ones' self, which in turn may motivate prosocial behaviours with family and friends or renewed performance in school. These are all factors that are commonly considered to contribute to the effectiveness of psychotherapy (Lambert & Bergin, 1994), especially in work with adolescents (Midgley, Hayes & Cooper, 2017). Lebow (2012) acknowledged that adolescents need to feel heard and understood, in order to be able to trust a therapist or an adult. Thus, we speculate that generating a

safe environment for conversation is a necessary feature for all conversational methods with depressed adolescents.

The second theme represents collaborative work in therapy, which is explicitly recommended as a key principle of the intervention within the BPI manual (Kelvin et al., 2010) and in clinical guidelines generally (Department of Health, 2004). Research supports the notion of shared-decision making and collaboration in therapy, which are shown to be preferred by adolescents (Kelsey, Abelson-Mitchell & Skirton, 2007), as they promote self-efficacy (Da Silva, 2012) and enable them to embrace an active role in therapy (Bodenheimer, MacGregor & Sharifi, 2005). In good-outcome BPI, adolescents experienced clinicians facilitating the discovery of their experiences through curiosity, active listening, and by being attuned to their affective states and pace in sessions. This form of collaboration resonates with the collaborative empiricism described in CBT (Dattilio & Hanna, 2012). The difference however is that this sense of collaboration was not described specifically in relation to a set of core negative beliefs (as seen in CBT), but instead appeared to be around the adolescent's engagement in adaptive prosocial behaviour, as a way of improving mood.

The third theme describes adolescents gaining a different perspective about their mental state of depression and their associated life experiences, through techniques used in BPI. The key psychoeducational task was to aid the young people distinguish between normal self and illness related mental states. In this study most adolescents mentioned being introduced to skills to help them cope with difficult experiences and feelings of depression during and after therapy. These therapeutic

aspects are identified in other psychological theories, including CBT, which endorses the learning of coping skills in young clients (Cohen, Mannarino, Deblinge & Berliner, 2009). Moreover, most adolescents found that talking about things with their therapist empowered them to gain a different perspective about their experiences of depression and understand relationships, hence modelling and supporting similar recalibration of the their relationships in their daily experiences. This is consistent with adolescents' expectations prior therapy (Midgley, Holmes, Parkinson, et al., 2016), where adolescents expected therapy to provide a space where talking would dominate, and some hoped to get a new perspective on their problems. In these ways the therapist would facilitate the process of change in the adolescent, mediated through changes in relationships.

Most importantly, the fourth theme indicates the critical value of BPIs therapist in good-outcome patients. The therapeutic relationship, and especially the therapeutic alliance is closely linked to increased client engagement and positive treatment outcomes, for individuals of all ages and is significant in most psychological therapies, including psychoanalytic psychotherapy and CBT (Easterbrook & Meehan, 2017; Bachelor, 2013; Bhola, & Kapur, 2013). The first three themes identified in this study could be understood as forming a foundation for the fourth theme, regarding the importance of the therapeutic relationship. In a qualitative study exploring adolescents' perspectives of therapeutic alliance, feeling heard and having a non-judgmental therapist led to adolescents building trust in their therapist and contributed to their successful treatment outcomes (Everall & Paulson, 2002). Moreover, Hatcher and Barends (2006) argue that at the core of a strong therapeutic alliance is the stability and quality of a collaborative relationship. This collaborative

work is beneficial for both the therapist and the client in developing a strong alliance, whereby therapists can gain a better understanding of the adolescent, but most importantly where the channels of communication, learning and change can open up for the adolescent with other significant people in their lives including family, friends and/or school staff (Fonagy & Allision, 2014).

The current results support findings of a study by Midgley et al. (2018), in which an exploration of techniques used by therapists in the IMPACT study found some areas of overlap in techniques across different therapeutic approaches, especially between CBT and BPI therapists. It could be hypothesised that one explanation for why BPI, CBT and STPP achieved comparable outcomes in the IMPACT study is that they share some common therapeutic features; ones that may be found in a range of well-delivered psychological interventions. Whether there are specific factors in each treatment that can be delineated as central to therapeutic effectiveness, may be revealed by further comparisons between the three treatments.

Limitations and Strengths

The participants in this study were a small group who were purposively sampled from the larger group of young people who took part in the IMPACT-ME study, and had achieved good-outcomes according to the primary outcome measure used in the IMPACT study, i.e. the MFQ. Therefore, their experiences, whilst giving an insight into the nature of good-outcome BPI, may not reflect the experiences of all adolescents that took part in the IMPACT trial, or among those whose outcomes were less positive. This means that the results from this qualitative study may not necessarily be transferable to other settings or experiences of other adolescents.

Additionally, it was challenging to interpret quieter participants efficiently, which limited the representation of their therapeutic experience.

However, this study is the first to explore experiences of adolescents in BPI, an approach that has proved to be equally effective in treating adolescent depression with other evidence-based treatments (Goodyer et al., 2017). This is an important factor because it addressed a gap in the research, inferred by the IMPACT paper, for future research to be directed towards further explorations of mechanisms that led adolescents to successful treatment outcomes.

Implications for practice and research

This research may be particularly helpful to contribute to understanding the significant mechanisms that facilitated change for adolescents and to explore some of the meanings behind adolescents' experiences. This can help in the quest to inform researchers and clinicians alike about the therapeutic approaches that may be most valuable and that can be adopted in other treatments as positive mechanisms for change. Finally, this study also provides some description of ways in which the effectiveness of BPI is manifested in lived experiences of adolescents during treatment. Whilst the IMPACT RCT provides the quantitative findings, the current study adds some finer grain explanation to better understand how BPI can be applied in practice.

Conclusions

BPI has demonstrated treatment effectiveness in treating adolescent depression and this qualitiaitve study suggests some of the elements that may contribute to good-

outcomes, from the perspective of young people themselves. Adolescents' experiences of overcoming depression in good-outcome BPI highlighted the importance of therapeutic factors such as providing a safe and trusting environment, building collaboration and maintaining a positive therapeutic relationship. These themes, which may be shared by other therapeutic approaches, help to identify what adolescents with depression felt made BPI effective in leading them towards recovery.

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Declaration of conflicting interests

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