

Chapter 3: The Stages of Treatment in STPP (15,000)

Although STPP is not a structured treatment in which formal ‘stages’ of treatment are explicitly delineated, it is helpful to distinguish some of the tasks and techniques appropriate to the early, middle, and late stages of such time-limited treatments. This chapter outlines some of the main features of the different stages of treatment in STPP and draws extensively upon Trowell and colleagues’ work (2004) and the work of Busch and colleagues (2004) in terms of overarching principles; it is also consistent with the American Academy of Child and Adolescent Psychotherapy (AACAP) Practice Parameter for Psychodynamic Work with Children (AACAP, 2012). A case study of fifteen-year-old Chloe will illustrate the clinical processes as they unfold through the course of her STPP treatment, and will also be used to demonstrate the writing of two clinical formulation reports: one during the beginning phase, the other at the end of the treatment. Key characteristics and clinical dilemmas are also noted as they are likely to arise during the process of STPP; some of these are explored further in the next chapter.

Assessment for STPP and psychodynamic formulation

As explained above, the psychoanalytic assessment for STPP may be conducted as a free-standing assessment (usually of three or four individual sessions) or as the initial ‘assessment phase’ of the 28-week STPP contract. In the latter case, it is important that the assessment phase end with a clear agreement being made between the therapist and the young person as to whether or not the treatment will proceed; the support of parents for continuing with parent work for the duration of the treatment will also need to be established.

An individual psychoanalytic assessment for STPP will include the following elements:

- Establishing the framework and setting for assessment and treatment;
- Balancing information-gathering with reflection on internal experience;
- Examining transference elements as they emerge and monitoring countertransference;
- Exploring the young person’s capacity for curiosity and ‘psychological mindedness’;
- Confirming the appropriateness and scope of time-limited work;
- Articulating the therapist’s understanding of the nature of the young person’s difficulties (psychodynamic formulation).

Establishing the framework and setting for assessment and treatment

It is essential to make clear from the outset what the number of assessment sessions is to be, and that they will take place at a regular time and in the same room. The space between each assessment session might be one week, and this has the advantage of giving the young person a taste of the rhythm of weekly therapy, but a two-week gap is also possible, and this arrangement provides more of a test of the young person's capacity to wait. It is vital to make the number of sessions clear from the beginning, including the point at which an agreement about proceeding with the treatment will be reached, if there is an 'assessment phase'.

A clear description of the structure of STPP itself is also vital: the number, frequency, and length of sessions; holiday structures; agreeing a regular time for the sessions; starting dates; arrangements about cancellations; and perhaps also clarity about roughly when the therapy will end, such as the likely month. This will establish the idea of a consistent setting (the same room and the same time each week, except when a change is unavoidable), so that disruptions can be kept to a minimum. It is also essential to explain that missed sessions will be counted towards the total unless the cancellation is by the therapist. Exceptions to this can arise, for public examinations or pre-booked family holidays. The therapist will establish arrangements for contact between sessions, which may be needed from time to time, within the parameters of whatever is acceptable to the clinic. For example, how would either therapist or patient communicate about illness or other problems about regular attendance? Many adolescents use text or mobile messages to communicate about arrangements, as letters feel outdated to them. The parallel work with the parent(s), and the implications for the young person's treatment, need to be discussed, as an integral part of the treatment.

It is also important to establish clarity around issues of confidentiality. This would usually involve explaining about the confidential nature of what is said, but also outlining the rare circumstances in which the therapist would need to share information with other adults, such as when there are concerns about the young person's safety. This may be especially important for young people with a history of suicidal attempts and deliberate self-harm; or where there have been concerns about physical, sexual, or emotional abuse. It can be helpful to explain how such

situations would be handled if and when they arise, with an emphasis on including the young person in decision-making as much as possible. The principle of holding review meetings with the family or carers also needs to be explained.

In establishing the practical framework for therapy from the outset, in this way, the therapist has the opportunity to convey to the young person the way in which the therapeutic setting can be reliable and constant, a place in which things can be thought about and explored in a non-judgmental way. Many depressed adolescents will have had experiences of significant loss, so the therapist will be implicitly communicating an understanding of the importance of presences and absences. As David Taylor puts it, the ‘framework provides parameters within which the patient can relate and the therapist work. A key part of the therapist’s work is the recognition and understanding of the patient’s reactions to the breaks, gaps, limitations and frustrations inherent in the therapeutic encounter’ (2008, p. 16).

Balancing information-gathering with reflection on internal experience

During the assessment for STPP, or the assessment phase of the work, the therapist must strike a balance between allowing the young person to take a lead in the sessions if they are able to do so and making sure that certain areas have been covered. The therapist has to combine important information-gathering about the patient’s external life context (home, school, friendships, etc.) with offering a space in which the patient is invited to focus on internal experience: whatever comes to mind in the session, dreams and fantasies, hopes, fears, and feelings of all sorts. The STPP therapist should try to establish a sense of space to explore the young person’s own concerns.

Not offering a structured set of questions and explanations is itself part of establishing the therapeutic frame for STPP, in which the content of the sessions is largely led by the young person. Unlike more structured approaches to psychotherapy, the initial sessions of STPP should be more like a ‘process’ than a ‘procedure’ (Waddell, 2000, page), one in which a space is created for ‘examining the anxiety and ambivalence which usually accompany a request for help [in order to determine] whether the fear of change is greater than the bid for relief and for emotional freedom’ (p. 146). It has to be borne in mind that very depressed young people may

not be able to say very much spontaneously and that such patients will need help through interpretation to find ways of expressing themselves. (This is discussed further in the next chapter.)

While STPP is not a symptom-focused form of treatment, the young person's particular symptoms of depression need also to be kept in mind. Busch and colleagues (2004) suggest that what is most important from the very start is that the patient is 'introduced to the idea that symptoms have meaning and are triggered by events in the present that evoke unpleasant affective experiences and the fantasies linked with them in the past' (p. 39). During the assessment phase, the therapist attempts to convey to the young person that the method of work involves developing an understanding of the meaning of all communications between them and trying to make connections between depressive symptoms and conscious and unconscious thoughts and feelings. What is said is only one part of the communication: all the external factors that enter the therapy will also be considered in this way, including missed sessions, reluctance to come, or reluctance to leave. In this way, the therapeutic setting is being drawn on all the time, providing a boundary around all aspects of the therapeutic work. Over time, the therapist will try to help the young person to see the deeper unconscious meaning of all their communications, verbal and non-verbal, and the links between this and past and present areas of conflict and difficulty.

Examining transference elements as they emerge and monitoring countertransference

During the assessment or assessment phase, transference elements can be observed as they emerge and the therapist's countertransference monitored closely, with the support of supervision. In combination with what emerges in the discourse as led by the young person, this allows for a psychoanalytic understanding of the young person's state of mind to take shape in the therapist's mind and a picture to form of the dynamic of current internal object relationships.

Exploring the young person's capacity for curiosity and 'psychological mindedness'

The assessment or assessment phase also provides an opportunity to explore the young person's capacity for curiosity about him- or herself, openness to linking comments ('psychological mindedness'), and responses to being understood. It is also important to assess the degree to

which the young person may feel a desire for change rather than an investment in things staying as they are. Whether there are developmental difficulties or deficits, cognitive or other, which might significantly affect the appropriateness of psychotherapy, is also essential to assess.

Confirming the appropriateness and scope of time-limited work [OK?]

It is important in the assessment phase to explore and take seriously what precipitated the referral: what was the particular issue and why did the referral come now? It is also important not to imply that all problems, conflicts, or concerns can be resolved during STPP. This is short-term work, and being clear in our own minds about the aims of the work will help to set realistic expectations for the treatment. In such time-limited work, we do not expect that every aspect of the young person's life will be changed, but the treatment does aim to address troubling symptoms and to begin to do some work on the underlying vulnerabilities so that the young person will have increased resilience in regard to depression in the future, and some grasp of their characteristic anxieties and defences.

Psychodynamic formulation: developing a picture of the young person's mind

In the concluding assessment session, or at the end of the assessment phase, some articulation of the therapist's understanding of the nature of the young person's difficulties is important. Indeed, one of the key tasks of assessment for STPP is to reach some assessment of the central dynamic processes that appear to be underlying the young person's depression (often referred to as a 'case formulation' in other treatment modalities). Whilst STPP does not make use of explicitly sharing such an assessment with the young person, an indication of it at this point is essential, to help the young person to feel understood and to feel engaged with the idea of STPP treatment. This may also be a good place to consider the explicit aims of the treatment or review any aims identified during the young person's first contact with the clinic.[OK?] (See Chapter 4 – [if we have section on ROM].)

To come to such a formulation, both external reality and internal reality need to be taken into consideration. Where, as so often happens, there have been major life events, these are likely to be significant, so it can be helpful to explore these in some detail. Some of the young people may have considerable problems with interpersonal relationships. There may be difficulties with

expressing feelings, initiating and/or maintaining relationships, and communication. Exploring these difficulties and promoting a capacity to relate to others, which is such a key aspect of adolescence, requires careful and sensitive work. The assessment phase should also take into account the particular ways in which depression may manifest itself during adolescence.

Whilst hearing and understanding the conflicts that the young person reports in their external world, it is important for the therapist to help their patient to think about the links with earlier conflicts and to try to sort out a sense of what belongs to external reality and what is internal, deriving from the here and now or from earlier experience. The therapist should work with the young person to try and help them to recognise some of the key processes that make them vulnerable to depression (e.g. excessive guilt, narcissistic vulnerability etc.).

A summary of the assessment process should be included in the young person's notes after the assessment or by the end of the assessment phase, in consultation with the clinical supervisor, in addition to any information gathered from the initial sessions with the young person and their parents or carers. This assessment can draw upon family information derived from the parent worker, and any earlier meetings with CAMHS clinicians prior to allocation to STPP.

This summary would usually include the following information:

- reasons for referral, and current difficulties, including some assessment of the severity and complexity of the young person's depression and a statement regarding any psychiatric diagnosis;
- a brief statement about family history, developmental history, and current care or family setup and dynamics;
- an assessment of risk, including potential risk to self (including self-harm and suicidality), risk to others (including violence), and any potential protective factors, including a risk assessment plan, in line with standard clinical practice;
- a statement of possible aetiology, including evidence of resilience and protective factors;
- a statement outlining the therapist's initial formulation and hypotheses about central psychodynamic features and how they link with the young person's depression.

The therapist should especially consider the following areas and develop some working hypothesis on how each of these areas, where relevant, may be contributing to the young person's depression:

- The narcissistic vulnerability so typical of adolescence: this may range from the ordinary narcissistic sensitivity and preoccupation which is part of the adolescent developmental process to more deeply entrenched pathological narcissistic personality disorders;
- Conflict: conflict is inherent to human existence but particularly intense during adolescence, especially with respect to adult authority figures, and often linked to depressive symptoms;
- The severity of the superego: involving very painful feelings of guilt and/or shame, this frequently underlies adolescent depression;
- Idealisation and denigration of self and others: this makes for a cycle of repeated disappointment and loss of hope, potentially leading to despair;
- Emerging sexuality in adolescence: this reawakens oedipal issues in an often intense form, which can make for great difficulty in both family and peer relationships and often evoke a sense of loneliness and failure;
- Defences against all these sources of psychic pain: these may further intensify depressive states.

Where the psychoanalytic assessment takes place during the early weeks of the STPP contract (as an 'assessment phase'), the therapist may choose to wait a little before writing such a formulation, in order to draw on their experience of the patient during the whole of the early phase of STPP, although colleagues and the patient's GP should always be informed of the decision to proceed with the treatment once this has been made. This was the case with 'Chloe', whose individual psychoanalytic assessment was conducted as the assessment phase of the STPP treatment; a description of the initial contact with the clinic and the STPP therapist, followed by the early stage of the STPP treatment, are given below (under 'The early stage of STPP'), followed by the summary report giving her therapist's formulation. There follows an account of Chloe's initial presentation to the team and the first consultation between her, her mother and the STPP therapist.

The therapist should continue to develop ongoing ‘working hypotheses’ throughout the treatment, which can refine the picture achieved during the early stages. This will draw on all the aspects of the assessment described above.

Chloe: presentation and initial assessment

Fifteen-year-old Chloe was referred by her GP for persistent low mood. She received an initial assessment in her local CAMHS which indicated that this low mood began after the death of her maternal grandfather the previous year. The assessing clinician noted that much of Chloe’s emotional turmoil and distress seemed to be hidden behind a façade of coping and competently getting on with her education. Later, in the middle phase of STPP, Chloe was to remember the clinician’s use of the word ‘façade’ and find it helpful in thinking about the quality of her emotional defences.

Chloe lived with her mother and three-year-old half-brother. Chloe’s father had left soon after she was born and there had been no contact since then. Her brother’s father was also not involved with the family. Chloe’s mother had a new partner who visited daily and occasionally stayed overnight but did not live with them.

At the point of referral, Chloe was due to begin her final year of compulsory education and had aspirations to be the first member of her family to go to college. The initial CAMHS assessment showed that Chloe was suffering long-standing struggles with low mood. Chloe described crumpling into tears, struggling with intense headaches which she described as ‘blackouts’, and feeling that her world was falling apart. The CAMHS worker suggested that an assessment for STPP might be appropriate. Consistent with usual practice in this CAMHS clinic, it was agreed that there would be an initial meeting between the psychotherapist, the parent worker, Chloe, and Chloe’s mother, and that this would be followed by series of individual sessions for Chloe as an ‘assessment phase’ of the STPP. If this assessment phase led to an agreement to proceed, she and her therapist would continue to the end of the 28-week treatment.

This initial meeting took place in the school summer holidays and provided an opportunity for the therapist and the parent worker to introduce the idea of both individual psychotherapy and the parent work element of the STPP treatment model. Both Chloe and her mother were receptive and open to embarking on psychotherapy. The only uncertainty was about how they could establish a weekly time slot at a stage when Chloe was about to embark on her final year in secondary school. A time was agreed upon and, because of holiday arrangements, it was agreed that the assessment phase of the psychotherapy – Chloe’s first experience of individual sessions - would begin in September. Her session time could be re-considered once her school timetable had been confirmed. The therapist was struck by their all being engaged in an amenable, compliant discussion about practical arrangements. There was little overt expression of anxiety or concern about Chloe’s emotional struggles, either from Chloe or her mother. This contrasted with the sense of crisis in the GP’s referral letter and the initial CAMHS assessment. Chloe’s low mood and struggles with bereavement seemed obscured behind a proficient engagement with information delivery and agreement about practical arrangements. It was as if the difficulties had been smoothed over.

It was established that, if they went ahead, the sessions would be weekly, with an acknowledgement that there would be a session during the October half-term school break. There would be breaks over the Christmas and Easter period and these would be clarified well in advance. The parent worker would meet with Chloe’s mother once a month and it would be possible to include her mother’s partner, which the STPP therapist and parent worker suggested would be helpful. There would be a break of several weeks after this initial session before the work began and Chloe’s therapist wondered whether they would take up this treatment.

The early stages of STPP

During the early stages of STPP, there are four primary aims (Busch et al., 2004):

- Establishing the therapeutic frame/setting;
- Establishing the therapeutic alliance;

- Identifying barriers to engagement in treatment;
- Developing a psychodynamic picture of the young person's mind and relationships and linking this to the experience of depression.

Each of these aims contributes to the ongoing therapeutic process and should not be thought of as separate 'tasks'. Some considerable work on these primary aims – particularly establishing a therapeutic setting and developing a psychodynamic picture of the young person's mind – will, of course, have begun during the STPP assessment (discussed above). Nevertheless, the early phase of STPP provides the opportunity to establish the setting and the alliance more firmly, identify any barriers to engagement that did not emerge in the assessment, and explore further the psychodynamic formulation (discussed above). [OK?]

What follows is a description of some of the ways of thinking that will help the therapist to facilitate such processes in an optimum way.

Establishing the therapeutic frame/setting

Hartnup (1999) suggests that in establishing a therapeutic setting for psychodynamic treatment, particular attention needs to be paid to:

- The practicalities
- The room
- Consent, trust, and confidentiality
- Beginnings, endings, and breaks.

As Peter Wilson (1991) has written:

the primary task of a psychotherapist [early on in treatment] is to ensure conditions of work that facilitate communication, and enable both psychotherapist and patient to observe and think about what is happening within and between them. The concept of a therapeutic setting refers to everything that forms the background in which psychotherapy takes place. (page)

The therapeutic setting should have at least begun to be established during the psychoanalytic assessment sessions or the assessment phase. Nevertheless, it is essential that this setting be firmly established with the young person during the early phase of STPP so that they can begin to internalise and make fuller use of it. Where the psychoanalytic assessment has been conducted as a freestanding assessment, rather than within the frame of the early phase of STPP, this may necessitate a delay of some weeks before the STPP treatment begins (as with Chloe) and possibly a change of room, or of time, at that point. For some young people in the earlier years of adolescence, it may also be helpful to provide a few art or play materials (which may or may not have been introduced during the assessment). (This is discussed in the next chapter.)

Establishing the therapeutic alliance

As discussed in Chapter 2, building up trust in one's therapist is essential and depends on the therapist being reliable and consistent; without that, it is very difficult to establish the sense of safety that is vital for the therapeutic work. The establishment of a 'secure base' or a 'therapeutic alliance' is one of the aims of the early stages of treatment, and is one of the greatest challenges when working with depressed young people. As Busch and colleagues (2004) put it:

As the therapist is seen as caring but dispassionate and dedicated to understanding the meaning of the patient's difficulties without 'taking sides' or being judgmental or invasive, a relationship evolves in which the patient learns to trust the therapist with the most intimate fears and sadness. This is crucial because only in the context of a trusting relationship can a patient feel truly comfortable exposing areas of shame and vulnerability in order to do the necessary therapeutic work. (p. 44)

Identifying barriers to engagement in treatment

There are a number of reasons why depressed young people may struggle to engage with therapy, and it is important that these are identified either in an assessment or early in treatment, in order to try and prevent premature termination. Busch and colleagues (2004, pp. 48-51) identify a number of particular issues pertinent to patients with depression, including:

- excessive shame and fear of exposure;
- oppressive, conscious guilt, and fear of its exposure;

- over-valued explanations for depression which the treatment may challenge, including the idea of a physiological basis for the depressed mood and a desire for medication in consequence. [MR added the 2nd half of this one, I need to check whether it is in Busch et al or reframe this so not all being attributed to B et al.]

Another important issue is hopelessness, with regard to circumstances both in the young person's external lives and in their private experience which they may feel are not open to change. This situation is often linked to fears concerning aggression, whether their own or the hostility and condemnation they may expect from another person, which make it difficult to engage in an emotionally important relationship. The STPP therapist must remain especially alert for indications of this in the negative transference and be prepared to interpret this when it has the potential to interfere with engaging in treatment. Such interpretation might take the form of a 'therapist-centred' comment (Steiner, 1993), which locates the problem in the therapist's mind, in order to contain feelings which the patient cannot yet own, such as, 'Perhaps you feel that I am very doubtful about whether I can help you.'

Chloe: the early stages

On the day of her first individual session, a few weeks after the shared initial appointment with her mother, Chloe sent a text (SMS) message to cancel the session. The therapist replied via text message, acknowledging the missed session, and confirmed the next week's appointment. Chloe arrived independently to her second session, explaining that as she had so much to attend to she had forgotten about coming last week. She talked about how busy she had been in starting a new academic year and feeling satisfied with her timetable. There was a surface confidence and competence to Chloe's accounts that left her therapist wondering where the struggle or uncertainty might be. Something was missing, much like in the initial session with Chloe and her mother together.

As if Chloe gauged what her therapist was thinking she went on to talk about how she often felt low and that this was linked to problems in her family. The words tumbled forth in a confused jumble. Chloe said that her problems started after a big family 'fallout'. A couple of months ago, her uncle had had an argument with his daughter, who was the

same age as Chloe. Chloe's cousin was pregnant and Chloe had been accused of being judgmental about this pregnancy. This had caused arguments between family members and Chloe felt that she had been misunderstood. Her description of these conflicts became increasingly tangled, as various cousins, pregnancies, and babies were added to her account about a complex extended family network. The overall impression was of a fifteen-year-old feeling unjustly blamed for creating a rift within a complex, yet closely-tied extended family, where the generational divide was blurred and parental function fluidly taken up by various adults.

The therapist experienced her mind being filled with a crowd of people whose family position, relationships, and functions were muddled. She resisted the temptation to ask questions that would clarify and order Chloe's narrative and instead she reflected on how 'big' the fallout seemed to have been. This must leave Chloe feeling in a spin, not knowing which way to turn and who might be able to help her. Chloe nodded, saying that she often got headaches, and then talked about suffering from back pain. Pain and sadness infused the session, contrasting with the initial speedy and energetic communications. Forlorn, Chloe quietly explained that her 'Nana' (maternal grandmother) had died when she was eight years old. Her Nana had looked after Chloe as a baby. Indeed, Chloe had felt as though she had two mothers. After a moment's pause, she said that somehow she had always felt like a foster child to her own mother.

Chloe explained that when Nana died, the family fell apart. The therapist described how Chloe had begun to let her know about important things such as this recent big family fallout and another big important family experience when she was much younger. The therapist talked about how Chloe might have felt that she had to manage these difficult circumstances independently, especially now that she was much older and getting ready for adulthood. It might feel as though it was best to get on without asking for help, especially when there might be a worry that nobody could be of real help; perhaps when help *was* available, it could easily be forgotten like the missed session last week. Chloe's therapist added that despite this, there were these big important things on Chloe's mind that hurt and that needed time to think about. Chloe listened quietly and seemed

thoughtful. The therapist explained that there would be time over the 26 sessions that now remained to begin to make some sense of the painful experiences that Chloe had been telling her about. Chloe nodded, yet appeared more vulnerable and lost.

Chloe then missed her next session without a message. It felt as if she had disappeared. When she arrived for her next session, she apologized for not having been in touch. Chloe explained that it had been a difficult time because her aunt's cat had died last week. This had coincided with the anniversary of her grandfather's death. She had also lost her mobile phone. In addition to this, she had had to do a lot of babysitting for her three-year-old brother and household chores to earn enough to pay for a replacement phone. Her therapist commented that as texting had been Chloe's preferred line of communication, it had been difficult to know how best to get in touch when there had been no response. Chloe nodded, saying that she had received her therapist's letter but then her mother had moved it and her baby brother had torn it up, making the telephone number indecipherable, and so she was unable to ring.

Chloe conveyed how hard it might be to hold the beginning of a link with her psychotherapy in the face of different kinds of losses: the death of the cat and the loss of her phone in the present and past bereavements. There was also the dynamic of Chloe feeling that she had to take on the responsibilities of looking after others. The intense activity that Chloe described seemed to function as a defence against the pain and vulnerability that had been glimpsed towards the end of the first session. It felt as though it would be premature and undermining to describe this dynamic to Chloe at this point, or to describe the transference dynamic of Chloe feeling that therapy was yet another demand or chore that she had to attend to, to meet another's needs rather than her own. Instead, her therapist reflected on how Chloe had made it here today even though things had been so busy and difficult. Chloe nodded and turned to describing how much she was enjoying school. Yet she went on to describe friction in her friendship groups, with conflicting loyalty and scapegoating. This resonated in her therapist's mind with the family 'fallout' that Chloe had described in her first session. The therapist found herself thinking about an underlying dynamic of insecurity and unpredictability.

Chloe then explained that she was unsure whether the session time was possible for her anymore because she wanted to attend a First Aid course that was taking place after school. The therapist experienced this announcement like a jolt to a fragile house of cards. The therapist reflected on how Chloe had to manage so much and asked Chloe whether it felt like there was anyone who could support her. Chloe explained that when arguments happened in the family, people would take sides; her mother would snap because she was tired looking after her little brother (a ‘handful’); and then her mother would shut herself away and Chloe would feel she had no one to talk to. Chloe explained that her baby brother had massive temper tantrums and Chloe would try to keep the peace. When her therapist commented on how hard this might be, Chloe said that she did often feel like she was falling to pieces. She described experiences of forgetting things and intense headaches that she called ‘blackouts’. When her therapist explored this, it became clear that this experience was one that occurred at night and that the ‘blackouts’ were Chloe’s experience of falling to sleep after feeling incredibly stressed and distressed.

Chloe began to talk about her experiences of bereavements, her grandfather’s protracted illness which also coincided with two of her cousins having babies, and then the argument with one of these cousins. Chloe’s therapist experienced an undigested mass of communications as the session drew to a close. Births and deaths mingled in a confusion that suggested that it might feel too unbearable; yet there was also an underlying sense of protest and anger about being confronted by these facts of life. She commented on the concentration of difficult experiences in a short amount of time. This seemed linked to painful loss when Chloe was much younger. Chloe’s therapist reflected on there being time to think about this: it was really important to try to make sense of it because of the headaches, pain, and stress Chloe was experiencing. Chloe smiled and seemed to value the idea of ‘time to think’. Aware that they were now at the end of the assessment phase of the work, the therapist took this opportunity to ask Chloe directly whether she felt she could agree to proceed with STPP, which she thought might be helpful to Chloe. Chloe nodded and said she agreed, and her therapist reminded her of what this would entail,

including the parallel work with her mother (and her mother's partner, when he was available). The therapist said that she would keep the time that they had agreed for next week and they could think together about different arrangements if this became necessary.

In supervision, Chloe's therapist was struck by how hard it was to describe Chloe's appearance, her descriptions falling into a rather vague sketch of a slightly overweight young person with a round and pleasant face. She did not particularly stand out. Some thinking about how easily Chloe could disappear from people's minds was helpful in deciding to conserve a steadiness around the agreed frame for attendance. The supervision group discussed the significance of early experiences and how this might inform Chloe's internal object relations, particularly maternal objects and oedipal dynamics. That Chloe was at the threshold between adolescence and adulthood seemed to be a particularly important developmental context for her. When Chloe's therapist came to her next supervision, she described how Chloe had been attending more regularly. Her therapist described Chloe's distinctive long auburn hair and how astonished she had been at not noticing this before. They discussed how the therapist could now map out some of the key internal dynamics contributing to Chloe's struggles in an initial report, which would draw on the transference experience in these early sessions of STPP (see below).

Now follows the summary report written by Chloe's therapist at the end of the assessment phase of their work [for whom? team, GP or both?], which includes the beginning of a psychoanalytic hypothesis of Chloe's depressive and developmental struggles.

Chloe: the assessment report

Referral

Chloe was referred to the local CAMHS by her GP. She was described as experiencing persistent low mood for approximately a year. The death of Chloe's grandfather last year was felt to be a trigger. Chloe was seen by a CAMHS practitioner who assessed that Chloe as suffering from persistent low mood and referred her for STPP with a Child and Adolescent Psychotherapist, with a Nurse Practitioner offering parallel parent work. The

structure and aims of STPP were described. Both mother and daughter conveyed their motivation to commit to this intervention, which involves 28 sessions of once-weekly psychoanalytic psychotherapy for Chloe and seven parent sessions for her mother. It was agreed that this work would begin in September.

Family

Chloe is the eldest child in her family. She has a half-brother aged three. Chloe's father left the family soon after she was born and there has been no further contact. Her brother's father is also no longer a part of the family. Chloe's mother has a partner of two years' standing, who lives nearby; he visits the family on a daily basis and stays overnight.

During her assessment for STPP, Chloe explained that since she was a baby she was primarily looked after by her maternal grandmother. Chloe described how, as she grew up, she never quite felt like her own mother's daughter. Her grandmother was experienced as her primary carer but she died when Chloe was eight years old and this was a devastating loss. Chloe has also described a large extended family living close by. There are rifts and tensions in the extended family that Chloe feels were exacerbated by the death of her grandmother. She conveys experiences of internal representations where relationships are confused. There are perceptions of blurred generations, where adults fluidly take up parental roles and where Chloe co-opts the parental mantle. This creates confusion in her mind about where she fits in terms of her identity and her developmental transition between childhood and adulthood, and has impeded her capacity to make sense of and mourn the death of central parental figures in her life.

Chloe's mother agreed to attend parallel parent sessions, but in fact has subsequently struggled to attend due to difficulties with childcare for her young son.

School

Chloe is in the final year of her mainstream school. She is keen to progress to college where she would like to study health and social care. She is academically able to achieve

this goal and in doing so she would be the first member of her family to go to college. However, she described struggles with peer relationships where she often feels antagonised or ostracised from various peer groups. The difficulty seems to be about what position Chloe takes in her friendships. Is it as a critical authority figure or as an adolescent peer who is exploring tasks of individuation and separation from parental figures?

Short-term Psychoanalytic Psychotherapy

Chloe had found starting STPP challenging. She initially struggled to commit to regular attendance. It was as if she experienced her sessions as an additional demand or expectation rather than something that had been arranged to offer help. There was an outward communication of capability and activity that belied the concerns about depression and struggles with bereavement. This carapace provided some protection from the underlying complex and confusing emotions that Chloe can push out of her awareness. Yet, with some space to explore this, Chloe described her frustration and distress about rifts in her family, the fracturing impact of family bereavement and the generational muddles that were illustrated by accounts of teenage cousins having babies. The death of her maternal grandfather last year was terribly upsetting, particularly as it also re-ignited unresolved loss from when Chloe's maternal grandmother died when Chloe was eight years old. Chloe expressed an experience of being left to fend for herself while also somehow having to take on the role of a matriarch in the family.

In her assessment and early sessions, Chloe's hurt and confusion were palpable but there was also a subtle quality of judgment and a feeling that she could look after herself better than the parental figures around her. This dynamic was played out in the immediacy of the therapeutic relationship. There were contrasting experiences of Chloe negating the need for another while also being hard to hold in mind. There was a dual impression both of psychotherapy being unnecessary, as Chloe was managing well, and Chloe seeming lost and without support.

Risk

The exam pressures of the last year of school are likely to cause additional anxiety and emotional strain for Chloe, who is struggling with mourning the death of her grandparents (particularly her grandmother who was a key maternal figure in her life). At times, Chloe can present as outwardly competent and self-sufficient. However, beneath this she has communicated an on-going experience of low mood, emotional turmoil, and confusion that leaves her vulnerable to sinking deeper into a depression that may risk her education and engagement with peer and family relationships.

Protective factors

Chloe has not self-harmed and does not describe any suicidal ideation. She is engaging in psychotherapy, attending school and is able to let key people know about her distress.

Psychoanalytic formulation

Chloe's description of the confusion and conflict within her family appear to mirror an internal relational muddle that leaves Chloe struggling to orientate herself and to feel coherent in her developing sense of self. This is significantly impacting on a significant threshold of emotional and psychological development as Chloe faces the transitions of the last year of school and putting strain on her family relationships. Chloe conveys a sense of not being able to access solid enough internalised parental figures from which she can then confidently address the tasks of individuation and separation. There seems to be profound confusion generated by the loss or absence of supportive internal figures (e.g. maternal grandmother, father) and also of not needing them because she is already in a parental role. It is significant to note that Chloe has experienced her mother's pregnancy and the arrival of a sibling on the cusp of her own adolescence and of being confronted with her teenage cousins' sexuality. Chloe's implicit criticism of this indicates hidden concern and fear about her own sexual development. It is as if Chloe is profoundly confused about where and how she fits into her life. During these initial sessions, it has been difficult to locate Chloe's aggression, as she can present as amenable and compliant. However, her aggression seemed subtly present in her initial struggle to engage in STPP, where there was quality of self-sufficiency and criticism which protected her from feeling dependent on another person. There may also be an

internalisation of aggression that is contributing to Chloe's experience of headaches (which Chloe describes as 'blackouts') and possible psychosomatic pain.

The middle stages of STPP

During the early stages of STPP with adolescents, the primary focus is on establishing the therapeutic frame or setting, building the therapeutic alliance, and identifying the barriers to engagement in treatment and the central depressive dynamics. It is hoped that this will have enabled a therapeutic relationship to begin to develop, and that the young person will have begun to get a sense that their symptoms have meaning connected to their underlying thoughts and feelings. In some cases, this may lead to some level of symptomatic improvement, which in turn will generate a level of hope that things may improve and that treatment may be of help.

These processes continue to be a focus of work throughout the course of the treatment. Unlike some more structured treatments, there is no clear-cut distinction between the early and later stages of STPP, although there may well be a shift of emphasis. During the middle stages of treatment, the earlier work is thus both continued and developed further. Its main features are:

- Building increased trust in the therapist;
- A deepening of the transference relationship;
- The emergence of a greater capacity in the young person to confront problematic areas in the self and their relationships.

These processes will be supported by the therapist's main tasks of:

- Enabling the young person to express him or herself, whether by means of words, play, drawings, or actions within the therapeutic setting;
- Finding a way to give meaning to the young person's communication, and to express this in a way that makes sense to the young person;
- Observing and reflecting on his/her own reactions to the young person and striving to be aware of the transference and countertransference;
- Selecting from the mass of verbal, non-verbal, and unconscious communication those areas which can be most helpfully addressed.

During this period of treatment, a high proportion of the therapist's interventions will probably consist of verbal description aimed at reflecting back the young person's experience, clarifying the emotions in play for younger adolescents, and making links with other relevant experiences. Some of the young people may speak about their dreams and this can facilitate a powerful focus on the evolving transference relationship. Enabling these processes to develop will thus involve – perhaps even more than in the early stages - drawing on the range of interpretive techniques described in the previous chapter.

This phase of treatment spans the period in which the time remaining in the therapy becomes less than the time spent in therapy. Although the therapy will continue to be patient-led and to proceed at the patient's own pace, the therapist needs to be aware of its time-limited nature, and to keep in mind the need to address issues that are being avoided or denied when the young person's behaviour indicates this to be appropriate. This can be particularly difficult, for the therapist as well as the young person, when important areas are being worked on. While there may be an experience of the patient-therapist relationship developing and deepening during this middle phase, there may also be a growing awareness, in parallel, of the limitations of the relationship, linked to the known time limit. This makes it significantly different from open-ended treatment. Experiences of loss, conflicts around separation, and difficulties with mourning are likely to be prominent in this patient group. The time-limited framework provides an opportunity to tackle these issues.

Increased trust in the therapist

The aim of STPP is that the young person's trust in the therapist and in the treatment should increase through the repeated experience that the therapist can understand and tolerate the young person's feelings, both good and bad, and can respond with continuing interest and concern and convey a sense of meaningfulness. Although in reality this may not always happen, it is important to be aware of how the therapist can work to give the best opportunity for the young person's trust to increase.

The therapist aims to do this by working on the topics raised by the young person, particularly focusing on what happens in the room and on the relationship with the therapist, making links with material identified in earlier sessions. The evolution of the relationship with the therapist is key, as is the therapist's capacity to face negative feelings, both within the young person and in the young person's attitude to the therapist.

One aspect of the development of this greater degree of trust is based on the experience of separating from the therapist for holiday breaks from which the therapist returns. It is important to prepare the young person carefully for these holiday separations, both in terms of giving adequate notice and in terms of addressing their emotional meaning. Some young people feel abandoned and uncared for, while others may find it difficult to consider the emotional significance of breaks in the therapy, or convey to the therapist their sense of being insignificant and forgotten. In each case, it is important to address the difficulty of imagining that any therapeutic relationship, particularly a relatively brief one, could make a difference, or that the therapist could be a reliable source of support.

Therapists in a study of the psychodynamic treatment of childhood depression (Trowell et al., 2003) found that holiday breaks presented an invaluable opportunity to address the young person's experience of the therapist in a way that felt meaningful and natural. The therapist's return after a break demonstrates to the young person that she has not been damaged by difficult interactions in the therapy or by the young person's negative feelings towards her. Increased trust can also be supported by the ability of the therapist to cooperate with other professionals in the young person's interest. It can be particularly important for the young person to know that the therapist cannot be divided from the parent worker (where there is one) or from other professionals (e.g. the psychiatrist with medical responsibility), but also that the therapist has a particular role and task and will remain loyal to that and not be drawn into other kinds of intervention.

While attention to the impact of separations is significant in time-limited work such as STPP, there are many other opportunities to make use of transference phenomena. For example, anxieties about intimacy and the sexual transference may be a prominent feature, given the

dominance of these dynamics in adolescence. It is both possible and useful to pick this up in a straightforward and clear way. Supervision helps the clinician to think about how to do this, particularly if there are concerns about addressing it in a time-limited treatment. Clinical experience suggests that engaging with this sexual transference reduces primitive Oedipal anxieties and is experienced as containing, opening up exploration and analysis of key relationships in the young person's external and internal world.

Deepening of the transference relationship, including resistance and negative transference

Increased trust brings with it a deepening of the transference relationship. This involves both a greater appreciation of the treatment alliance and a heightened capacity to bear aspects of the treatment that are frustrating. It will help the therapist, in working out the most relevant material to bring to the patient's attention, to scrutinise his or her own countertransference responses, as well as the overall clinical picture.

As the relationship deepens, negative aspects of the transference may emerge more clearly. The therapist is likely to be tested as to her capacity to bear the patient's doubts about the therapy being helpful, for example; if so, her willingness to face profound despair will be vital. [Cross-ref to an example here?] From the perspective of the therapist in STPP, the emergence of the negative transference is a hopeful sign, in that it indicates sufficient trust in the therapist's capacity to work with these difficult feelings.

If young people or their families say that things are getting worse and the therapy is not helping, this may be a realistic assessment and needs to be taken seriously, but it may also be an important stage that has to be tolerated. When anxiety is high, if it cannot be managed within the individual work with the young person and their parents, there needs to be the opportunity for a professionals' meeting to evaluate the situation. The therapist's supervisor may be an important member of such a meeting. (Such communications may involve queries about introducing medication, and this is discussed in the next chapter.)

Greater capacity to confront problematic areas

The experience of the therapist as an adult with emotional resilience contributes to the young person developing the capacity to try out new modes of relating. Although the therapist will not suggest specific problem-solving techniques or make suggestions, she can support her patient in thinking through the issues they raise by asking questions, commenting on outcomes or reactions that they may be concerned about, highlighting inhibitions, and so on.

The process of delineating the young person's experience of the therapist and their expectations both of her and of other significant people can help in the process of distinguishing phantasy from reality, and can therefore support the young person to achieve a more realistic picture of what they are (or are not) responsible for. With this can come a lessening of the inhibitions stemming from anxieties about expressing aggression, and, therefore, an increased sense of agency. Equally, for those young people with a pronounced narcissistic vulnerability, the sense of self and, through this, the sense of agency can be strengthened through the experience of having their emotional experience recognised. For example, very small steps to move out of depressive apathy need to be noted and described; young people in the grip of passive hopelessness will be helped by very close observation of any change in their level of vitality and exploration of such changes.

The young person's depressive symptoms must be continually monitored and the therapist must remain aware that crises may occur. For example, depression or anger may escalate. It is important to anticipate these crises where possible and to be able to think about them and put them into words. This will help the young person consider more realistically what might be the consequences of a suicide attempt or other serious acting out. If a crisis occurs, it must be taken seriously; the therapist may need to discuss this with the young person and consider the need for other adults (such as the parents or psychiatrist) to be consulted. The young person may need to realise that in an extreme situation, the therapist has a duty as a responsible citizen to protect their client in consultation with others. (Such situations are discussed in the next chapter.)

Chloe: the middle stages of STPP

As Chloe progressed into the middle stages of her STPP sessions, an eagerness to attend her sessions regularly developed and she often arrived early. This contrasted with the stop-start experience at the beginning.

Chloe talked about rows with her mother. She also let her therapist know that she had a boyfriend who lived in a neighbouring town, something that she had not indicated at all in the earlier sessions. In one session, she described an anticipated overnight visit from her boyfriend and the demanding arrangements around tidying her room, making sure that he knew how to get to her home, and the worry about whether he would actually come or not. Chloe's therapist picked this up in relation to the initial uncertainty that she had about whether *she* was going to come to her therapy. Chloe agreed, explaining that it made sense to postpone the First Aid course she had wanted to pursue. Chloe said that she felt bad about missing those sessions and her therapist reflected on how hard it might feel that she needed some help or 'first aid' herself, rather than her being the one to take on the care-taking role. Chloe's therapist was also struck by this news of a boyfriend who had not been mentioned in the earlier sessions. This more adolescent part of Chloe seemed harder to explore in a more straightforward way and outwardly seemed indicative of a natural reserve and self-consciousness about talking about intimacy and sexuality with her therapist. However, there also seemed to be a deeper communication about competition or rivalry with an internal maternal figure that Chloe might unconsciously feel she was triumphing over, as well as a fear that her development might elicit an envious or judgemental reaction. In the countertransference, her therapist felt as though she were an old woman somehow needing a younger person to enliven or humour an otherwise drab or lifeless existence.

In another session during this middle phase, Chloe explained that she liked keeping busy with schoolwork and extra-curricular activities. It meant that she did not have to look after her brother or her cousin's children. Chloe explained her keenness to come to her session this week so that she could let her therapist know about an argument with her mother over money and how annoyed her mother was about providing more money to Chloe. A thought about Chloe's father came into her therapist's mind and she asked

Chloe about this. Chloe explained in more detail about how she had never known her father and how she had lived in her Nana's home with her mother. Her Nana had been more like her mother than her actual mother. When Nana died, Chloe began to have terrible tantrums and would not do as she was told. Then her grandfather died. This was said as if the two deaths had happened in close succession rather than six years apart. Chloe's therapist reflected on Chloe's experience of people leaving her or a relationship that did not feel quite right, like with her mum. Maybe her struggle in attending her sessions at the beginning might have been to do with a feeling that the same would happen in her therapy: that it would not feel right with her therapist and that it would suddenly end. Chloe looked thoughtful, as though her therapist's reflection were resonating in her mind.

Chloe became more reflective in her voice and began to talk about different family members who suffered from depression or other forms of mental illness. Chloe explained that her Nana had been depressed as well as an aunt, and at times her mother had been depressed. Chloe used to look after her mother. Chloe described often feeling older than her age and said she thought that this used to create problems in her friendships as a little girl. Even now, she felt older than she was. Chloe's therapist wondered whether this would also cause problems in Chloe's current friendships. Chloe was thoughtful as the trans-generational aspects of her distress came into view, and her depression seemed more accessible to exploration.

As the middle sessions of STPP unfolded, Chloe's therapist talked about how there would be an ending and how this would be carefully thought about and was still several months away. Before then, there would be a break over the Christmas holiday period. Chloe accepted this in a realistic way, as if the finite period of her psychotherapy could be trusted and could be used. She reliably attended her sessions, even before and after the break. At times, she seemed authentically cheerful, describing enjoyable times with her mother. She explained in one session during this period that it was hard to see the point of coming to her sessions when she had had a good week.

In session 16 (several weeks after the Christmas break), Chloe linked her feelings of happiness to her mother's partner not visiting so regularly. Chloe described a cosseted family experience of watching a film at home with her mother and brother. The therapist was struck by this rather infantile scene from which both her mother's partner and Chloe's boyfriend were excluded. The idea of interpreting this dynamic at this moment [check with Rajni: I think you mean that the therapist didn't make the interpretation now – please confirm; if I am wrong, I'll change the wording] made Chloe's therapist feel concerned about being violently intrusive, bursting the bubble of maternal cosiness and comfort that seemed so hard-won and precious. Chloe's story shifted gear as she began to talk about how much shopping, dog-walking, and babysitting she had done of late. She did not mind this because she wanted to help her mother, but her brother was sometimes really difficult to look after and once kicked her and bruised her leg.

Chloe's therapist reflected aloud on the contrast between the two accounts of family life: between the lovely cosiness of being with her mother and baby brother with no boyfriends to complicate things and then the annoyance of ending up having to do a lot for them. It was as if Chloe were being thrust forward to be in charge like a boyfriend or father. There did not seem to be possibility of a balance between the two. Chloe did not seem to take up her therapist's thoughts, instead continuing with another description of being expected to look after her brother too much, getting him up and ready for school. The therapist suggested that maybe Chloe felt that she was not really listening to how hard it was for Chloe when everything landed on her shoulders and it could feel like Chloe was the only one who was doing all the hard work. Chloe nodded. They were then able to think together about how complicated it was to experience work being done together as a joint endeavour: work that it was not possible to do single-handedly. Chloe found herself at times feeling either that she was having to do everything or that she wanted to be looked after and held in mind completely, a little like a mother would care for her baby. The descriptions of a younger brother having tantrums also provided an opportunity to think about these aggressive and protesting parts of Chloe.

The ending stages of STPP

Since beginnings and endings are so intrinsically linked in all life experience, the care taken during the initial consultations in setting treatment up is ideally counterbalanced by a similarly painstaking process at the point of considering entering the last phase of therapy. (Lanyado, 1999, p. 364)

[Wittenberg book also here.]

As STPP is a time-limited form of treatment, the young person will be aware throughout of the length of the treatment and the reality of an ending after the planned 28 sessions. However, as the treatment begins to move closer to the end, the significance of ending is likely to become increasingly central. As with all forms of psychotherapy, most endings are less than ideal, but a ‘good enough’ ending in STPP allows enough time for the following to take place:

- A review of events and changes during therapy, as well as identifying feelings or symptoms which may herald a recurrence of depression;
- Eliciting feelings about ending treatment and working through reactions to ending;
- Consideration of the future, including possible need for further treatment.

(adapted from [?] Fonagy et al. 1993; Busch et al., 2004) [check this means all 3 bullet points and think about how to cite/cross-reference]

The ending phase of STPP may also raise specific countertransference issues for the therapist. This will be discussed at greater length below, as will issues of ‘premature’ requests to end treatment and the question of post-treatment contact with the therapist.

Review of events and changes during therapy and identification of warning signs

During the ending phase, reviewing the course of treatment (using, for example, the metaphor of the photo album as described by Wittenberg (1999)):

enables reflection on the experience [of therapy] and offers a third position. When the work is ongoing the experience is from inside. But when the work is ended the experience is from the outside. (Ryz and Wilson, 1999, p. 399)

A kind of speeded-up reworking of all the major themes of therapy often occurs in the last phase, as will be discussed further below, although how much of this will be a conscious verbal exchange will vary greatly. This may give rise to a flare-up of the original problems at this stage. The therapist will need to assess whether this is a communication about the difficulty of ending, or whether it needs to be addressed by realistic measures. Consultation with the parent worker and other colleagues will be important in coming to a conclusion about this. While the therapist's role will involve the interpretation of the young person's experience of ending, specifically in terms of the kind of person the therapist is felt to be in that context, the parent worker may, for example, need to alert the network that the young person may require extra vigilance and attention for a time.

Eliciting feelings about ending treatment and working through reactions to ending

The termination of an analysis stirs up painful feelings and revives early anxieties in the patient. (Quagliata 1999, p. 411)

In this phase, the fact of the approaching ending becomes the central focus, though not, of course, to the exclusion of important issues in the young person's life. In addition to the aims previously discussed, the therapist will strive to help the young person to be fully aware both of the changes that have been achieved during the course of the therapy and of their frustration and feelings of disappointment at what it has not been possible to achieve. This may take the form of reproaches against the therapist for not extending the treatment, for leaving the client with unresolved problems, for being uncaring, and so on. The therapist can often feel extremely guilty, which is complicated by the fact that her own wish may be to continue treatment and that she may feel unfairly blamed for something that is not her choice. Additional complications can come about if the parents express similar feelings towards the parent worker, leaving both workers with the fear of having been useless.

It is important to address such feelings as fully as possible, and for the therapist not to confine herself to pointing out the progress that has been made in the attempt to part on a good note or to defend herself from the pain of these accusations. The therapist should beware of avoiding hostility in this way. Some young people will also avoid expressing negative feelings or hostility

for fear that expressing any disappointment or resentment will leave them with a sense of the good aspects of the therapy being irreparably spoilt. In this case, it is essential for the therapist not to give in to the temptation to go along with this. It can be particularly hard not to do so in cases that have gone well, and where the therapist feels that precious gains may be lost. However, as mentioned previously, having a good outcome at follow-up may be associated with the therapist confronting hostility during the termination phase of the treatment (Long and Trowell, 2001).

One useful way of approaching this can be to explore the possibility that the young person's complaints may be justified: in view of their difficulties and the many issues they could profitably address, it is reasonable for them to feel that they should have had more, and for them to harbour feelings of disappointment, resentment, and even hatred. However, when these negative feelings are taken seriously, patients are generally able to recognise that they also feel lasting appreciation of the therapeutic opportunity; thus loving and hating feelings may become better balanced.

Confronting the negative feelings strengthens the young person's sense of inner security, which is based on hope that their good feelings outweigh their aggression, and that both can be recognised and accepted. As Isca Wittenberg puts it:

the [therapist] is seen to survive attacks and continues to care, and is seen to be attentive and loving in spite of the patient's disappointments, accusations of abandonment, betrayal and disloyalty; the analyst goes on being concerned and understanding even if the patient temporarily turns away in anger; is able to bear and share the grief at losing what is valued. (Wittenberg, 1999, p. 355)

This very difficult work is therefore essential to their later capacity to draw on the internalised experience of the therapy:

The work of learning to let go of having an analysis can ... be of great value as a preparation for later experiences of loss and relinquishment. (Wittenberg, 1999, p. 355)

Some young people put the therapist in the position of being the one who is left behind: the one who would like to continue working with a patient who, on the contrary, is looking forward to a new life in which the therapist has no part to play. This can be acted out by non-attendance of the final sessions. This may sometimes be understood as age-appropriate in part, but can also contain an element of role reversal and revenge for the pain of dependence. Whichever form it takes, the work of the last phase places considerable emotional burdens on the therapist and parent worker, and support from team meetings and from supervision is essential.

In one sense, the termination phase may be considered to start whenever thoughts of ending are raised and discussed as a realistic possibility by the therapist or the young person. Some patients are so anxious about having to stop before they are ready that they cannot get started at all until their fears about premature loss of the therapist have been analysed.

Issues of separation and loss are likely to have been central for young people with moderate to severe depression, given the links between depression, mourning, separation, and loss. The ending phase provides the opportunity to work on this in the here and now, as this is a planned ending. Reflecting on the process of the treatment will be helpful, as will reviewing what has been worked on and achieved. The phase of ending is likely to encourage thoughts about the future, of what may come next, and encourage the client to think about what kind of person he or she might develop into.

As mentioned above, towards the end of STPP, the therapist may expect some reappearance of themes which have been worked on earlier in therapy, allowing a final working through and consolidation of internal changes. Certain feelings and behaviour are therefore common. These may include some of the following:

- Return of symptoms, especially depressive symptoms, and pleas of helplessness (Wittenberg, 1999): one needs to assess whether this is an attempt to hold onto dependency, a reworking of earlier phases of treatment as part of integration/working through, or a real setback;
- Denial of dependency and dismissal of the need for the therapist;

- Reactivation of ‘that part of their personality, which tries, through a phantasy of omnipotent possession, expressed through pathological projective identification, to obscure the reality of separateness and loss’ (Quagliata, 1999, p. 412);
- Enactments of rage about dependencies or unconscious enactments of feelings of rejection, including ‘acting out’ and risk-taking behaviour;
- Fear of the work done being lost;
- Jealousy or envy of the fantasised new baby/patient (Wittenberg, 1999, p. 352);
- Reworking of the young person’s fundamental object-relationship in the context of facing loss.

Consideration of the future, including the possible need for further treatment

Sometimes the clinical team may feel that the young person is in need of prolonged work. It is preferable not to raise the possibility of this in definite terms during the ending phase, since this can otherwise serve to gloss over the experience of ending. The follow-up review provides an opportunity to reassess the situation.

Young people’s ambivalent feelings about the end of the therapy may be expressed particularly in relation to the idea of further sessions. For example, a girl in her last session of psychoanalytic psychotherapy during Trowell and colleagues’ (2003) study of adolescent depression said that she hoped that when she had stopped, all the progress would not get lost; but she would not want further treatment if it were available because she had a lot to do at school. She then went on to describe a good time she had had with friends, and how sad it had been coming back to a darkened house; her mother was probably depressed and had just gone to bed. The therapist took up how important it was for this girl to feel that the therapist was prepared to let her go; but thought on reflection that it would have been useful to link the girl’s fear of losing the improvements she had made with the fear that these left her mother and therapist in the depressed state she herself had been in previously, which would not feel like a secure foundation to build on.

Countertransference issues for the therapist during the end stages of STPP

[The therapist] and patient alike will be beset by doubts: is this the right time to end? Is it too soon? Will the patient be able to manage to preserve what has been achieved? Will he manage without further help to face difficult times ahead? (Wittenberg, 1999, p. 351)

The ending of psychotherapy always raises specific countertransference issues, but this may be especially true with young people who have depression, where the developmental question of separation from or dependence on parents is fraught. Working with young people at risk of self-harm and suicide creates a number of specific countertransference anxieties for therapists.

According to Ryz and Wilson (1999), ‘endings, with their accompanying connotations of loss, separation, death and bereavement, are a good illustration of experiences that can be felt as angular and nasty and can have a powerful impact on patient and worker alike’ (p. 399). Especially in time-limited psychotherapy, such as STPP, the countertransference feeling associated with ending ‘can be one of cruelty and deprivation, leading to feelings of guilt and inadequacy’ (p. 399). Wittenberg reminds us:

Not only do we take on board the patient’s pain, but it is essential that we are aware of our own feelings of loss at parting from a patient in whom we have invested much time, energy, thought, love and hope and who has stimulated our thinking, helped to increase our understanding and stretched our emotional capacity ... We may also miss being needed, so much the focus of passionate feelings. (Wittenberg, 1999, p. 353)

For Lanyado (1999), the ending of therapy (perhaps especially with adolescents) is a ‘letting go’, equivalent to the task that parents go through with their own children. This process of ‘letting go’ is the counterpoint to the ‘holding’ of the young person in mind that is central to the therapeutic task. In order truly to let go of the patient, the therapist needs to be aware of the whole range of ‘troublesome’ countertransference feelings that they may experience, in order to help the young person to recognise and accept their own feelings about ‘moving on’. From this perspective, the so-called ‘termination’ phase is better thought of as a transitional stage: not just an ending, but also a new beginning. The loss and pain of this process may be balanced by the excitement of wondering ‘what next?’; alternatively, the relief of ending the difficult work of therapy may be balanced by considerable anxiety about the future.

Chloe: the ending stages of treatment

The ending stage of Chloe's therapy coincided with her public exams. Outwardly, Chloe seemed quite unconcerned by the pressure of her exams. The structure of her studies was based around incremental assessment of course work, with which she had progressed steadily, much as she had engaged with her psychotherapy. Her course work results to date indicated that she would achieve the grades she needed to go to college. There was also another break in treatment for two weeks after session 24, over the Easter period. Soon after this, Chloe had her sixteenth birthday. Chloe talked about how neglectful her mother's partner had been in remembering her birthday. She was open about how hurt she felt. In another session, Chloe described a state of acute anxiety at school, which she labeled as a 'panic attack'. She was able to get help from her teachers, yet described this experience as evidence of everything going back to the beginning. This felt like a powerful accusation of failure and of protest in the transference which left Chloe's therapist concerned that the ending was premature and somehow precipitous (despite having acknowledged the time-limit sensitively throughout), rendering it inadequate and ineffective.

Chloe explained that she had to sleep with her mother because she felt so frightened of everything going wrong. Over the course of treatment, she had described how she often retreated to her mother's bed at night, particularly when her mother did not have a boyfriend. A sense of looming disaster was tangible and when this was named, Chloe responded by saying that she had images in her mind of her mother dying and this made her question who she would then have to turn to. Chloe's therapist talked about the sense of endings being sudden, painful, and shocking, like the experience of her Nana dying. She also suggested that Chloe might feel very angry about this, that too much was being expected of her too soon. The therapist expected Chloe to block these interpretations by communicating something about how she could manage. However, Chloe was thoughtful and there was an emotional quality to her acknowledgement of the pain and enormity of her circumstances that did not feel persecutory. Chloe could allow her therapist to be alongside her. Indeed, her reliable and emotionally engaged attendance during this final

stage was remarkable, with a passionate and open communication of conflicted states of mind that could be borne and processed. The sadness felt poignant and shared.

As the treatment progressed through the ending stage, it felt as though too many changes were coming at once: the end of school, end of therapy, and end of childhood. The feeling that fragile developments were being put at risk by a premature ending was worrying for Chloe's therapist. The question of whether additional sessions might help to bridge the transition into college felt like a clinically appropriate consideration. This was discussed in supervision. The fantasy that the ending could feel like a sudden and cruel disaster was explored not only in terms of external contexts but also in terms of Chloe's internal object relations. The supervision group discussed a feeling that extending the work would create an incongruity that would enact something of Chloe's central struggles about blurred boundaries. By staying within the framework of STPP, endings could be thought about as stepping-stones rather than as a catastrophic severance.

In the final sessions, Chloe could cut a lonely figure. In one, she talked about a planned family summer holiday which would include her mother, her mother's boyfriend, and Chloe's little brother, where she felt uncertain if she would be invited. On another occasion, she arrived with a terrible cough and wet from the stormy weather. Chloe talked about how she had ended the relationship with her boyfriend as she had discovered that he had been unfaithful. It was possible to think about the symbolism of these experiences in the aliveness of the therapeutic relationship because Chloe attended regularly and communicated a need to want to think and make sense of them. Chloe's therapist reflected on how Chloe might feel as though her therapist were turning away from Chloe during the break and at the end of her therapy to be with other people. Maybe Chloe felt that her therapist was ending because Chloe should be able to manage like an adult (now that she was sixteen) or because there were other younger patients who needed to be seen. It might be hard for Chloe to trust that all the hard work of thinking and understanding that had gone on between them over those last few months would still be inside her. Could her therapy be a little like her experience of the learning she had done in this exam year: providing the foundation to college where she hoped to build

upon her learning with the support of teachers, friends, and family? Her therapist reflected on it not being easy because it could feel as though nothing had been achieved and it could be hard to trust the work done in therapy. Chloe seemed interested in these ideas.

[Rajni, I have changed the order of things within these last paragraphs as the sequence didn't seem quite right. Please check that you find this acceptable.]

In the last few sessions, Chloe talked about her worry about her mother and the state of her mother's relationship with her boyfriend. She worried about the relationship breaking down and her mother being alone. Chloe also talked about how people should not have babies 'just like that' and instead should think about what life was going to be like for the baby. Space opened up to think about partners and parental couples. Chloe talked about what it felt like not to know her father; some family members had described how kind he was, but then it felt as though everyone knew him except her. She thought about the idea of seeing him in the street and not knowing that he was her father. Yet he might recognize her because she looked so much like her mother. Access to an internal creative, caring parental couple seemed more explicitly available, as did the idea that there could be time to work things through and to plan, and time for significant life events (such as having a baby) to take place and be processed, rather than happening out of the blue. The concept of being recognized and recognizable felt significant, as there was a quality of Chloe becoming more coherent and recognizable to herself, rather than feeling that psychic experience was catastrophic or disastrous.

Chloe and her therapist discussed the availability of review appointments at the end of treatment that Chloe could ask for on her own terms. This was contrasted with the reality of the actual ending of regular contact. In her final session, Chloe talked about feeling more confident but not being sure if this feeling would last. She described how the prospect of not coming for her sessions felt 'weird'. She repeated this word several times and when her therapist asked if she could explain a little more what she meant, Chloe said, 'I think I'm ready'. Some exploration of Chloe's resilience followed and how even through the recent intense struggles, Chloe could talk and think about them without it

feeling like her world was falling apart so completely. They talked about how understandable it was for this to feel strange, yet noticed that somehow this did not feel as dangerous as a few weeks previously, when Chloe had described her panic and sense of foreboding.

Chloe's therapist also wrote a final summary report about Chloe's progress for her GP. This was designed to be read in addition to and in conjunction with the initial report written during the beginning phase of treatment.

Chloe: summary report

The unfolding experience of Chloe over the course of STPP

Chloe established a regular rhythm of weekly attendance. She only missed a further two sessions after the beginning stage of this time-limited psychotherapy. One occurred at the time of her public exams and one also related to Chloe engaging with processes of separation at the end of treatment. Chloe significantly invested in STPP and this was most vividly evidenced in her capacity to explore complex and unsettling feelings of frustration, criticism, and the painfulness of loss. These conflicts underpinned Chloe's experiences of low mood and feeling that her world was falling to pieces, as she had experienced over the previous year.

Underlying dynamics of Chloe's experiences of low mood

At the point of Chloe's referral to CAMHS, she was assessed as suffering from long-standing low mood, which had most likely been triggered by the death of her maternal grandfather the previous year. Her emotional struggles were often hidden behind a façade of coping and competence, and her tendency to step into relationships as the caregiver or as a parental authority. Chloe also described experiences of intense headaches or bodily pain (such as back aches) that seemed psychosomatic in nature. Chloe was able to feel contained by the development of a therapeutic relationship over regular and reliable weekly contact. The possibility of exploring Chloe's states of mind and patterns of relating as they were played out in the therapy sessions enabled an exploration of some of

the deeper hidden dynamics contributing to Chloe's experiences of low mood. These dynamics fell into the following key areas:

Struggles with individuation and separation in adolescence

The level of confusion and blurring of internal representations of parental figures has been significant and long-standing. This is likely to have been influenced by Chloe's experience of an absent father, and transient paternal figures, and by her experience of a dearly-loved maternal grandmother whom she experienced as her 'real mum' even though Chloe's mother lived within the household. During psychotherapy, it became possible to understand that Chloe was struggling to find a position in her relationships because of an unconscious, confused relational configuration. An example of this was of an internal maternal figure that was quickly inter-changeable with a sister or child figure. This seems to have pushed Chloe into the position of carer in her close-knit extended family. The death of Chloe's maternal grandmother when Chloe was eight remains keenly felt. It seems that Chloe's perception of the family tumult and conflict that followed this bereavement came to the fore when her grandfather died. This also coincided with the complex developmental tasks of adolescence.

At the time of her grandmother's death, Chloe described being out of control much like a toddler having tantrums. However, it seems that the understandable distress and protest that generated these intense behavioural outbursts were quickly gathered into a persona of a competent and pseudo-adult little girl who entered into puberty and early adolescence in a state of strong identification with a confident and in-control parental figure. This emotional defence seems to have crumbled at the point when she was faced with negotiating the transition into adulthood, with school education ending, the death of Chloe's maternal grandfather, and teenage cousins becoming pregnant. This has generated an emotionally disorientating crisis where Chloe's unconscious positioning as a capable moral authority could no longer defend her from feelings of falling apart, uncontrollable crying, and psychosomatic pains (e.g. intense headaches and bodily pains). It has been possible for some of these unconscious dynamics to come into view and to be thought about in her therapy. Chloe has been curious and engaged in exploring these

dynamics and has expressed how helpful it has been to make sense of her experiences. In turn, it has become possible for Chloe to feel more balanced and to consider her struggles while keeping in sight her emotional and educational strengths.

Mourning

Over the course of treatment, the underlying dynamics that left Chloe struggling to mourn and recover from the death of her grandmother came to the fore. She particularly described the visceral shock of her grandmother's death and how this made her feel physically sick and led to powerful behavioural outbursts. It seems that she has held on tightly to her relationship with her grandmother by internalizing it and installing it as a representational figure that is mature and able to get things done in an organized and diligent manner. In some respects this has held Chloe in good stead as she has progressed well through school and managed the arrival of a half-brother when she herself was entering into adolescence. Yet Chloe has avoided the usual tasks of separating and re-defining her identity that are characteristic of adolescence. This has put relationships with peers under strain, as Chloe often feels older and tends to feel critical of their adolescent behaviour and has created a competitive relationship with authority figures (particularly within the family). Chloe has described feeling profoundly confused about where she fits into her life, making it hard to separate from family or to find herself into a peer group. The latter continues to be difficult, yet Chloe has gained insight into the feelings underlying her perceptions and sometimes polarized relational experiences with key family members. She has been able to explore how she has been affected by experiences of both her grandmother's and her mother's depression and she been able to talk about how vulnerable and lost she felt as a little girl. This has offered relief from similar experiences in the present. As Chloe's psychotherapy has progressed, she has become more able to notice her need for help and to access this from family, school, and in her therapy. This seems to have increased her resilience in the face of acute distress and emotional states of fragmentation. Chloe's experiences of somatic pain and headaches have significantly reduced. [OK to add 'significantly'?)

Risk and protective factors

In my experience of Chloe at the point of ending treatment, there is negligible risk of self-harm. She is well prepared for college and excited at the prospect. However, she is vulnerable to further depressive episodes and it is significant to note that she described a family history of depression in her maternal grandmother and mother. Chloe is alert to the signs that might indicate a slip back into low mood and she is aware of how to get help for this.

Post-treatment contact

Traditionally, many psychoanalytic psychotherapists have seen post-treatment contact between the therapist and their child or adolescent former patient as unhelpful, because it has been seen as counterproductive in regard to the resolution of the transference. However, if the therapeutic relationship is conceptualised more as a new attachment relationship (e.g. Lanyado, 1999), or if the developmental aspect of the therapy is a strong element in the therapist's thinking, or if the patient's capacity to internalise needs ongoing support (Rustin, 2004) [JC to discuss with MR and needs ref], then the attitude to requests for post-treatment contact may be somewhat different. As Edith Buxbaum put it, when making the case for building in contact after the ending of therapy as long ago as 1950: 'I think that such a procedure removes the traumatic effects of ending an analysis ... the analyst refuses to let it be the threatening and sadistic "never more"' (quoted by Wittenberg, 1999, page [check 2ary ref necessary]).

At present, therapists of all theoretical orientations offer follow-up appointments where this seems likely to be useful, which is particularly the case with young people for whom loss or fear of damage has been a particular focus. Where appropriate, a follow-up session somewhere around four to six months after the end of treatment can be offered, an appropriate interval for this relatively short treatment. The young person may not respond to this offer and it is important that he or she is free to refuse. This underlines the reality of the therapist having to cope with letting go and often not knowing what the young person is making of the therapeutic work done.