Volume 2:

Literature Review

Empirical Research Project

Reflective Commentary

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Part 1

Literature Review

Dropout from treatment when treating depressed adolescents with a focus on psychoanalytic psychotherapy

A review of the literature

Abstract

Aim:

This literature review aims to explore dropout as a clinical phenomenon and how it impacts depressed adolescents in psychotherapy. It further attempts to examine what we understand about depressed adolescents who drop out from psychoanalytic psychotherapy and what the gaps in clinical understanding might be.

Method:

The literature for this study was collected mainly through advanced database searches. Keyword searches generated substantial articles dealing with depression in adolescence in general, but there were relatively few on the topic of dropout from psychoanalytic psychotherapy in this group. The databases used in this study were PsycINFO, PEP-Web, PubMed and MEDLINE. Further reading and research were done using psychoanalytic psychotherapy textbooks, clinical supervision and research-based supervision.

Findings:

This study presents a literature review that considers dropout with an inclined position towards psychoanalytic psychotherapy for depressed adolescents. It has identified an area lacking in empirical research, and in need for greater investigation, to enable a better understanding that can inform clinical practice. It also highlights the need for ongoing research into this specific modality of treatment and dropout for this group. Furthermore, it sheds light on the need to understand dropout in the

context of adolescents as a developmental stage as well as on the different meanings of dropout, with there being different ways dropout can be understood and is being used in empirical studies.

Introduction

The World Health Organization (2018) recognises depression as the leading cause of disability in the world. This has financial implications for health services and puts a strain on resources attempting to treat this clinical condition adequately. Over half of the mental health expenditure in Europe each year goes towards the treatment of people suffering from depression (World Bank & World Health Organization, 2003). A high proportion of those diagnosed with depression report that they first suffered from depression during their teenage years, and 60% identified depression to be a part of their adolescent developmental experience. Rice and Rawal (2011) draw attention to depression as one of the most common psychiatric disorders in adolescence. For adolescents suffering from depression, the outcomes have been determined to be worrying. They are at a high risk of having further significant mental health issues such as suicide, self-harm, anxiety, etc.; furthermore, other mental and physical systems often lead to comorbid presentations (Jonsson et al., 2010; Rudolph & Klein, 2009).

Across the UK, a growing number of children and young people are referred to the Child and Adolescent Mental Health Services (CAMHS) each year with a diagnosis of depression, and the prescription of antidepressants is on the rise

(Green et al., 2005). With research showing such worrying findings, it is increasingly important to understand how depression can be treated effectively.

The Department of Health's National Institute for Health and Care Excellence (NICE) guidelines clearly state that psychological or 'talking' therapies are the first line of treatment for moderate to severe depression in children and young people (NICE Guidelines, 2015). When these are either declined or ineffective after three months, NICE recommends that antidepressant medication be considered, with close monitoring and often alongside further psychological therapy. Talking therapies have been identified as effective in the treatment of adolescent depression (Fonagy et al., 2015); however, disengagement from therapy is a common occurrence among adolescents, with dropout rates between 16% and 72% (de Haan et al., 2013; O'Keeffe et al., 2018). The majority of the literature on dropout to date has focused on adult clients.Therefore, research centering on dropout among adolescent samples is needed as they have been found to be at a greater risk of dropping out compared with adults (Roseborough, McLeod, & Wright, 2016).

The dropout of depressed adolescents is particularly worrying given that the outcomes for them into adulthood reflect a high risk of ongoing significant and comorbid mental health issues. For example, the IMPACT study highlighted that those receiving manualised short-term psychoanalytic psychotherapy (SSTP) had a dropout rate of 43%, when dropout was defined as 'ending therapy without explicit agreement of the therapist'. Dropout from the other treatments was also noted, with cognitive behavioural therapy (CBT) having 32% and brief psychosocial intervention (BPI) having 36% (O'Keeffe, Martin, Goodyer, Wilkinson, & Midgley, 2018); nonetheless, it was higher for psychoanalytic psychotherapy. This has implications

for patient engagement, treatment outcomes, and the understanding and improving of psychoanalytic practice when treating depressed adolescents.

This study aims to explore what dropout is clinically understood as and highlights that there is not one consistent understanding of this clinical phenomena. It further seeks to review the literature available on the prevalence of dropout with a focus on depressed adolescents and psychoanalytic psychotherapy. This is done through the following subsections:

1. What dropout is clinically understood as and how the term has been operationalised in research

2. Understanding the unique developmental stage of adolescence

3. Prevalence of dropout from psychoanalytic psychotherapy in relation to depressed adolescents

4. Why do depressed adolescents drop out from psychotherapy and psychoanalytic psychotherapy and what is the link between dropout and outcome for this group?

The literature for this study was collected mainly through advanced database searches. Not an extensive amount of empirical research on dropout from psychoanalytic treatment among depressed adolescents was found, although keyword searches for ‘depression’ and ‘adolescents’ generated substantial articles. The databases used in this study included PsycINFO, PEP-Web, PubMed and MEDLINE. Further reading and research was done using psychoanalytic

psychotherapy textbooks, clinical supervision and research-based supervision, as well as through recommended studies by those who have a specialism in the topics explored. Due to its small scale, this study aims to highlight the key findings and explore what can be understood from them rather than presenting a detailed systematic review.

1. ***What dropout is understood to be clinically and how the term has been operationalised in research***

The Oxford Dictionary of English defines dropout as an act of withdrawing participation or terminating involvement from a particular activity. This implies that to dropout of something, the first requirement is actually to start something in the first place. In the clinical context, dropping out as an action in treatment is understood with more nuances.

As the term ‘dropout’ is used in different ways in clinical literature, it has been difficult to agree on its exact meaning and can be used interchangeably with ‘premature termination’. Perhaps this illustrates the difficulty in grappling with the phenomena of dropouts and why they emerge so frequently in child and adolescent cases. Karekla, Konstantinou, Loannu, Karekla, and Gloster (2019) explain that there is unfortunately no consensus definition about what constitutes a treatment dropout for either child and adolescent therapy or adult therapy. Some of the common definitions of dropout include the termination of treatment prior to the patient recovering from their symptom(s) for which the treatment was initially sought (Hatchett & Park, 2003; Swift, Callahan & Levine, 2009; Warnick, Gonzalez, Weersing, Scahill, & Woolston, 2012), or treatment termination without the

therapist's agreement and before the scheduled end point (Stone & Rutan, 1984). Notably, in some research protocols and treatment guidelines, premature termination or dropout may be defined by the patient missing a pre-arranged number of sessions (Linehan, 1993), but in others, it may be based on the therapist's judgement. O'Keeffe et al. (2018) explain that the therapist may partly base their judgment that cases have dropped out on non-attendance of sessions. The therapist may not perceive any determining factors or causes as to why the patient is not attending. In relation to adolescents who may have only temporarily disengaged and therefore intend to return to sessions, these research findings may suggest that what the clinician sees as a dropout situation may instead be considered a temporary pause by the patient—not as a complete termination. Armbruster and Kazdin (1994) use the term 'definitional chaos' when examining how dropout has been operationalised in the research literature.

Definitions based on treatment duration have markedly different criteria across studies in differentiating completers and dropouts, making comparability between studies problematic, where studies have based dropout on attending below the average number of therapy sessions for the study sample (Swift et al., 2009), failure to attend a specific proportion of the sessions (Lock, Couturier, Bryson, & Agras, 2006), or the full treatment protocol as pointed out by Wergeland et al. (2015). This approach to defining dropout is problematic as dropouts can happen at any time during the treatment and as there is no clear number of sessions that defines a 'good enough' treatment duration. Goodyer et al. (2017) argue that for depressed adolescents, responses to treatment may occur with as few as one or two sessions or as many as 30 sessions over a period of six–nine months.

In the field of psychoanalysis, treatment termination has received more of a focus than dropout itself. Midgley and Navridi (2007) point out that dropout from therapy poses a crucial challenge for psychoanalytic treatment, where the child or adolescent has searched for an effective therapy, where the expectation would be to attend to build a relationship that can support the difficult psychological states of mind; therefore, attending is crucial. However, dropout has not been investigated and written about as much as the phase of termination within psychoanalytic literature.

Further complexities arise when considering incomplete treatments for children and adolescents as different psychoanalytic therapists may have varied understandings of when a treatment is completed or finished early. Different psychoanalytic therapists may not consider dropout to be the same thing based on their subjective views. In fact, many psychoanalytic clinicians have questioned the terminology used and its appropriateness. Wittenberg (1999) argues that the terms 'termination' and 'termination phase' are not appropriate; instead, Wittenberg would suggest that the therapist establishes some sort of finality by saying the analytical work is terminated, and yet the patient's process may be ongoing. Novick and Novick (2006), on the other hand, express the importance of a pre-termination phase that leads to the planned termination of the therapy, allowing for a joint process of thinking about what might need to be worked on before the final ending arrives.

The many confusing elements of understanding termination, planned or unplanned, or how dropout is used within research in any of its definitions, do not detract from the potentially detrimental effects dropout can have on patients and clinical practice. This study has a particular focus on the patient group of depressed

adolescents and what can be understood in relation to their engagement or lack thereof with psychoanalytic psychotherapy. This area of focus is clinically important and worth reviewing as dropout, for the depressed adolescent, may result in the patient needing adult mental health services, amplify the patient's suicidality, lead to increased comorbidities and stop developmental progress (Fombonne et al., 2001; Pine et al., 1998). Moreover, given there is research to support psychoanalytic psychotherapy for depressed adolescents, having ongoing empirical studies to explore what helps them engage and what hinders engagement and leads to dropout could be viewed as an area of clinical relevance.

The following sections will explore adolescence as a developmental stage, as this study focuses on this particular patient group, leading to an examination of the prevalence of dropout from this group in psychoanalytic psychotherapy in relation to the condition of depression. The following sections will draw on adolescence as a particular stage of development and how it is understood and why it may relate to there being an increase of depression and a likelihood of dropout from psychotherapy.

2. *Understanding the unique developmental stage of adolescence*

A brief overview of the adolescent period of development will be presented in this section to provide context to some of the unique challenges in working with and engaging adolescents in treatment, discussing some insights from the psychoanalytic understanding of adolescence.

Adolescence is the period between childhood and adulthood during which biological, psychological and social transitions take place. This is considered a period when adolescents move towards a more ‘adult’ identity by becoming independent from their parents (Erikson, 1968; Winnicott, 1965) and developing uncertainty about figures of authority (Block & Greeno, 2011). This developmental period involves numerous transitions including identity development, the formation of friendships and romantic relationships, puberty and the management of academic demands (Wilson, 1997).

Adolescence is often regarded as one of the most stressful periods in life as this developmental stage involves many challenges that are important for successful development and maturation (Susman & Dorn, 2009). Stressors have been shown to increase from pre-adolescence to adolescence (Rudolph, 2002), and this may explain the increase in the prevalence of mental health problems from childhood to adolescence. For instance, while the prevalence of depression in children under the age of 11 is relatively low, with estimates between 0.5–3%, the incidence increases dramatically in adolescents, with an estimated 12-month prevalence rate of 7.5% in 13–18-year-olds (Avenevoli et al., 2015). Adolescence is therefore a significant period for the onset of mental health problems across westernised cultures (Vyas, Birchwood, & Singh, 2015), making it vital to establish effective treatments for this age group so that early intervention can be provided for disorders when they are first presented.

Until recently, the scarcity of post-mortem brain samples meant that the knowledge of the adolescent brain was extremely sparse (Blakemore, 2012). However, since the advent of magnetic resonance imaging (MRI), a number of brain-

imaging studies, using large participant samples, have provided further evidence on the ongoing ‘cortical maturation’ (Blakemore, 2012) into adolescence and even into adulthood. Adolescents show great activity and vulnerability in their amygdala (the integrative centre in the brain for emotions, emotional behaviour and motivation) (Thomas et al., 2001). The frontal lobes in the brain, which control important cognitive skills such as emotional expression, problem solving, memory, language, judgement and sexual behaviours are still developing (Blakemore & Choudhury, 2006) and often continue to develop until the young person is in their early 20’s.

Adolescence has been regarded by many psychoanalytic authors as a likely time when premature termination or dropout is the most likely end to the treatment that will take place (Freud, 1970; Novick, 1990; Wilson, 1997). Wilson (2001) explores different emotional forces with which an adolescent has to contend and which may cause extreme and polar mood states. This author explains that, despite their excitement and potential for creativity, adolescents’ developmental experience leads to inevitable stress and disturbance. Their sense of being young adults is still ‘embryonic’; thus, whilst they long for separation from the parents and family, they also yearn for the sense of togetherness they experienced when they were younger. They struggle with intimacy and loneliness alike, continually negotiating feelings of not knowing who they are or where they belong (Wilson, 2001).

Blos (1980) describes adolescence as the second separation-individuation process, which follows the first separation-individuation process in toddlerhood. This first process involves a certain detachment from the mother or primary caretaker to separate and achieve more independence. This applies with regard to bodily care in

particular but is also true in terms of emotional independence. During adolescence, children must loosen ties with their parents and family to become more independent members of the society and the adult world. This requires changes in their way of relating and changes in the way they perceive themself and others**.** This may therefore be a time when attending therapy and forming a relationship with the therapist feels counterintuitive. Adolescents may well want to separate themselves from adult figures and not want to make attachments with them, which may explain why dropouts can be expected, as can early termination by those engaged in therapeutic process.

This challenging time of transition is key in adolescents in relation to their forthcoming adult life. During this stage, the brain and the mind are vulnerable as they constantly have to deal with a variety of emerging emotions (Giedd et al., 1999). Consequently, depression becomes a threat, to varying degrees, particularly for those who have suffered traumatic events in earlier childhood (Balvin & Banati, 2017). The following section will discuss the prevalence of dropout for adolescents suffering from depression.

3. *Prevalence of dropout from psychoanalytic psychotherapy in relation to depressed adolescents*

As mentioned in the above section, the developmental stage of adolescence has many advances to contend with, and it can be understood from the literature and available studies that, in general, adolescents have been found to be at greater risk of dropping out of therapy than adults (Roseborough et al., 2016). In the meta-

analysis of dropout in child and adolescent outpatient care, dropout rates reported in the studies ranged between 16% and 72% (de Haan et al., 2013). However, it has been difficult to estimate the average dropout rate with precision due to the lack of consistency in how dropout has been operationally defined across different studies (Cooper et al., 2018). Dropout rates have been calculated to be lower when the definition of dropout is based on therapists' judgement, with an average of 35% dropout, compared with definitions based on treatment duration, which had a higher average dropout rate of 45% (de Haan et al., 2013). The meta-analysis compared dropout rates in efficacy studies, which aim to determine whether an intervention can provide significant benefits in a controlled environment, with dropout rates in effectiveness studies, aimed at evaluating interventions in a naturalistic setting, to reflect how the intervention will work when practised in the real world. Dropout rates varied according to the type of study: efficacy studies, which have strict selection procedures and protocols, tended to have lower dropout rates at an average of 26%, compared with effectiveness studies, having more naturalistic samples, that had a far higher average dropout rate of 45%; this was when dropout was defined according to therapist judgement.

To date, little is known about treatment dropout rates specifically among young people with depression, with the IMPACT study being few of the pioneers to address this. Nevertheless, we do know from the literature that dropout frequently occurs across mental health services, spanning across a range of client groups, disorders, treatment modalities and settings.

A meta-analysis (Fernandez, Salem, Swift, & Ramtahal, 2015) of CBT dropout found a notably higher dropout rate of 36.4% for depressed adults compared with

other client groups, such as those with anxiety disorders, having a dropout rate of 19.6%, and psychosis, with a dropout rate of 20.1%. The dropout figures in this study were estimated by considering the definition of dropout as the failure to complete the planned treatment protocol. Given that adult clients with depression have been found to be at an increased risk of dropout (Fernandez et al., 2015) and that adolescents are at greater risk of dropping out than adults (Roseborough et al., 2016), there is a potential need to clinically focus on dropout specifically in relation to adolescent depression and to have ongoing empirical studies to enhance what we understand.

Psychoanalytic therapists treating depression will focus on working with the adolescent mind, particularly unconscious matters that might be contributing to depression. Their particular theories will influence their thinking and therapeutic technique. There may be an assumption within the field of psychoanalytic psychotherapy that a certain level of dropout is to be expected in adolescent psychotherapy due to the forces the patient is developmental contending with such as the need to separate oneself and have feelings of independence. As highlighted in the introduction of this study, psychoanalytic psychotherapy saw a higher dropout level than other the treatments offered during the IMPACT trial. There are not many studies available wherein psychoanalytic psychotherapy specifically can be observed with a particular focus on depressed adolescents who have dropped out from treatment; therefore, the findings from the IMPACT study offer a valuable opportunity to concentrate on psychoanalytic practices for depressed adolescents.

Those patients receiving manualised STPP (short-term psychoanalytic psychotherapy) had a dropout rate of 43% when dropout was defined as ‘ending therapy without explicit agreement of the therapist’ (O’Keeffe, Martin, Goodyer,

Wilkinson, & Midgley, 2018), although psychoanalytic treatment was proven to be effective for depression within the trial. Some of these findings were consistent with other studies. For example, Trowell et al. (2007) found psychodynamic interventions as well as family therapy–based treatments for clinical depression to be effective, with promising long-term effectiveness. Their study had a multicenter design carrying out a randomised control trial that showed time-limited individual psychodynamic therapy along with parallel parent work for the treatment of depression for those aged 10 –14 years. In the psychodynamic patient group, there were no relapses in the six months following the end of treatment (Trowell et al., 2007).

Trowell et al. (2007) did not report on dropout and showed for most cases in both the psychodynamic and family therapy arms of the study different measurements were available at different points including the six-month follow up; only 4 cases out of 72 did not have outcome measures in the family therapy arm. Dropout perhaps was not an issue in this study; it is a limitation that it was not reported, but the study did initially have 100% of its patients attending the RCT for treatment in the psychodynamic arm. These findings may be influenced by the age of the patients, who are entering adolescence and are in early adolescence where the parent’s/guardian’s consent and involvement will determine attendance and dropout rates more than it would for later adolescence. This would suggest that all patients in the psychodynamic arm agreed to do measurements at different time points, but whether they engaged in the treatment and to what degree is difficult to determine.

Other research studies such as by Target and Fonagy (1994a) also point out the effectiveness of psychanalytic psychotherapy for depression across a varied age

sample of children and adolescence. Their study demonstrated that 75% of patients with major depression showed reliable improvement and no depressive symptoms at the end of treatment. Their study focused on different numbers of sessions per week and concluded that the more intensive the psychotherapy, such as 4–5 sessions per week, the better the outcomes. The limitation of Target and Fonagy's study is that they did not report or define dropout per say but described cases having early termination and this being associated with higher levels of depression. They also highlighted that older children were more likely than younger children to terminate the therapy before six months, although an influencing factor in securing engagement in psychoanalytic psychotherapy was having a parent who was committed to the therapy, echoing the results from the study by Trowell et al. (2007).

Some key studies and their findings regarding the effectiveness of psychoanalytic approaches have been discussed in this section. As well as their prevalence to dropout for depressed adolescents receiving treatment, not many studies were identified that specifically addressed dropout rates among depressed adolescents from psychoanalytic psychotherapy, highlighting a need for undertaking relevant empirical studies. The following section will examine why depressed adolescents may generally drop out from psychotherapy and go onto specifically explore psychoanalytic psychotherapy. It will also attempt to discuss what the link between dropout and outcome might be for this group of patients.

4. *Why do depressed adolescents drop out from psychotherapy and psychoanalytic psychotherapy and what is the link between dropout and outcome for this group?*

Specific studies involving psychoanalytic psychotherapy and dropout in relation to adolescents, particularly depressed adolescents, were difficult to identify. Studies tend to address the effectiveness of psychoanalytic treatment in empirical research; therefore, there is a gap in the literature concerning dropout from psychoanalytic treatment for depressed adolescents. This section will draw on studies that cover a wider domain of psychotherapy including psychoanalytic psychotherapy, as well as citing some studies that help identify the link between dropout and outcome for depressed adolescents.

To reduce dropout and potentially improve outcomes for depressed adolescents, understanding what factors may be contributing to dropouts is of clinical relevance. Baruch, Vrouva, and Fearon (2009), in their study based on the findings from a follow-up study on the contributing factors determining whether young people (aged 12–21 years) drop out or continue once-weekly psychotherapy, found that older age and self-reported issues of anxiety and depression led to lower levels of dropout. Their study was based in a voluntary sector psychotherapy service and took data that were systematically collected from 1992 to 2005 on 882 young people. Their study suggested that although age may contribute to a lack of engagement in psychotherapy, having depression did not stop young people engaging with the once-weekly treatment offered. Depression was not necessarily clinically diagnosed for the young people who made use of the treatment, but these findings do lend an insight that the diagnosis of depression in adolescents may be a factor leading to engagement with psychotherapy. Perhaps, in the context of this study, it highlights that, compared with adolescents relying on family support, the older and more independent patients can engage without access restrictions. This study also revealed that depressed adolescents engaged better than those with behavioural

problems, perhaps indicating treatment choice for conduct-based issues not being weekly psychotherapy.

Baruch et al. (2009), instead of focusing their study on depressed adolescents, were interested in an overview of the characteristics of young people who discontinue or continue psychotherapy. Studies particularly based on dropouts among depressed adolescents were absent in the literature. This absence in research is identified by O'Keeffe et al. (2018), acknowledging the scarcity of studies available when they carried out their study focused on the predicting factors that may determine dropouts in depressed adolescents in therapy.

O'Keeffe et al. (2018) investigate if dropout among depressed adolescents can be predicted from a range of child, family and treatment factors in a sample of cases taken from a larger IMPACT study. They found that the only significant predictors of dropout were age, verbal intelligence scores and antisocial behavioural traits. According to this study's findings, older adolescents were more likely to dropout than younger ones. This was inconsistent with Baruch's findings. However, other studies that have examined adolescents in terms of age have also found that older adolescents are more likely to drop out of treatment (Mendenhall et al., 2014). Where there was anti-social behaviour, the rate of dropout was increased in parallel to the reported severity, a pattern other studies reported (Baruch et al., 2009; Kazdin & Mazurick, 1994). Verbal intelligence could also have affected dropout, given that most therapies would use talk therapy, recommended for depression in the NICE guidelines. O'Keeffe et al. (2018) highlight the importance of thinking about ways of treating depressed adolescents who have varied needs and not assuming that all depressed youths will find therapies relatable. The gender of the adolescent or the

wellbeing of the parent(s) were not factors that influenced dropout in this study. However, the adolescent patient's gender has shown mixed findings in other studies, and adolescent groups alone have not had extensive research in the way mixed child and adolescent groups have. O'Keeffe et al. (2018) give some insight into depressed adolescents and the factors associated with dropout. Nevertheless, further studies would be needed to determine if these findings remain consistent.

When looking at the treatment factors impacting dropout, therapeutic alliance was noted by O'Keeffe et al. (2018) as an important factor to influence the chances of dropout. Patients who reported a better therapeutic alliance six weeks into treatment were significantly less likely to drop out. Existing literature has also supported this finding (de Haan et al., 2013; Zack, Castonguay, & Boswell, 2007). These studies suggest that establishing a good psychological contact with the depressed patient to aid therapeutic alliance is important from the early stage of treatment to improve engagement. Besides identifying therapeutic alliance as key to establishing engagements, O'Keeffe et al.,(2018) analyse what may promote or hinder therapeutic alliance. They used data from the IMPACT-ME study (Midgley, Ansaldo & Target, 2014) to consider the types of endings depressed adolescent patients receiving treatment had, including cases that dropped out of treatment. Therapeutic alliance and rupture-repair during therapy were found to be similar for those who completed treatment and for the dropout group who felt they got what they needed. In comparison, the dropout group who felt dissatisfied had poorer therapeutic alliances, more unresolved therapeutic ruptures, and therapists who were contributing to the ruptures (O'Keeffe et al., 2019). This suggests that resolving ruptures in a therapeutic relationship helps with therapeutic alliance for depressed adolescents and leads to more satisfactory treatment experiences. According to the

findings of these studies, the therapist's skill in investigating how ruptures may be identified and managed whilst the depressed adolescent is in treatment enhances therapeutic alliance and encourages the patient to make use of the treatment on offer. This may lead to a decrease in the number of dropout cases, but it also indicates that even if patients do choose to drop out, they may be leaving treatment with a sense of satisfaction and ability to better manage their depression. Therefore, it may not be detrimental for the depressed adolescent to drop out from psychotherapy per se, but rather why they may be dropping out.

The study by O'Keeffe et al. (2019) took into consideration what the patients believed led them to dropping out of treatment; they could identify three categories pertaining to dropouts based on their findings: 'dissatisfied', 'got-what-they-needed' and 'troubled'. Dissatisfied dropout cases stopped therapy as they did not find it helpful; got-what-they-needed cases felt they no longer needed to be in therapy due to the improvements made; troubled dropout cases could not continue the therapy due to the lack of stability in their lives. This study emphasized that using a blanket term such as 'dropout' for all cases that leave treatment prematurely can be problematic, as can assuming that dropout will result in poorer outcomes for depressed adolescents. The nuances and meaningful understandings that can emerge from further exploring dropout cases can support researchers and clinicians to make meaningful distinctions between various types of dropout and therefore provide insights into the clinical management of both dropouts and engagement with patients at a particular risk of dropout. This study reported on all three treatments available in the IMPACT study and was not specific to psychoanalytic psychotherapy; therefore, it did not report on the techniques or considerations specific to this treatment.

It can often be assumed that dropping out of treatment will lead to poorer clinical outcomes than if the treatment is completed (Kazdin et al., 1994). However, little research has empirically tested this assumption with depressed adolescents in psychoanalytic therapy; when considering the relationship between dropout and outcomes, it can be acknowledged that studies currently investigating the relationship between dropout and outcomes cannot tell us whether dropping out is causally associated with outcomes.

In children and adolescents, some studies on the treatment of conduct problems have found that children who drop out of treatment have poorer clinical outcomes compared with those who completed treatment (Boggs et al., 2005; Kazdin & Wassell, 2000). One of the major limitations of these studies has been the lack of long-term follow-up; so while there is some evidence indicating poorer outcomes of dropouts in the short term, little is known about their impact in the longer term. While there is a lack of studies investigating outcomes associated with dropout in adolescents undergoing depression therapy, studies involving adult clients receiving therapy in the UK have found dropouts to cause poorer outcomes by the end of treatment, but these studies did not include a long-term follow-up (Cahill et al., 2003; Saatsi, Hardy, & Cahill, 2007; Saxon, Firth, & Barkham, 2017)

Conclusion

Depression is a debilitating condition with a high risk of recurrence and is associated with both self-harm and suicidal ideation (Callahan et al., 2012). The increase in adolescent depression further leading to adult mental illness is an area of current concern within health services (World Health Organization, 2003). The

number of 15–16-year-olds in the UK suffering from depression has more than doubled since the 1980s, and at present, an estimated 80,000 young people have been diagnosed with serious depression (Young Minds, 2020). This calls for an appropriate availability of treatments and understanding which treatments are effective and why. However, even effective therapies can only be effective for those who engage to a certain extent in a treatment. This study highlighted that this can be associated with regular attendance or attending enough sessions to find the intervention helpful; in particular, psychoanalytic psychotherapy will work within a relational context wherein having some kind of relationship that the adolescent can use will be fundamental for the treatment to be effective.

Adolescents with depression who receive psychological treatments are noted to be vulnerable to dropout (Freud, 1970; Giedd et al., 1999; Novick, 1990; Wilson, 2001). This can be understood in terms of their normal developmental struggle, with important milestones for adolescents including attempts to gain more autonomy and desire for independence from parental authority figures. However, having depression can interfere with development, so the need for psychological support for depressed adolescents is imperative. They may perceive the therapist providing the treatment as an authority figure, desiring freedom and a departure from therapy. Therefore, the therapy itself may conflict with the patients' need for independence (Block & Greeno, 2011; Bolton Oetzel & Scherer, 2003). The therapist will have to not only understand the developmental stage the adolescent is at and how to keep them engaged but also understand the impacts of their mental health condition and the importance of treating it.

As noted in this study, the developmental stage of adolescents calls for the additional understanding of why this particular group are vulnerable to both

depression and dropouts. There is a robust understanding of this within psychoanalytic literature and thinking, but this does not transfer to empirical studies. The empirical literature is in its infancy within the field of psychoanalytic treatment and the links between dropout and outcomes for depressed adolescents.

Researchers are beginning to develop a greater focus on the treatment of adolescent depression, with current studies offering a richer understanding of adolescent depression and what can be learned from available treatments and clinical practices (Goodyer et al., 2017; O'Keeffe et al., 2018, 2019). However, as this study points out, there is little research focused directly on dropout from psychoanalytic therapy for adolescents suffering from depression; there may be specific technical factors that could be scrutinised further to support an understanding of how to improve outcomes and reduce dropout, particularly noting early signs of rupture in the relationship and what technical considerations might be important when building therapeutic alliance as noted by O'Keeffe et al. (2019)

This study has attempted to address what is understood in relation to adolescents who are depressed and their dropout from psychotherapy, with a particular focus on psychoanalytic understandings of adolescent development and psychoanalytic psychotherapy. Broader studies covering other modalities were used to draw on what we know from current empirical studies and what the gaps might be.

The term dropout and how it is understood was explored, highlighting the many different interpretations of it, as well as the mistaken assumption that all dropouts may lead to negative outcomes for depressed adolescents. Further, the prevalence of dropout among depressed adolescents and why they may dropout from psychotherapy was discussed using key studies available. There were some

studies highlighted that dealt with psychoanalytic psychotherapy specifically and others that used various modalities of psychotherapy including psychoanalytic. The literature was lacking on more specific studies that looked at dropouts when treating depressed adolescents with psychoanalytic psychotherapy. Some studies have recently made attempts to think about what psychoanalytic techniques may support engagement and perhaps reduce the probability of dropout; however, these empirical studies are still in their infancy and a greater focus on this particular area is needed to fill the current gap.

Overall, this study has compiled key studies to identify a need for undertaking empirical research into understanding dropouts in the context of depressed adolescents receiving psychoanalytic psychotherapy.

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Part 2

'It's Time to Stop' – A Case Study Exploring Session Endings in Short-Term Psychoanalytic Psychotherapy with Depressed Adolescents

Impact Statement

Currently, there is a gap in clinical literature and empirical studies in relation to how individual psychoanalytic psychotherapy sessions come to an end. Yet, from clinical experience, this is an area of clinical practice that likely influences patient experience and potentially treatment outcomes. This study makes an attempt to start addressing this current gap in empirical research using a qualitative approach.

By analysing a single case study employing conversation analysis as its methodology, this study explores how individual sessions come to an end when a psychoanalytic psychotherapist is treating a depressed adolescent using short-term psychoanalytic psychotherapy. This study identifies four types of endings, which could open up clinical discussions in training, clinical supervision and clinical practice related to how therapy sessions end. Findings from this study have the potential to stimulate an ongoing exploration of session endings that may impact clinical practice.

On the level of clinical practice, the current study can help question the understanding of the final moments in each therapy session and how they may play an important part in the overall treatment process. This research project may also inspire additional research in this area, no studies within psychoanalytic psychotherapy on children and adolescents were identified that focused on how individual sessions end, the way therapists approach session endings, and why this may be of importance to patient experience and outcome.

Abstract

Objective

There have been some attempts within the field of psychoanalytic psychotherapy to closely examine endings as a phase of treatment. However, how particular therapy sessions end in a weekly treatment has not been an area of particular focus either in theoretical literature or empirical research. Thus, the aim of this study was to explore how individual therapy sessions between a depressed adolescent and a psychoanalytic therapist in a short-term treatment came to an end in the context of a young person who dropped out of treatment.

Method

This was an exploratory, qualitative single case study selected from the arm of psychoanalytic psychotherapy of a randomised control trial. The final minute of each therapy session with one patient from the IMPACT study was transcribed and analysed using conversation analysis, alongside a broader focus on what was happening in therapeutic interactions in the ending stages of each session.

Results

This study identified four different categories of endings: interrupted endings, abrupt endings, organic endings and prepared-for endings. Findings highlighted that therapy sessions end in varied ways in a short-term psychoanalytic psychotherapy treatment.

Discussion

The categories and exploration of how sessions come to an end in this single case study provide a basis for carrying out further research, exploration and

reflective practice concerning how the end of psychotherapy sessions may be thought about. This study offers a starting point for exploring an area of clinical practice that has yet not been explored, thus allowing for an opportunity to further enhance clinical knowledge and fill the gap in the current literature.

Introduction

Psychoanalytic practitioners have had a long-standing interest in endings and the questions they raise in psychotherapy. Sigmund Freud, in his paper 'Analysis terminable and interminable' (Freud, 1937), initially brought this phase of treatment to attention in 1937. He spoke of endings as a phase of treatment rather than an ongoing phenomenon that is held in the mind of the therapist. The many meanings of endings and the ending of the treatment are highlighted by Freud, such as the ambivalence that might exist for a patient between feelings of dependency and the desire for independence; feelings of abandonment that may be complex and related to infantile anxieties; and using this phase of therapy as an opportunity to work through old conflicts in the hope of gaining a more mature understanding and resolution.

Freud (1937) pointed out themes that may arise in ending analysis, but, overall, throughout his collected works including his published case studies, he paid little attention to ongoing endings that arise in treatment and what their significance may or may not be, such as breaks in treatment as a way of practicing the final ending, or how each session ends and what significance this may have on the patient. There was also little reference made to the therapist's role in bringing therapy sessions to an end and what significance this may have. This left a gap in the early formations of psychoanalytic psychotherapy that was not picked up or examined further by Freud or those who developed psychoanalytic psychotherapy further.

No literature or research studies were identified when exploring session endings related to psychoanalytic psychotherapy that focus on how the therapist and

adolescent patient are managing the end of the session whilst completing this study; however, there were two recent empirical studies that looked at session endings more broadly in psychoanalytic psychotherapy.

Della Rosa and Midgley (2017), in their recent study, investigate the therapeutic interpretation process related to endings. Using clinical data from sessions wherein depressed adolescents received psychoanalytic psychotherapy, they pay special attention to the use of transference interpretations. Della Rosa and Midgley (2017) highlight factors that psychoanalytic practitioners may take for granted, such as the technique of using transference interpretations, and stress the need to think about how interpretations are used clinically when discussing endings with depressed adolescents. These authors' specific focus is on technique and the ending phase of therapy. Their study does not look at the actual endings of sessions but gives insight into how clinicians may manage the ending phase of treatment with depressed adolescents.

Dittmann (2016) does take up the endings of individual sessions as an area and subject for empirical research and focuses on how both the therapist and patient manage the ending of individual sessions; his focus, using a single case study from an adult psychotherapy case, is to examine the dyadic process taking place between the patient and therapist as the session approaches the end. This study found identified active steps that are taken conversationally to bring a therapy session to an end. Sometimes the therapeutic dyad (the patient and therapist) manages to do this together, and other times, the therapist takes the lead vocally, and the patient needs to manage having open sequences of verbal interaction closed down as the end of session approaches. Dittmann (2016), in his study, stresses that there is a 'blank space of research' that does not address how actual psychotherapy sessions

are ended; his study makes a contribution to filling in this ‘blank space’ and provides a starting point for other studies to follow.

How therapy sessions end may be viewed as a significant part of psychotherapy, both as way of practising the final ending of the treatment and as an important phenomenon within treatment that has yet to be explored further. Holmes (1997) emphasises that session endings throughout the treatment lead to an experience of ‘cumulating’ endings that will be present in the overall ending of the therapy. Holmes (1997) states, ‘Ending is ever present, long before the final separation, casting its shadow on therapy from the start and, when it comes, is a culmination of all the countless little endings that have prefigured it’. (p. 170)

Holmes’s writing gives emphasis on the breaks in therapy serving as a type of ending, such as holidays, illness, and unexplained cancelled sessions. He highlights the importance of the ongoing endings within psychotherapy before the final ending; however, he does not discuss individual sessions coming to an end and what significance it may or may not have.

In the existing literature and empirical studies, how psychoanalytic psychotherapy sessions end is not something that has received much focus. Little is known about their clinical significance; in the researcher’s own experience as a trainee psychotherapist, the only time session endings were discussed or thought about was when something difficult to manage manifested at the end of the session, appose to predetermining that the session ending may be an important part of the therapy session itself or the treatment in general. The ending of a session will be the last encounter the patient has with the therapist; perhaps this will have meaning to the patient as something to hold on to before they are reunited for the next session?

It may serve as a bringing-together, a gathering of the session and the therapeutic work before the therapist and patient are reunited.

In clinical literature, there is some indication of the importance of holding how sessions end in mind and the significance it may have. Hurry (1977) sheds light on a clinical case wherein a depressed adolescent at the end of an assessment session is informed she would have the choice whether she would want to pursue therapy. The patient receives this message not as a choice due to her state of mind and perhaps diagnosis of depression, and she goes onto have a serious attempt at suicide post the assessment session, feeling hopeless and rejected. Whether there was significance in what Hurry said and when she said it (at the session's end) is open to different explorations. One hypothesis may be that had this been discussed with the patient earlier on in the session, there would have been an opportunity to clarify what was being said by Hurry as the therapist; however, that was also perhaps an indication of how the patient might have interpreted what was said. What is said at the end of a session may carry a lot of weight for patients, such as the case of Hurry (1977) suggests; this particular depressed adolescent may have been contending with so many emotions around developmental changes and loses and grappling with depression; therefore, she may have needed more 'scaffolding' and a clearer, sensitive management of the assessment session's ending.

We currently don't know what the link is, if there is one between the ending of sessions, breaks in therapy, and the ultimate ending of a treatment. An area of exploration might be the way individual sessions end may be linked to the way the treatment itself ends, and perhaps difficult endings of individual sessions may be associated with premature endings or dropout in therapy itself. We also don't know if

there is way of ending therapy sessions that offers greater containment to the patient, especially those suffering from troubled mental states such as with the patient Hurry (1977) describes. The literature is in its infancy at this stage with regard to exploring the endings of sessions. Therefore, this study aims to make a start at exploring how a psychoanalytic psychotherapist and a depressed adolescent patient manage the endings of sessions using a single case study, examining what can be learned that may be of clinical use. This study will serve as a starting point in filling in the 'blank space' referred to by Dittmann (2016) in his study.

Current study and aim

Currently, very little is known about how therapy sessions end, and almost no empirical literature is available on the topic. Therefore, the aim of this study is to look at how sessions end through a single case study and scrutinise what can be understood from this particular case study. As it stands, how psychotherapy sessions end is an unknown in terms of studies and available literature. This study will aim to start to investigating this area of clinical practice by describing how sessions end in the treatment of a depressed adolescent by a psychoanalytic psychotherapist using short-term psychoanalytic psychotherapy. There will be a particular focus on what happens between the therapist and the young person at the end of the session, trying to understand what occurs in the interaction between them as a therapeutic dyad. In this particular case study, the context is one wherein the patient has ended treatment prematurely and dropped out.

Method

Design

This study uses a single-case study design, selecting a previously recorded case from the short-term psychotherapy arm of the IMPACT trial. A case from a larger trial was chosen to obtain a more detailed understanding of the psychotherapy process in relation to session endings and to potentially complement the overall RCT results.

IMPACT *Study*

The current study is part of the larger IMPACT study. The IMPACT study (Goodyer et al., 2017) was a randomised clinical trial (RCT) comparing the effectiveness of short-term psychoanalytic psychotherapy (STPP) with cognitive behavioural therapy (CBT) and a brief psychosocial intervention. In the IMPACT trial, adolescent patients of 11 to 17 years old with a diagnosis of depression were randomly selected to have one of the three interventions for depression available. The study was conducted in 15 child and adolescent mental health services (CAMHS) across three English regions. The study found that there were no statistically significant differences in either clinical outcomes or cost-effectiveness among the three treatments (Goodyer et al., 2017).

The study concluded by suggesting that all three treatments should be made available to young people with depression to support patient choice within the NHS clinical setting. The strengths of the study were that it used a large sample and standardised outcome measures and had a long-term follow-up. Furthermore, the outcome assessors were blind to treatment allocation, and the treatment reliability was assessed by independent raters (Midgley et al., 2014).

This study focuses on data from the STPP arm of the study. This was a 28-session model in which the manual defines three stages within the psychotherapeutic treatment, with a clear ending phase. The therapy was provided by child and adolescent psychoanalytic psychotherapists or those in training as child and adolescent psychanalytic psychotherapists.

Case study

For the purposes of this study, a case was purposively selected in which the average number of sessions was attended, but the therapy ended prematurely without an agreed ending between the therapist and the young person. The case was from the STPP arm of the IMPACT study, in which the audio for all sessions was recorded. The case that was selected had an attendance for 12 sessions, which met the average number in this arm of the trial.

The patient was a 17-year-old female, referred for treatment to CAMHS after receiving some school-based therapy. She did not complete the full treatment of 28 sessions. She attended 12 sessions, cancelled 3 sessions, and decided to dropout of from the treatment without discussing it with the therapist. There were two breaks in the treatment due to therapist’s holidays. The patient did not cancel the sessions before or straight after the therapist’s breaks.

At referral, the patient had suicidal ideation and self-harming tendencies. The patient was prescribed antidepressants before the treatment began. It is unknown if she took the prescribed medication and for how long.

The patient’s parents did not attend any of the parent sessions offered and therefore no feedback or outcome data was available from them. The patient herself completed both the Moods and Feelings Questionnaire (MFQ) at baseline, mid-

treatment and in the long-term follow-ups; there was no MFQ data at the end of treatment prior to her dropping out. The Working Alliance Inventory (WAI) measures were also completed by her, and she was open to taking part in the IMPACT – My Experience (Midgley et al., 2014) qualitative study following the trial.

Her outcomes suggested that her depression had improved, highlighted in her MFQ scores that did not decrease significantly whilst in treatment but showed significant improvement in the longer term. Her score at the beginning of treatment in the MFQ was 46, 42 at mid-point (around 14 sessions of the trial) and 21 at the 52-week follow up. Her WAI measure was 47 at 6 weeks and 32 at 36 weeks, marking some improvement in how she felt about her experience of the therapy and therapist in the longer term. Her qualitative interview highlighted her unsatisfactory experience of how sessions ended in therapy, with her stating that she felt that the therapist and she would be in the middle of discussing something important when the session would be over, often surprising her.

Conversation Analysis

Conversation analysis (CA) was used as the methodology for this study, with the final minute of sessions being transcribed and analysed with the application of CA. The researcher first familiarised herself with the full transcription of each session. The final minute was then chosen to examine the very last encounter between therapist and patient, although what lead up to the final minute was also taken into consideration when ending categories were identified within the results. CA is a qualitative approach for the study of the structure and process of social interaction (Schegloff, 2006). CA concentrates on ‘how’ rather than ‘what’ or ‘why’, lending itself

to explorative process studies such as this one. CA is concerned with what's happening in interactions between people and therefore was appropriate as a method for exploring the very end of a therapy session that was using talk therapy. CA studies focus on intersubjective phenomena: the ways in which participants demonstrate interaction display and orient to each other's interactions and understandings through their verbal and non-verbal expression.

The data, in this case the final minute of the each session, was transcribed using the detailed notation developed by Jefferson (Schegloff, 2006) and in this case listened to alongside what was pre-empting the final verbal encounter, investigating what lead to the kind of session ending that took place in each session.

Procedure

The researcher initially listened to all 12 recorded sessions available in this case study to familiarise herself with the case study. The researcher then listened to the sessions a second time and summarised them thematically into three minute segments. The aim of these segments was to note down what type of interaction was taking place between patient and therapist, how were they responding to each other and how this may influence how the session may come to an end.

Once the sessions had been listened to, the researcher listened to the final nine minute segments of each session and transcribed the segments verbatim. However, the formal CA was only applied to the final minute of each session, which became the focus of the formal analysis. This was to gauge the very final verbal encounter, studying how each therapy session ultimately ends between patient and therapist.

Analysing the data

The final minute of each session was analysed in detail using CA to identify how the sessions ended during this treatment. It involved paying close attention to the communication between patient and therapist, resulting in an intricate analysis of the interactions, use of language, utterances, silences, and overall dynamical understandings. CA examined the engagement of the therapist and patient during the course of their communication. Although, the formal CA was only applied to the last minute, in order to understand each session's end, the researcher also examined the period leading up to the end, and this wider context informed the analysis.

The researcher worked together with her research supervisor and then presented the data to the larger supervision group, which included a second supervisor. Working with the research supervisor, all of the final minutes of CA-analysed data was examined to identify the appropriate process involved. Samples that demonstrated a particular style of ending were brought to the supervision group for further exploration; based on these styles of endings, categories were identified, and particular patterns were noted in the ending sequences of the data. The session endings were then catalogued into four particular categories based on the patterns of conversation that emerged in the data, whilst also taking into account the broader context that led up to the end of the session, each reflecting a subtly different way in which the end of the session took place.

Throughout data sampling, there was an integrated process of using consensual analysis in the research group. This entailed my fellow research

colleagues and our supervisors checking and analysing the data together. This led to a more robust approach in exploring the researcher's findings and ensured that there was a validation process.

An example of each category of session ending will be presented in the findings section of this paper. Each example has been selected to illustrate the category type. It has been analysed using an edited CA coding system originally created by Jefferson (2004). The data is analysed by an initial CA coding and examination as well as by drawing on the researcher's psychoanalytic training.

Ethics

The study protocol for the IMPACT trial was approved by Cambridgeshire 2 Research Ethics Committee, Addenbrooke's Hospital, Cambridge, UK (Goodyer et al., 2017), and informed written consent was obtained from all the participants in the study. This included parental consent for those participants who were under the age of 16. In order to protect the participants' confidentiality, all identifiable details were excluded or altered. Furthermore, the participants were described using only their gender and age at the start of the study. All therapists and young people in the IMPACT study agreed for audio recordings to be made of their sessions for the primary purpose of assessing treatment fidelity and, additionally, for examining the process of psychotherapy.

The case study used in this project was managed confidentially by restricting access to the data via a secure website with regulated software. No data were stored on any devices that could be accessed without security, and all data were carefully coded and altered to further protect both the patient and therapist in the case study. Any paper copies of transcriptions were also further anonymised, and after their use

within supervision sessions, all paper copies were returned to the researcher and shredded.

Findings from the study

How the therapy sessions come to an end

The data analysis showed that it was the therapist who always initiated the end of the therapy sessions and never the patient. It was noted that the end of the majority of the sessions had a surprising and sudden quality to them, and the patient's response to the ending of the therapy session was minimal. The manner in which the sessions ended was highlighted by the patient in her qualitative interview post treatment, pointing out that she was not prepared or that she did not expect the session to end when it did. The patient further explained that she felt interrupted and that the therapist would end the session in the middle of a discussion. Therefore, taking the patient's experience into consideration, this became the area of primary focus of the analysis. The final stages of the session were explored through transcription and the very final minute was analysed using CA, which allowed the researcher to observe and explore the vocal process between the therapist and patient as the session ended.

From the final stages of the session and the detailed formal CA of the last minute of each session, four main categories of endings were created based on the vocal interactions between the therapist and the patient:

- Category A –‘***The interrupted ending’***: The patient is talking and the therapist ends the session with no prior notice (sessions 3, 4, 5, 11, and 15).
- Category B –***‘The abrupt ending’***: The therapist makes a point at the closing of a session and then ends it (sessions 6 and 7).
- Category C –***‘The organic ending’***: The therapist and patient are discussing something together, and the session comes to an end (sessions 1, 8, and 12).
- Category D –***‘The prepared ending’***: The therapist gives prior notice about the end of the sessions (sessions 2 and 13).

Category A – The interrupted ending

This category of endings was found to be the most common, occurring in 5 out of the 12 sessions.

The example considered here is taken from session 3, in which the patient has been exploring intimate relationships, and the therapist brings their therapeutic relationship into focus. The therapist talks about the transference relationship with him as the session approaches an end. The patient has used the word “clinical” to describe how she finds him. The therapist has interrupted the patient’s flow at a few occasions in the lead up to the ending, sometimes talking over her and sometimes by adding a vocal response as she speaks.

The therapist was exploring the transference relationship just before the final minute of the session. The timing of this discussion in the final minute made it seem like the session was being interrupted and ended in spite of being on an important topic. The nature of a therapeutic relationship may need more time for discussion

and would be better placed earlier in a session with ample time and space for exploration. A depressed adolescent such as one in this case study may be sensitive to how they experience relationships and how they are perceived in them.

Final minute of the session:

1. **P** – emm (.) yehh (.) I know (.) I'm worried it might come off as personal but
2. it's //
3. **T** – // ↓ right
4. **P** – not so it's not like aimed personally (2) it's just ehm (.) I don't know (2) in
5. terms of the (2) ehmm (.) the I don't know what you're supposed to be doing (3)
6. don't know it's → cool ↓ that you don't care (.) ↓ if that makes sense ↑
7. doesn't bother me because it's supposed to be like that ↓ (laughs under her breath)
8. **T** – °but it's not what you're looking for
9. **P** – ehm ↑ I don't know (.) I think I think here it is but you know obviously like
10. in general life it's not (.) in like this circumstance (.) it's (.) fine that you don't
11. care
12. **T** – it's time to stop (*no particular tone identified*)
13. **P** – → cool (.) thank you (*no particular tone identified*)
14. **T** – see you next week (*no particular tone identified*)
15. **P** – → cool (*no particular tone identified*)

In the final minute of session 3 the patient is expressing her concern about how the therapist might perceive her experience of him (line 1, '*I'm worried it might come off as personal but it's…*'). She does not finish, but the therapist, in line 3, comes in with his use of *'right*' during her incomplete turn and speaks at the same time as her, thus disrupting the sequence. The use of '*right'* from the therapist can be viewed as a back-channel comment (Yngve, 1970) and may indicate the therapist's awareness that something difficult is forthcoming. Using *'right'* in this way can be seen as a withdrawal from conversational engagement or a wish to change the direction of the conversation. He is responding to the patient's comment, in line 4, that what she is saying is not aimed personally at him, thus mitigating a complaint or potential attack from her. The patient then continues to reclaim the conversational floor in lines 4–8, although her rhythm changes with a total of seven silences. The turbulence in her speech follows the difficult utterance of *'right'* from the therapist. The patient pauses for 2 seconds after stating she is not being personal in line 4, then quickly pauses again in line 4 briefly, and then again for 2 seconds after stating that she doesn't know. In line 5 there's a further 2-second silence followed very quickly by a pause. The patient makes a statement that could be a question, '*I don't know what you're supposed to be doing*', and then leaves a 3-second gap (the longest gap), not getting a response to her utterance; an interruption in their flow of conversation is noted here. The patient invites the therapist to come onto the conversational floor and take his turn, but this does not happen. Her tone remains hard to identify, and her pauses could potentially indicate apprehension or caution. Given that she has been interrupted before, she may be feeling cautious about what she says.

In line 6, the patient has established that the therapist is not answering her, therefore not taking his turn in the sequence. This potentially causes a rupture in their turn-taking sequence as the therapist has gone from frequent interruptions to not saying anything. The patient continues and states that it is '*cool*' that the therapist does not care and then asks another question '*if that makes sense*'. The use of the word '*cool*' (usually a colloquial agreeable expression) is a potential attempt to repair the rupture. Lines 6–7 leave no space and no pauses for the therapist, and the patient concludes her turn by stating it doesn't '*bother*' her because '*it's supposed to be like that*', emphasising that things are cool (agreeable, satisfactory) for her. This sequence concludes with unusual laughter from her, this time under her breath; the communicative intent of her laughter is unclear. The patient may be using laughter to keep things satisfactory and remove any potential unease that may have occurred in the sequence between the therapist and patient.

In line 8, the therapist reflects back to the patient, in a quiet pitch, that not being cared about is '*not what you're looking for*'. In lines 9–11 the patient uses four small pauses and informs the therapist '*it's fine that you don't care*'; instantly, the therapist takes his turn in line 12 by stating '*it's time to stop*', with no affect in tone discernible from the recording. It is hard to determine wither the patient would have carried on had the therapist not ended the session, which came across as an interruption to what was going on in the conversation between them. The patient accepts this verbally by using the word '*cool*' in line 13 and then thanking the therapist. The patient uses the word '*cool*' again in line 15 as she exits, now having used this word three times in the final minute of dialogue with the therapist. The use of '*cool'* from the patient is a pragmatic marker: 'cool' would normally indicate agreement, a positive tone, and perhaps something that is unusually exciting or

impressive. The patient has used '*cool*' in a complex way, trying to both demonstrate her non-value-judgment concerning the therapist and, perhaps, her apathy towards him. In lines 12–15, both the therapist and the patient enter a sequence with no recognisable tone or inflection, which gives the final exchange between them an unemotional quality.

The patient does state her feelings that the therapist, because of his profession, is not supposed to care about her (lines 6–7). The therapist speaks at the same time as the patient (overlapping) and uses the word '*right*', which has multiple potential functions. It can literally mean 'correct', as in 'you are right', but can also have the connotation of waiting for an explanation or being offered as an indication of acknowledgment of listening. The patient seems to understand *'right'* as a difficult response from the therapist. The patient reinstates her belief that '*it's fine you don't care*', and she is then told '*it's time to stop*'. The session ended whilst they were still exploring the area of their relationship, with no suggestion that they may return to this discussion in the next session; this gives the sense of being interrupted and implies that something has been left unfinished.

The interrupted endings all had significant topics being discussed in the lead up to the ending of the session, which gave the implication that the patient may still have had something to say. There was no vocal sign that the therapist had picked up that suggested that the patient may want to continue exploring. Furthermore, the therapist did not articulate that the session was coming to an end and that it may interrupt the patient's process of exploration.

Category B – The abrupt ending

This example is taken from session 6. There were two sessions with this type of ending. The two sessions categorized as abrupt endings are very similar to the interrupted endings, the only difference being that in Category A the patient was interrupted not only in the final minute but in the lead up to it, while in Category B, although there is an instance in the final minute where the patient is interrupted, she is not interrupted in the lead up to the session's ending. The abruptness is more associated with the fact that, after the patient takes her turn in the conversation, the therapist announces the end of the session in what can be perceived as an unexpected declaration in the middle of the conversation they are having.

In this session, the patient is questioning the use of the therapy; as they approach the ending of the session, there have been discussions around not finding the therapy useful or questioning the therapist.

Final minute of the session:

1. **P** – (laugh) (.) like (.) if (.) ↑ I'm here so you can comment on what tell you↑

2. (.) to make me think about what I'm ↑ saying in terms of what I don't ↑<u>realise</u>

3. (3) I don't know (.) like (.) if I haven't already realised it (.) then how am I

4. going to (.) realise it by someone else saying it (*vocalises beginning of words*)

5. (.) mmm so I don't know (2) I just (.) [*xxx starts talking interrupted...hard to make*

6. *out x*]

7. **T** – = [can] can I really help you ↑

8. **P** – (laughs) yeah (laugh) yeah

9. **T** – but it's interesting isn't it you say that I might recognise or realise

10. something about you that that you might not have (.) so the question is

11. whether that (.) can you find that helpful or whether that it's come from me

12. not you (.) is that what's difficult

13. **P** – ↓ hmm I guess so

14. **T** – anyway ↓ it's time to stop

15. **P** – → cool (2) thank you (*mimicked tone*) (.) bye

Close to the ending of the session, the patient has brought up her experiences of the therapy and the therapist. The patient, in lines 1–4, uses raised annotations and pauses to express her uncertainty about the therapist's approach. The patient is trying to articulate something related to her uncertainty. In line 3 she asks: '*if I haven't already realised it then how am I going to realise it by someone else* saying *it* [?]'. The patient then starts to say something but does not complete the word; she carries on in line 5, pausing as she speaks, although she has not finished. It was agreed during consensual analysis in the supervision group that, based on the recording, she is still looking for the right words or attempting to make her point clearer (i.e., to finish her turn) when the therapist interrupts her in line 7. The therapist articulates a question related to her stance by raising his intonation: '*can I really help you* [?]'. In line 7 the patient confirms that this question addresses her point by saying '*yeah*' on two occasions as well as by laughing twice. The patient may laugh in agreement with the therapist to lighten the potential rupture that may follow, or the laughter may be a way to cope with the potential hostility she may be experiencing within herself.

In line 9 the therapist explains that he might understand something about the patient that she does not, *'I might recognise or realise something about you that that you might not have*', and he asks whether such a realisation from their exchange can be useful to her or whether it might become difficult for her (lines 8–11). The patient gives an uncertain and minimal response to his point in line 12, starting the response in a lower intonation: '*hmm I guess so'*. Immediately after this, in line 13, the therapist marks the end of the session without providing the patient a chance to respond in detail or finish the sequence she had started in line 5. Line 13 is pragmatically started with '*anyway*' (a concluding pragmatic marker (Levinson, 1983), followed by '*it's time to stop*' in a lower intonation. The patient uses the word '*cool*' again to accept what is happening and to show satisfaction with it but then pauses for 2 seconds, allowing an opportunity for the therapist to take a turn. This demonstrates that the patient may be expecting something else before the very end, but then she thanks him, followed by another pause. The patient concludes by saying '*bye*' to the therapist. The therapist does not audibly respond to the patient, and the session ends; therefore, the therapist does not take a conversational turn in responding to the patient's goodbye. The turn-taking stops in the final minute in an unexpected way; within average conversations and discussions, there would not be a sudden termination of dialogue and unresponsiveness to vocal linguistics such as greetings to start and end conversations. The abrupt nature of what happens in the vocal process between the patient and therapist could lead to further apprehension or mistrust of the therapy and therapist. This was a process that took place in the final stages of the session.

The key feature of this type of ending is related to the unexpected nature of the ending and the suddenness of the final minute. It was noted in the wider data

analysis of the final stages of the session that instead of the patient being interrupted in her process, the therapist seems to be making his point and then declaring the end of the session.

Category C – The organic ending

This example is taken from session 8. There were three sessions with this type of ending. The patient and the therapist have together been talking about how the patient manages her emotions and moods. The therapist is exploring with the patient how she experiences feelings. The final phase of the session has a dyadic flow where the turn-taking process is happening in a natural way. In this particular type of ending a pattern of synchronicity is identified, which is not clear in either the interrupted or the abrupt endings.

Final minute of the session:

1. **T** – well I think there's something about ↓ (.) I think you tell me about
2. somebody that can ehm you can feel very enthusiastic about things ↓ (.)
3. and really keen ↓ (.) and (1) If that's how you feel you also get ° hurt ↓°
4. more ↓(.)↓ it hurts more °
5. **P** – ↓mmhhm
6. **T** – so in a way it's a bit like kind of perhaps (.) somebody who's very
7. passionate ↓but is really trying not to be but she can't quite ↓ hide it ↓
8. **P** – yeah

9. **T** – so that's when you get upset and <u>you really get upset</u>

10. **P** – yeah (*laughs softly*)

11. **T** – it's not that it doesn't ↓ hurt ↓ (.) it really <u>does</u> (.) anyway

12. **P** – (*slight laugh*) ok (*breathing sound*)

13. **T** – we have ↓ to stop ↓

14. **P** – thank you (*animated tone*)

15. **T** – bye-bye

In lines 1–4 the therapist is expressing his reflections about the patient's emotional experience. In line 1 he lowers his intonation, followed by a pause; he repeats this pattern in line 2 and twice in line 3. In line 4 an opening is left for the patient to respond and take her turn. The patient uses this opening by making an acknowledgment sound in line 5 that is not a clear agreeing or disagreeing response to the therapist's reflection. Her intonation commencing at a lower tone mirrors the therapist's tone in his prior turn.

In line 6 the therapist continues in a similar pattern, making use of a pause; then, in line 7, he lowers his intonation after emphasising the word '*passionate*' as part of the patient's emotional experience. He emphasises the word '*be*' and then lowers his intonation when stating '*hide it*' to the patient. The patient, in line 8, responds with certain agreement '*yeah*', followed by a laugh. The therapist carries on with the exploration in line 11: he lowers his intonation when using the word '*hurt'*, followed by a pause, and then emphasises the word '*does*'. There is another pause, and then he uses the word '*anyway*'. The use of '*anyway*' by the therapist brings in a

'concluding pragmatic marker' (Levinson, 1983) to shift the talk and, therefore, the therapy session from an exploratory dialogue to an ending, with no transition communication. The patient responds to this with the word '*ok*' in the middle of a slight laughing sound and then a breathing sound, which is recorded and transcribed as it is heavier than usual, perhaps an attempt at responding to the concluding pragmatic marker.

In line 13 the therapist informs the patient that they have to '*stop*'. Up until this point the therapist has been exploring with the patient, allowing her turns, and the patient has been agreeing with the reflections offered. The therapist makes use of lowered intonation for the final time in this sequence with the words '*to stop*' in line 13. The patient uses an animated tone to thank him in line 14. The patient is noted to be marking her response to the ending by her heavy breathing in line 12 and by using a tone that is different from her natural way of speaking. Her animated thanks may indicate her response to the ending of the session. The therapist acknowledges her thanks and ends the session completely by saying goodbye in line 15, '*bye-bye*', taking his turn, and allowing an opportunity for the patient to end the vocal sequence if she wishes by having another turn.

In the lead up to the final minute, the therapist has used the ending phase of the session to explore the internal world of the patient; this seems to have been received by her, as evident through her minimal yet affirmative responses towards the end of the session. In the organic sessions the patient is more responsive to the therapist, and they arrive at an ending after following a dyadic pattern in communication. The ending does not come across as sudden or interruptive; there seems to be a reflective pause, and the patient can express her depression by losing a level of animation, which is more apparent in the other sessions, and by being

quieter herself. Her breathing more heavily is also an indication of a more somatic response. There may also be a hypothesis that she is potentially demonstrating some adolescent rebellion by choosing not to return the goodbye greeting at the end.

Overall, organic endings can be viewed as a process between the patient and the therapist; they arrive at the ending together rather than the session being marked complete by the therapist, which can signal a communicative atmosphere of interruption or abruptness. The dyadic quality of these endings can also be observed in the prepared endings discussed in the next category.

Category D – The prepared ending

This example is taken from session 13, in which the therapist has been discussing holidays as breaks in the therapy and relating them to therapy's ultimate end. The broader context of endings is introduced near the end of the session; different types of endings such as breaks and session endings are also discussed by the therapist before the ultimate end of the therapy session. Two sessions had this type of ending, where the therapist attempts some kind of preparatory context in general but also gives the patient an opportunity to prepare for the therapy session's particular end before it arrives. The patient's responses are minimal, and it is hard to gauge how she is impacted by the preparation or the wider discussion of endings; the theme of endings being explored in the final stages of the therapy session may feel like too many endings at the same time. This particular session was also the final session before the patient dropped out of therapy.

Final minute of the session:

1. **P** – =↑yeah/see I kind of↑ find it hard to relate things like these to therapy↓
2. (.) because I'm so blasé about it
3. **T** – but this ↑ is this therapy ↓
4. **P** – yeeeahhh ↓
5. **T** – this is what happens ↑
6. **P** – ↓ hmm ↑ (laughs)
7. **T** – ↑ we're going to have to end in a minute
8. **P** – ↑ (laugh) yeah
9. **T** – ↓ even less time ↓
10. **P** – yeah ↓ (laugh)
11. **T** – whether you'll have any feelings about that or not (.) 'cause I don't know
12. whether you really are blasé (.) I wonder whether it's difficult particularly when we're
13. <u>ending</u> kind of to think (.) maybe blasé is a way of being you know (.) you talk
14. about somebody acting or being <u>different</u>
15. **P** – yeah
16. **T** – not being quite really who they are (.) it's time to stop (*T laughs?*)
17. **P** – laughs (2) ↑ goodbye (animated tone)

In the final minute of session 13, the therapist and the patient commence the ending sequence to this session by 'taking conversational turns' (Sacks, 1975) as a process of 'joint activity' (Clark, 2006). Turn-taking can be observed in lines 1–10. The therapist responds in line 3 to what the patient has said. The patient, in line 4,

has an opportunity to respond and uses her turn to give a prolonged agreement in a lower tone. The therapist then reflects in line 5, '*this is what happens*', raising his tone, and the patient acknowledges his comment via a sound ('*hmm*'). Her acknowledgment followed by laughter leads the therapist to clearly state in line 7 that the session will need to end soon: '*we're going to have to end in a minute*'. The patient laughs at this, and in line 9 the therapist acknowledges the time again. It is unclear why she may have laughed.

In lines 11–14 the therapist summarises his stance on what might be going on with the patient, and there are four pauses in the therapist's closing interpretation/comments. The length of the pauses is under a second, indicating that they are pauses for thought. Within the Jefferson method, these could be analysed as 'standard maximum' (Jefferson, 1989b), which indicates that they do not cause a conversational 'rupture' (Safran,, et al. 2011) by being too long.

In line 16 the therapist ends the session completely by making a comment that could be interpreted as a question: '*not being quite who they really are*'. He then ends by stating '*it's time to stop*'. Although it is difficult to be certain, due to the quality of the recording, the author hears both the therapist and the patient laughing at the end (consensual analysis also found this), indicating they are both sharing a non-vocal experience together. Although there is no time for the patient's turn, in lines 16 and 17, the patient and the therapist together mark the ending through a shared sonic experience of laughter. The patient says '*goodbye*' in a tone that is animated (line 17), and no verbal response is given to her by the therapist; therefore, he does not take his turn in an expected way. The patient's communication style of using an animated tone returns, this time as she says '*goodbye*'; this may represent

her challenge to the therapist, downplaying the theme of endings that he has introduced.

There is an element of a dyadic rhythm to these sessions, which is also noted in organic endings, with the patient responding to the therapist's comments about what is going on. The patient and the therapist sounded harmonised in the lead up to the end of the session as reflected by fewer overlaps or interruptions in the final minute. In terms of his therapeutic technique, the therapist may be trying to prepare the patient for the ending of the session as well as endings in the wider context; however, doing this at the end of the session, rather than earlier in the session, may have seemed overwhelming to the depressed patient.

In this particular category of prepared endings, the therapist facilitates an ending, with there being a noted mention of the approaching end of the session before it actually does end. This removes any surprise elements before the therapist and the patient depart until the following session.

Discussion

The aim of this study was to explore what happens as the end of individual therapy sessions between a psychoanalytic psychotherapist and a depressed adolescent patient approaches. This exploratory study was focused on the notion of endings for this particular therapist and patient, in relation to their vocal interactions with each other at the end of their sessions together, and its implications. By focusing on the end of the sessions, the current study aimed to address a gap in the current literature, where scant attention has been given to how sessions end.

Endings have been explored, in a broad manner, in recent years as a phase of treatment; in particular, the need to have ‘good enough’ endings with patients who are engaged in psychoanalytic psychotherapy has been studied (Holmes, 1997, 2001;; ,Lanyado, 2018, 2004). It provides; Parsons, 2004 time and space to review the patients’ progress, to work through any difficulties in the therapeutic relationship, as well as to think about accessing therapy again in the future. Specific session endings and their influence on clinical treatment remains an unknown within psychoanalytic psychotherapy. The present study, by using CA and paying attention to the final stages of each session, found that certain linguistic characteristics could be identified when sessions came to an end between this particular therapist and patient. A broader analysis of the ending phase of the session and a focused CA detail on the final minute helped classify the session endings for this patient into the following categories: A – interrupted endings, B – abrupt endings, C – organic endings, and D – prepared endings.

Similarities and overlaps were observed between the categories, highlighting that the therapist did not use a single technique in ending the sessions. The patient’s experience of being interrupted or surprised by the ending, which she highlighted in her post therapy qualitative interview, was particularly relevant to this case. The context of this case study is one where the patient chose to drop out of the treatment. There were a set number of sessions (28) offered to her as part of the clinical trial, but it is hard to determine from this study how these factors may have contributed to her decision to drop out and how she experienced the session endings. Holmes (1997), in his article on treatment endings, does point out that psychotherapy treatments carry a multitude of endings that influence the final important ending of treatment. Holmes chooses to focus on breaks in the treatment

as smaller endings, both planned and unplanned, that may influence the final ending. However, individual sessions' contributions to the final ending of treatment is yet to be explored. This study attempted to initiate this exploration.

Hurry's (1977) clinical case study indicates that what is said by the therapist at the ending phase of a session makes a significant impact on the patient's mind and experience of therapy. For the patient in this case study, Hurry's hypothesis could be in its primary stages of being tested as the patient herself mentions her experience of being interrupted or surprised by how therapy sessions ended. There would need to be further studies to explore how the ending of each session may relate to the ending and outcomes of therapy itself; however, this study makes nascent attempts to encourage clinicians to think about the ending of individual sessions and their potential importance for the patient.

Limitations

The limitations of this study pertains to its single-case-study design. While it highlights that the therapist and patient under consideration ended their sessions using the four particular categories found in this treatment, these findings cannot be automatically transferred to other cases. It cannot support larger claims, such as how the sessions end and their importance for the patient or its link with this particular patient's choice to drop out. It is impossible to determine if similar cases would produce similar categories or altogether new ones; potentially some therapy treatments may have more than four categories and some may have a consistent manner of ending. The influence of session endings on patient experience and outcome of the treatment could be of clinical relevance and can, hence, be

researched further. However, it currently remains an unknown within the extant literature and empirical studies.

Further limitations of this study include that its focus was on a psychoanalytic case, exploring things from only this modality of psychotherapy; it also had limitations that stemmed from the patient's particular age and stage of development. The findings, therefore, are located within the unique context of psychotherapy, with a particular approach, a patient who is in a particular phase of development, and a particular diagnosis. Being a small-scale study, it did not offer opportunities for a wider exploration of the different types of psychotherapy or different kinds of patients from this particular clinical group; therefore, it can only give a small insight relevant to the case study under consideration.

The methodology applied in this study also has limitations. The transcription of audio recordings allowed for a detailed vocal CA; however, elements such as body language, somatic experience, and clinical atmosphere could not be noted or analysed. Another limitation of the method concerns the long duration of time needed for CA. The process of segmenting data, transcribing, analysing, and then presenting to the supervision group for transcription analysis was labour and time intensive, leading to a limited amount of material in each session that could be formally analysed using CA. This highlights that CA may not be suitable for research projects that have restricted resources, and it may be more appropriate with smaller samples.

Conclusion and future direction

This study has initiated an exploration of the area of clinical practice related to the endings of individual psychoanalytic sessions with depressed young people. This

is an area of clinical practice that is yet to be studied and researched in depth; therefore, this study attempts to foreground its relevance to treatments and their reception.

Further research with other cases using the same design is needed to confirm if these categories of session endings are specific to the therapist in this case, or are more widely applicable, and to ascertain if further categories can be established. Furthermore, it would be clinically important to understand if certain categories of endings strengthen or potentially hinder the treatment process and outcomes. This involves employing CA to provide information about how the sessions end, coupled with a psychoanalytic understanding in order to address why the sessions may be ending the way they are and its potential implications on the patient and treatment outcomes.

It is hoped that the present study might offer an example of research on session endings and some clinical considerations as to why session endings are important and need to be further researched.

Within my own practice as a child and adolescent psychotherapist, I have become more mindful of preparing patients for the session endings and have come to realise that the end of the session can be extremely difficult for some patients.

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Part 3

Reflective Commentary:

A diagnostic profile of carrying out empirical research as part of psychoanalytic psychotherapy training

Abstract

Modifying Anna Freud's original categories for the diagnostic profile (Freud, 1965), this paper will explore a trainee child and adolescent psychoanalytic psychotherapist's experience of completing an empirical research project as part of their overall doctoral training. It will explore the personal and professional experience of encountering the research field and the engagement and resistance of the research project within the different aspects of the training program.

***Keywords*:** Provisional Diagnostic Profile, psychotherapy training, research.

Introduction

Anna Freud herself was considered a researcher in the field of psychoanalysis. As Lustman (1967) reminds us, Freud was able to use observation and other research methods to deepen her understanding of psychoanalysis, and she made key contributions by researching clinical tasks at the Hampstead Child Therapy Clinic (now The Anna Freud Centre). Like Sigmund Freud, Anna Freud used research methods to deepen the understanding of the practice of psychoanalysis and, crucially, to develop techniques for working with patients. Her pioneering work was even considered to be more research- and education-based than purely psychoanalytic (Young-Bruehl, 1988). This paper aims to make use of the Provisional Diagnostic Profile, a research and assessment tool created by Anna Freud, while also considering how the empirical research element of child psychotherapy training can be experienced. It will use original categories from the profile modified into headings that relate to the author's experience of research within the current doctoral training.

The Provisional Diagnostic Profile is an assessment tool developed by Anna Freud that reflects her ethos of understanding a child in their entirety. Essentially, the Diagnostic Profile aims to clinically research the child’s life by taking into account as many aspects of their life as it can as well as to observe and assess the child in order to come up with hypotheses and provisional formulations using as much information as possible about the child. Anna Freud’s stance can be considered as one where the patient is encountered as an exploratory research study by the clinician who will learn as they go along, without any set answers about pathology or treatment.

Malberg and Pretorius (2017) explain the importance of developing a psychoanalytic diagnostic framework using tools such as the profile. Such an approach to childhood mental health would highlight the value of observation, encourage the integration of various disciplines in the process of exploring a child’s world, and then construct a picture which includes the influence of ‘*external forces in the process of personality development and organization*’ (Malberg & Pretorius, 2017). Malberg and Pretorius emphasize not only the clinical value of such a framework but also its usefulness in communicating findings to professional practice systems, since the sharing of clinical practice across disciplines is in the best interest of the child.

The Diagnostic Profile was originally developed with Freudian metapsychology and drive theory at its core. In 2001, a research group congregated to consider how the profile could be updated and put to better use in the current psychoanalytic climate. In 2016, the group eventually created an updated version of the profile, which included responses to new perspectives on development rooted in contemporary empirical research, shifting psychoanalytic emphases, and the cultural

context within which we work (Green & Joyce, 2016; Malberg & Pretorius, 2017). The aim of the new profile was, additionally, to be more user-friendly and, hopefully, to serve as a tool that trainee and qualified child psychotherapists could access to enhance their practice by understanding a child to a greater degree. Further, they hoped that its use would lead to better treatments and outcomes that were individualized with the child in mind rather than presumptions based on prior knowledge the clinician might hold (Joyce, personal communication, 2019).

Elements of the child psychotherapy training

In the current climate of the NHS, where training placements for child psychotherapists tend to take place, the presence of the Diagnostic Profile has been lost. This is also true within training institutions. The new profile has not reached circles outside the Anna Freudian tradition, and in my experience, even if it is passed on by an Anna Freudian supervisor, the time constraints and constant demands of the overworked clinical environment do not leave any time or energy to accomplish such an extensive task. Furthermore, the profile is not in the ACP training requirements, and some supervisors feel that asking the trainees to accommodate the Diagnostic Profile in addition to their regular workload might prove burdensome (Zaphiriou Woods, personal communication, 2019).

I felt fortunate as a trainee to be supervised by people who had extensive experience of the Diagnostic Profile and who wanted to pass on this fundamental learning. Even with my intensive workload, I was encouraged to take on the task of completing the Diagnostic Profile to enrich my psychoanalytic training and understanding of the extensive psychoanalytic assessments that investigate the entirety of the patient’s life before making treatment choices. The Diagnostic Profile

became an integral part of my training, influencing my assessments and understanding of the children I encountered clinically. However, the process of fully understanding the profile was a daunting one. I found that my initial encounter with it brought up many feelings of inadequacy; it felt like a large piece of work that I did not have the time to do. Furthermore, I felt the profile used psychoanalytic language I was not familiar with or did not fully comprehend. My initial Diagnostic Profile was the original 1965 version. Subsequently, I went on to complete the 2016 version and understand the differences between them.

Over the four years of training, I was guided by two different supervisors to complete different profiles, and I gradually felt less intimidated, more engaged with the process, and able to approach the profiles with a desire to learn about the child. My focus changed from a narcissistic point of reference concerning what "I" can or cannot do to a more curious and interested point of reference that allowed me to realise what could be learned about the child and how this tool could help me to help them. Now, as I complete my child and adolescent psychoanalytic psychotherapy training, I can think about the implications of the process of completing the profile in relation to my understanding of the child's world. Some of my experiences with the Diagnostic Profile were echoed in my four-year process of coming into contact with a research-orientated world at The Anna Freud Centre. I feel there were parallels in my experiences of both the research requirements and my choice to learn about the profile.

Similar to the Diagnostic Profile, I felt the empirical research project was daunting and raised feelings of inadequacy. I came to training with no prior research experience and, as I sat in Year 1 with other students completing other trainings in introduction classes, I really felt out my depth and overwhelmed. The language being

used felt alien, the surroundings and environment mismatched, and I felt hugely disorientated. I was aware that Anna Freud had accommodated the Wednesday case discussions in the library where we now sat discussing statistics. The Freud statue was looking down at the students, and various books on psychoanalytic history and wisdom sat around the space while statistics were being taught as a part of research methods. It was a strange experience, and I found myself fantasizing about being part of "proper" psychoanalytic training, where cases would be discussed as subjects of research. I had a sad sense that I had come to the training at a time when something very valuable was being lost, and I did not see the research element as valuable experience at the beginning of my training. I was eager to do well and apply myself, but my efforts felt forced, I was not enthusiastic about the research tasks, and I felt they were duties to be completed in order to check the boxes along the path to the Doctorate. Although I was encouraged to view my training as an interlinked process, I could see that my engagement and libido were far more invested in the theory seminars and in my clinical practice.

The NHS placement, in my experience, was hostile to elements of the four-year training that did not align with the system that already existed. Time constraints and lack of awareness meant that there was no space for the Diagnostic Profile in assessment procedures, and I also felt that my placement did not have a space for my research-based tasks. The following section will further explore some of the ideas and thoughts introduced above, using Diagnostic Profile categories. I have selected the category titles from the original Anna Freudian profile. I have renamed sections from the original Diagnostic Profile as categories and will number them as I further explore and reflect on my experience.

Personal history related to research

Over the course of my professional and academic journey I had avoided having to partake in research. My undergraduate degree was in social work, which provided the option of continuing into an honorary year consisting of completing a research project. Desperate to start working, I chose not to take this option. At the time I felt that I wanted to do “real work” and not hang around the University for another year. I made a similar choice during postgraduate therapy training, where again I decided not stay on in academic studies that were research based. In considering child and adolescent psychoanalytic training, after completing my observation pre-training requirements, I had planned a research question and proposal and had secured a place to complete an MA research dissertation; however, concerning the observational training that was prerequisite for the Doctorate, I got entry a year earlier than planned. Therefore, in an uncanny way, the pattern of not engaging with research as part of my academic training repeated itself.

Unconsciously, I continued with my attitude of regarding clinical work as the authentic work and relegating research as secondary. Consciously, I was ecstatic about coming to London and engaging in the training, and I was very excited about learning both independent and Anna Freudian-influenced psychoanalytic practices. I was aware that I was in a training course that had an academic research-based component, and while I consciously agreed to take this research on, I do not think I was excited about it. In contrast, I was daunted. Furthermore, I think the impact of moving just before the training, changing analysts, and culturally acclimatising myself were all difficult; therefore, finding familiarity in the clinical work helped ground me. The research, however, was something I had to tackle from the very beginning; it was therefore a more difficult task.

I chose the category of endings as my project for the empirical research. Reflecting back on this choice, I was drawn to this topic because life as I had known it had just gone through its own ending. I had moved to London to do the training and was adjusting to a completely new lifestyle. I believe there is an element of entering a new lifestyle for all the trainees. In my case this may have been heightened by my move across countries. Similarly, everybody had to take on the temporary identity of a trainee. For me, losing and ending my previous professional role was also hugely significant. Amidst the excitement of starting the training lay many anxieties, endings, and losses.

Possible significant factors: environmental factors in the training that are significant to the research process

NHS clinical placement.

The IPCAPA training program, being a collaboration between the Anna Freud Centre and British Psychotherapy Foundation, was itself something the wider child psychotherapy community were just getting to know. Although there was a trainee in my clinical placement from the IPCAPA training program, he had started the training before the Anna Freud Centre and UCL had become a part of it, so he did not have to complete the research elements. Whilst attempting to complete my first research assignment, which was a clinical audit, I really struggled to find my bearings. I worried how I would manage the audit in the clinic as a child psychotherapy trainee, since no other child psychotherapist trainees in my clinic had engaged with audits before. Eventually, I joined a quality-improvement project team that was working within the service. They were welcoming, and this helped move me along to a certain extent. However, the project was an isolating experience. The child psychotherapy

team showed little interest in what I was doing, and to my surprise, the clinical management team members within the placement were more interested and able to relate to what I was doing. This unfortunately added to my belief that research was of more value and interest to those outside the child psychotherapy field.

Through the course of the training, I had to keep reminding my placement supervisor of the research requirements. Requesting for study leave for the research workshops was also an issue, as my placement supervisor felt that we should use the weeks before academic holiday breaks to organise reviews for cases. The reality was that reviews were very difficult to manage during the course of the term alongside ongoing cases, and time was extremely limited. However, I felt a real resistance within the clinical placement against managing this issue in a creative way and allowing me to access the research workshops with less anxiety. I believe, within the placement, the research elements of the training often felt like an impingement. There were many times I also felt this way, especially when there were cases that proved difficult, and I had to give up sessions to attend the longer research workshops.

Overall, I did not feel my NHS placement supported the research elements of the course. Little was required in relation to the research, interest was rarely shown, and in order to complete tasks on time, I had to be assertive and able to manage negative reactions. I observed a similar pattern when assessing cases. If I wanted to complete the Diagnostic Profile, then I had to advocate for the time this would take and facilitate the supervision for it on my own time. The placement did not see any merit in trying to support this learning.

Both the research and the Diagnostic Profile were supported outside the placement by supervisors involved with them, but neither the research nor the profile ever had a presence that was appreciated within the NHS placement. The clinical placement perhaps felt overwhelmed with the management of matters related to it directly, and hence, it was not easy for the placement to accommodate new developments or approaches.

Time constraints.

On our very first day of training, we arrived at the Anna Freud Centre for an introductory talk. As we were taken through the training program, I recall thinking how all these requirements would fit into four academic years. The geography of managing the clinical placement and analysis sessions already felt like a daunting prospect. Coming from a smaller city, training in London brought demands of commuting in general that felt overwhelming to me. The additional burden of the research program that was running alongside the clinical requirements of the training felt almost impossible to manage. Yet the program was being presented to us as a manageable prospect, which gave me hope, as did that fact that there were trainees in years above us who were already close to completion. I remember thinking that if even one of them could complete the training program in four years, then I should be able to as well. This was a positive thought to hold onto, and indeed the first-year group above us did have a trainee who completed the program and two others who followed close by. This was neither everyone nor even the majority; however, these examples sent a strong message to me that completing the program was possible. I could not always see this while I was in the process myself, but it was a good place to come back to when I felt I had no time to do all the requisite tasks.

Group dynamics: research project held in a group setting.

Prior to the commencement of the research projects, the whole cohort was kept together for all research teaching. We shared camaraderie, supported one another, and talked through our experiences to get to know one another, especially in the beginning. Nobody in the group had significant research experience, although the majority had some experience with master's projects or degrees that were psychology-influenced. The group dynamic at this time felt settled and maintained a supportive space.

Once the research projects had been chosen, the group was divided into two, which brought a new dynamic. The two groups were managed differently, having different supervisors, a situation which led to feelings of competitiveness about the inputs from their respective supervisors. Was one supervisor more caring and personable than the other? Was one able to better understand child psychotherapy? With both the groups held and managed differently, an assortment of feelings came up that were sometimes, in my experience, difficult to manage and even understand. Furthermore, we had our methodology selected for us and, in addition, a named supervisor to consult on matters related to the methodology. This could be perceived as either an advantage or a disadvantage, whereas the other group had a process of choosing methodology. Perhaps some of us found it useful to have the freedom of choice and others not so much. At times, feedback sessions in the whole cohort or within our groups felt difficult, and I found myself not wanting to present, preferring individual supervision.

Freud and Burlingham (1942) spoke of the dynamics within children's groups, examining what could be used to an advantage and how the groups in the war

nurseries they pioneered successfully worked. Their work with the Hampstead war nursery (Burlingham & Freud, 1942, 1943) pioneered the study of how children related to each other in a group setting. Others, such as Piaget (1969), would go on to speak about the benefits for children of learning and being in groups. However, Paulus (2000) highlights that this is not always conducive to adult learning, and groups of adults are not always placed well together. There were times when I felt being in a supervision group was more of a hindrance than a supportive or robust learning environment. Perhaps this was related to several different elements including the supervisor's teaching style, my own personal anxieties, group dynamics, and the group being subdivided and brought together as a whole at different times.

Libidinal development in research elements of the training

With all the insecurities and anxieties I had about the research, coupled with time constraints and often a lack of external support besides the Anna Freud Centre, I had to work hard at *'libidinally binding'* my aggression (Parsons, 2007) towards both the literature review and the tasks related to the empirical research paper. In this situation, the key questions I had to ask myself were: How can I help myself value and feel affection for these studies, and hopefully build some passion for them? How can I see them as creative learning processes and not just dry and crude requirements to gain a qualification?

When completing the literature review, I decided to keep a robust psychoanalytic focus, exploring how depression, endings, and adolescence are perceived within psychoanalysis and why research into endings is needed. The process of reading the psychoanalytic literature and reviewing its developments

strongly enhanced my knowledge base. I understood depression and adolescence in much greater detail, and I felt privileged to have a deeper understanding of these key areas, beyond what was offered in the clinical training. This was worthwhile labour. As I found myself enjoying the vast amount of reading, completing the literature review became more of a pleasure. This was my first draft, however. I did not actually go on to submit this literature review but created a second one that was more focused on a particular clinical phenomenon affecting depressed adolescents. It was a frustrating experience going through this process. I found myself again asking questions that would motivate me and help me build positive feelings towards this unexpected change. In my second attempt, I learned to a greater degree about the techniques and external factors that influence dropout in adolescent cases. This added to my learning and knowledge, which I found quite valuable.

Similarly, after completing the empirical project using Conversation Analysis (CA), the manner in which I listened to patient material and sessions changed, and I felt I connected to techniques that linked me back to Freud. Listening to the data for the research study enhanced my listening skills as a clinician. CA studies pay attention to the '*design of the utterances*' (Drew & Heritage, 1992), such as choice of words, syntactic properties, intonation, rhythm, and other elements of prosody in speech that take place during the encounter between therapist and patient.

Often these skills are lost in training for child psychotherapy, where we look at play and symbolism to an extensive degree, while unsuspended listening (Freud, 1912) to verbal material is not given the same priority it would have when working with adults. Having this experience of CA felt really important; it was something I could enjoy as well as learn from. Opting to do a single-case study project also felt like an enhanced clinical activity, in which I got to "know" the case well through the

recorded sessions and available data. I felt I built a level of intimacy with the project that might have been lost had there not been a single-case study. Listening to the same therapist and patient and following through the treatment by listening to each session in the research study allowed for a deeper understanding of what was beneficial and challenging within this particular therapeutic dyad. In this process, I often reflected on my adolescent cases.

Ego development in child psychotherapy research

So far, I have focused on the challenges of my research experience. My research learning was very much a process of development, and I have had to hold on to the notion that all development comes with challenge and loss. Development is, however, an achievement and can be a process of strengthening the Ego. I feel that, now that I have completed the clinical training and I am preparing for my *viva voce* exam, I can reflect upon my achievements, what I have learned, and what I have come to value. Psychoanalytic psychotherapy is part of a wider network of working systems, and having a research base is just as important for us in the field of psychotherapy as it is for any other discipline. This was certainly a stance Anna Freud took in developing child analysis and psychotherapy. Developing skills around how we do what we do, and whether or not it is effective, is fundamentally important if child psychotherapy wants to grow and develop as a field. I particularly realised the importance of research studies that take into account a larger reality, and not just the clinician’s experience, when I encountered the IMPACT ME study (Midgley et al., 2014) as part of my project. I came to understand the adolescents’ and parents’ experiences of taking part in the trial and encountering psychotherapy (O’Keeffe et al., 2019). The importance of learning from adolescents’ and parents’ experiences, in my view, is vital when contemplating building treatment alliances as a clinician. I also

had a real sense that my empirical study gave me clinical insights that I would not have had otherwise. Paying attention to endings and, in particular, to how sessions end supported my clinical work, giving me a finer focus in this part of the sessions than I would have had if I had not completed the research study. I also believe that learning CA, my assigned methodology, has sharpened my attention as a clinician to verbal and vocal phenomena that arise within the psychotherapy sessions as well as the dyadic turn-taking.

Having now developed a language and foundation for research, I feel far more confident in bringing my research and clinical practices together. I feel able to have conversations and ask questions when other disciplines present research, and I feel I have bridged a gap, to some degree, between my own discipline of child psychotherapy and other disciplines such as clinical psychology and psychiatry. Perhaps there is also more of a bridge being built within myself between clinical practice and research, one that I will come to appreciate in my post-qualification life.

Conclusion

I began this paper by highlighting the researcher in Anna Freud as a pioneer in child psychoanalysis and psychotherapy, focusing on her Diagnostic Profile. I have used it as a template to discuss my experiences as a trainee while completing the research elements of the training program. I have learned to value having completed my training and research with input from the Anna Freud Centre. My anxieties, insecurities, and the demands of the clinical training got in the way for the most part, and I often completed what I had to do from a cognitive space as opposed to a creative one. When I did fully engage with and relate my tasks to psychoanalysis

more directly, I found the experience enriching and supportive to developing my clinical work. Letting my anxieties settle and becoming more confident in engaging with research has helped develop the skills that I hope to carry forward in my post-qualification life. Although, as I now find myself in qualified child psychotherapy posts, I am not sure that child psychotherapy research, like the Diagnostic Profile, is allowed a place within the strained NHS and childcare settings.

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