The therapy process with depressed adolescents who drop out of psychoanalytic psychotherapy: an empirical case study

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Abstract

Psychotherapy dropout is a common phenomenon in youth mental health, often due to dissatisfaction with treatment. However, little is known about the therapeutic processes that precede dropout due to dissatisfaction. This mixed-methods empirical case study aimed to explore the therapeutic process of a 12-session, prematurely ended therapy with a young person with depression in short-term psychoanalytic psychotherapy (STPP). The Adolescent Psychotherapy Q-set (APQ), an empirically validated process measure, was used as a framework for qualitative analysis exploring the therapy process over time. Analysis of APQ ratings of the 12 sessions found a productive patient-therapy dyad working collaboratively to understand the young person's experiences and emotions. Following an initial phase of the young person presenting as emotional and vulnerable, she became increasingly ambivalent about continuing in psychotherapy. A lively and argumentative period exploring the young person's ambivalence and increased sense of well-being culminated in eventual dropout. This study suggests that even in a strong, collaborative working relationship with an engaged young person, ambivalence around dependency and vulnerability can threaten treatment completion. Therapists' enhanced sensitivity to relevant processes that precede therapy dropout have the potential to improve engagement of young people in psychotherapy, which may optimise outcomes.

Keywords: *adolescence; psychotherapy process; psychoanalytic psychotherapy; case study;; dropout; STPP*

Introduction

Adolescence in Western cultures is understood as a time of great change and potential turmoil with unique developmental tasks and challenges. Psychodynamic conceptualisations consider adolescents' high levels of ambivalence, the negotiation of peer and romantic relationships, growing independence and separation from parental figures as some of the tasks necessary to establish a stable adult identity (Stambler, 2017). Failure to adapt to these developmental demands can cause internal and external conflict and, in some cases, clinical levels of depression (Cicchetti & Rogosch, 2002). Talking therapies have been identified as effective, including cognitive-behavioural therapy (CBT), interpersonal therapy (IPT), short-term psychoanalytic psychotherapy (STPP), or a combination of psychological therapy and anti-depressant medication (National Institute for Health and Care Excellence, NICE, 2019).

Despite the overall effectiveness of psychological therapies, it has been estimated that between 28% and 75% of young people drop out of therapy (de Haan et al., 2013). In a recent large-scale clinical trial – the IMPACT study – comparing psychological treatments for adolescent depression, of those adolescents who attended at least one session the dropout rate was 41.6% (O'Keeffe et al., 2019). However, dropout level varies hugely depending on how it is operationalised. Treatment dropout is widely defined as an ending of therapy not mutually agreed between patient and therapist, but can have different definitions, e.g. minimum treatment length or independent patient decision (O'Keeffe et al., 2018). Research exploring dropout in adolescent therapies has primarily focused on risk-factor models (Kazdin, 1996), examining the effects of pre-treatment factors, treatment factors and patient characteristics. In the IMPACT trial, older age, the presence of antisocial

behaviour, lower verbal intelligence, lower therapeutic alliance early in treatment, and early missed sessions were found to be associated with increased risk of therapy dropout in the context of adolescent depression (O'Keeffe et al., 2018). Another study of psychotherapy for young people who had experienced trauma found that lack of caregiver attendance and low parental treatment approval predicted adolescents' dropout of therapy (Ormhaug & Jensen, 2016). There is mixed evidence as to whether dropping out of treatment necessarily leads to poorer outcome in adolescents (Edbrooke-Childs et al., 2021; O'Keeffe et al., 2019). There is a need to better understand the process of therapy dropout among adolescents, to inform how treatments can better meet the needs of young people.

A crucial approach to improving our knowledge of dropout in adolescent therapy is a client-led perspective. O'Keeffe and colleagues used retrospective client and therapist reports to differentiate between adolescents dropping out of treatment for different reasons (O'Keeffe et al., 2019). Some young people reported they 'got what they needed' from therapy, whilst others appeared 'too troubled' by other life stressors to focus on therapy. A third group explicitly expressed dropping out because of dissatisfaction with aspects of treatment. The therapists of such dropout cases reported a reluctance in the young person to engage. These findings shed light on particular types of dropout that might be expected to fare worse in therapy, e.g. 'dissatisfied dropouts'. However, adequately powered studies to investigate whether treatment effectiveness does actually differ between dropout types are still needed (O'Keeffe et al., 2019).

Conceptualisations of in-therapy processes leading to drop out are typically theoretical in nature. Blotcky and Friedman (1984) conceptualise potential processes in treatment dropout as including: (1) denial of depressed feelings by translating

them into action and drop out of treatment to free themselves of the exploration of emotions in therapy; (2) unaddressed difficulties in the adolescent-therapist relationship, such as rebellious feelings in the transference; (3) strict adherence to a therapeutic model without attention to the young person's suitability to the treatment, which might leave the young person feeling misunderstood and left out of treatment decisions; and (4) parents undermining the therapeutic work through overtly and covertly pressurising the young person to abandon treatment.

Limited empirical research on in-therapy processes preceding dropout has been conducted. One recent study explored the in-therapy processes using an observer-rated measure of ruptures in the therapeutic alliance. The authors found more confrontation and withdrawal ruptures in the sessions for dissatisfied dropouts, compared with adolescents who completed treatment and those who dropped out reporting that they had 'got what they needed' (O'Keeffe et al., 2020). They also observed that 'dissatisfied dropouts' had comparably lower working alliances than the other two groups and that their working alliance scores declined over the course of therapy. Taken together, this research supports some of Blotcky and Friedman's (1984) conceptualisations of dropout. Importantly, it highlights in-therapy processes, patient-therapist interactions and therapist activity as highly promising areas of research into the potential factors contributing to dropout.

Of the three distinct types of dropout identified in previous research (O'Keeffe et al., 2020; O'Keeffe et al., 2019), the dissatisfied group is particularly worthy of further examination to elucidate therapeutic processes influencing dissatisfaction that may be avoidable. This has potential for adaptations of technique that could address aspects of therapy experienced negatively by young people. The current study therefore aims to explore the therapy processes that may precede dissatisfied

dropout in STPP for adolescent depression, by conducting an empirical, mixed-method case study.

Methods

Setting for the study

This study was part of, and uses audio data collected for, the Improving Mood with Psychoanalytic and Cognitive Therapies (IMPACT) study, a randomised controlled trial assessing the clinical and cost effectiveness of three psychological therapies in the treatment of adolescent depression (Goodyer et al., 2017). To situate the case study, the current study also draws on interview data from the IMPACT-My Experience (IMPACT-ME) study, a qualitative, longitudinal study investigating expectations and experiences of young people, parents, and therapists taking part in the IMPACT trial (Midgley et al., 2014).

The present study focuses specifically on the STPP arm of the IMPACT study. STPP is a manualised psychoanalytic once-weekly treatment model for adolescents delivered in 28 sessions (Cregeen et al., 2016). STPP is designed to respond to adolescents with a complex clinical picture including losses, trauma and developmental difficulties. STPP builds on theoretical formulations of depression and has clearly formulated aims and techniques based on psychoanalytic principles (Cregeen et al., 2016).

The study used an exploratory, single-case, direct-observation design to explore the therapeutic processes preceding dropout.

Case selection

The sampling criteria for case selection were as follows:

a) allocated to the STPP arm of the IMPACT trial;
b) categorised as having dropped out of STPP by the therapist;
c) classified in a previous study of the dataset as having dropped out due to dissatisfaction with treatment (see O'Keeffe et al., 2019);
d) had attended of a minimum of 6 sessions prior to dropping out;
e) therapy session recordings being available to enable therapy process exploration of an entire therapy.

Of the three cases meeting these criteria, one was selected at random. The young person sampled for this single-case study identified herself as 'White'. She will from here on be called 'Megan'. (For details about Megan's presentation at the start of therapy, see 'Results', below).

Data and measures

The primary data used for analysis of the therapy process were the audio recordings of Megan's psychotherapy. Primary analysis was undertaken using the Adolescent Psychotherapy Q-set (APQ). The APQ is a pan-theoretical therapy process measure suitable for quantitative analysis, describing the psychotherapy process in adolescent therapies in basic language (Calderon et al., 2014). It is comprised of 100 statements on the therapeutic process that are ranked according to their prominence within a session. The set of 100 ranked items creates an individual session profile, or Q-sort, which allows for statistical analysis of all its constituent parts, rather than focusing on one particular dimension (Calderon et al., 2017; Jones & Ablon, 2005). The items are grouped to describe: the young person's feelings, experience or

behaviour (e.g. item 84 ‘Young person (YP) expresses angry or aggressive feelings’); the therapist’s actions and interventions (e.g. item 27 ‘Therapist (T) offers explicit advice and guidance’); the interaction between the therapist and young person (e.g. item 38 ‘T and YP demonstrate a shared understanding when referring to events or feelings’) (Calderon et al., 2014).

A clinical judge studies the entire therapy session (transcript, audio, or video) before sorting each item into one of nine categories ranging from ‘least characteristic or negatively salient’ (1), to ‘neutral/irrelevant’ (5), and ‘most characteristic or salient’ (9), according to a fixed normal distribution. The forced distribution method ensures that coders prioritise one item over another and is aided by a digital sorting application (Dawson, 2013).

The first author was trained in using the APQ and attained reliability. The audio recordings of sessions for this case were coded by the first author, and 25% of sessions were double coded by two other reliably trained coders. The overall intraclass correlation coefficient was 0.722, which lay above the acceptable level (Ablon et al., 2011). The author was blind to the order of sessions unless reference to this was made during the therapy session. At completion of all coding, the order was unblinded to allow for further analysis.

Mood and Feelings Questionnaire

The primary outcome measure in the IMPACT trial, the Mood and Feelings Questionnaire (MFQ), was used to track the young person’s depression severity over time, at baseline, and at 6, 12, 36, 52, and 86 weeks (Angold et al., 1995).

Working Alliance Inventory

The Working Alliance Inventory (WAI), is a self-report measure, completed by patient and therapist, and was used to assess the quality of the therapeutic alliance at 6-, 12- and 36- weeks (Tracey & Kokotovic, 1989).

Qualitative interviews

In-depth interviews with the young person (before therapy started, after therapy had ended and one year later) and the therapist (at the end of therapy), conducted as part of the IMPACT-ME study, were consulted. These interviews were not formally analysed but were drawn upon to situate the case and enhance perspectives on the therapy process as presented in the main analysis. To prevent biases gained from this information, these data were only consulted after primary data coding and analysis had been completed.

Data analysis

To start with, simple descriptive statistics (means and standard deviations) were performed on the 12 blindly-coded APQ session ratings to identify the most salient items throughout treatment. Secondly, the order of therapy sessions was unblinded and a sequential qualitative reading of the entire data set allowed the author to identify two distinct phases of engagement. Thirdly, to identify differences in therapeutic process between these two phases, APQ item means were computed for each phase and differences between these two means were then calculated. Finally, further analysis tracked APQ item clusters that were relevant to the research question. A three-item cluster named ‘disengagement process’ consisted of items 73 (YP committed to therapy), 75 (T focuses on ending) and 95 (YP finding therapy helpful) and was tracked across all 12 sessions. A three-item cluster named ‘sense

of wellbeing' consisted of items 28 (YP communicates sense of agency), 59 (YP feels inadequate) and 94 (YP feels depressed) was tracked across the last five therapy sessions.

APQ codings were the starting point of analysis, followed by qualitative analysis of APQ codings to piece together a dynamic and rich picture of the therapeutic process preceding dropout. Session transcript excerpts evidence the findings.

Reflexivity

This study was undertaken as part of the first author's training as a psychoanalytic child and adolescent psychotherapist. As a trainee member of the profession, the first author had an interest in STPP and in contributing to the growing adolescent therapy process literature. Regular supervision, by the co-authors, and double-coding provided a method of assessing the validity of the findings. The triangulation of findings with outcome data enhances internal validity.

Results

Overview of the case

Megan started treatment aged 17 years and had a baseline Mood and Feeling Questionnaire (MFQ) score of 46, indicating severe depression, substantially higher than the clinical cut-off for depression (≥26, Goodyer et al., 2017).

Megan had sought help from CAMHS on recommendation by a counsellor who had been supporting Megan previously. Megan's depression presented in the

form of marked periods of feeling low in mood, unmotivated, emotionally overwhelmed and angry, and she would cry for extended periods of time. Megan described in therapy sessions using alcohol to try to help her feelings of stress and loneliness. Yet she also presented as upbeat and thoughtful, and at times was functioning well both socially and in her education.

The therapy took place within a CAMHS clinic as part of the IMPACT trial and was delivered by a male psychoanalytic child and adolescent psychotherapist. Their early therapeutic alliance was high, as rated by both Megan and her therapist, but later decreased (see Table 1). Megan did not return to the therapy after session 15, having missed three previous sessions, of the 28 sessions on offer. At 6 weeks from baseline, Megan's MFQ score had reduced to 37 and continued to decrease at each time point up to the final research assessment at 86-weeks (see Table 2). Megan improved more than the average young person in the STPP study arm (see Table 2). Taken at face value, these scores also indicate that she was not experiencing clinical depression from about one year after treatment started. Megan did not take anti-depressant medication, although this had been offered. Megan's parents were not involved with the therapy despite parent work being made available.

Megan was interviewed by the IMPACT-ME research team at 36 weeks and 86 weeks about her experience of therapy. In these interviews she expressed dissatisfaction with her therapy, which placed her into the 'dissatisfied' dropout type (O'Keeffe et al., 2019).

Table 1: Working Alliance Inventory (WAI) scores as reported by Megan and her therapist

Week	**WAI score**

	Megan	Therapist
6	53	54
12	-	42
36	33	-

Table 2: Scores on the Mood and Feelings Questionnaire (MFQ) for Megan compared with the average MFQ score within the STPP IMPACT sample

Week	**MFQ score**	
	Megan	STPP arm in IMPACT trial
0 (baseline)	46	45.4
6	37	34.9
12	-	33.1
36	30	26.6
52	21	23.0
86	8	21.8

Note: 'STPP IMPACT sample' denotes those cases within the IMPACT trial that received STPP as treatment. Outcome measures for IMPACT STPP sample from tables in Goodyer et al. (2017, pp. 76-77, p. 82). IMPACT STPP data based on all data available from between n=83 and n=156 cases.

Overall therapy process descriptors

The seven 'most characteristic' and the three 'least characteristic' APQ items across all 12 sessions are shown in Table 3. The relative importance of the top and bottom end of a q-sort distribution is not necessarily symmetric. A rating closer to 9 indicates

an item is ‘most characteristic’ of the therapy, and a rating closer to 1 indicates an item is ‘lease characteristic’. Inclusion of items into the ten most salient characteristics was decided by the author upon qualitative analysis of salience.

Table 3: Overall therapy process descriptors. Ten most prominent (seven most and three least characteristic) APQ items overall

Item number	**Item description**	**M**	**SD**
9	T works with YP to make sense of their experience	8.83	0.39
60	T draws attention to YP’s way of dealing with emotions	8.58	0.51
98	The therapy relationship is a focus of discussion	8.50	1.00
6	YP talks about emotional interactions with others	8.00	1.28
50	T draws attention to unacceptable feelings	7.75	0.75
74	Humour is used	7.33	0.65
97	T encourages reflection on internal states	7.25	0.62
5	YP does not understand T’s comments	1.67	0.89
15	YP does not initiate or elaborate on topics	1.33	0.49
58	YP resists the T’s attempts to explore	1.17	0.39

Note: M=Mean; SD=Standard Deviation; T=Therapist; YP=Young Person. This table shows each item’s mean placement (between 1.0 and 9.0), and their standard deviation.

Based on the most/least characteristic items on the APQ, we get a picture of Megan’s therapy in which the therapist consistently works hard to make sense of

Megan's experience (item 9) by focusing on her internal states (97), the way she deals with emotions (60) and feelings she might find difficult to accept (50). Megan, in turn, initiates topics and elaborates (15), readily understands the therapist's comments (5) and allows further exploration (58). Their exchanges are also marked by humour and wit (74). Finally, the therapist consistently brings the therapy relationship into sessions (98). The following extract from session two gives an example of the above:

> ***Megan**: I guess in the past (...) it never really occurred to me majorly until, like, going out with [ex-boyfriend] or like, certain things made me really angry and stuff. Like, I noticed that I had to, like, breathe and calm down and stuff, erm. But yeah.*
>
> ***Therapist**: So, it sounds like (...) you could have quite a powerful response to these things. And it quite worries you how much you can react ("yeah") and feel out of control. And I don't know, I was thinking, maybe, maybe there was something about, thinking about 'what's this going to be like, coming here'. And whether you're going to have a bit of a reaction to it, (...) am I gonna upset you ("yeah", [laughs]) are you gonna feel vulnerable, are you going to feel all of those things, or are you going to feel cross, and would you really want to?*
>
> ***Megan**: Yeah. Yeah, that was kind of one of the first things that came into my head when they, like, suggested, erm, like therapy ("right"). Just 'cause talking about things brings up a lot and it just makes me think about more things, so (...) [laughs].*

Megan and the therapist began to talk about how Megan manages emotions and relationships early in the therapy. Megan appears in touch with her feelings, and the therapist follows her narrative and highlights the way of her internal workings. From the beginning he brings the feelings voiced by Megan into the therapeutic relationship. Megan agrees with him and elaborates on her fears about therapy. This robust interaction structure of a curious therapist exploring the unconscious workings of Megan's affect in the transference and Megan as an open and collaborative young person persists throughout therapy. However, Megan's discourse on talking about her emotions markedly changed through the course of therapy. The following vignette is drawn from session seven:

> ***Megan**: I'm the kind of person that if I'm upset, I'm upset. But if something's happened that's really upset me and, like, I'm explaining it but not thinking about it, I don't really feel it. (...)*
> ***Therapist:** So, you're distancing yourself from the feeling.*
> ***Megan:** Yeah. Which I don't think is a problem. 'Cause it's just like, it's like a way of confiding in someone without getting tears out of -*
> ***Therapist:** Without it becoming overwhelming. Well, I suppose, (...) maybe you wonder whether I can cope with you being distressed, actually. Whether I'd be interested or whether I'd say that 'that's enough, actually, sorry, we gonna end the session now'. (...)*
> ***Megan**: [Laughs]. No, not so much, 'cause, like, it's your job, so you kinda have to deal with it, [laughs].*

Megan and the therapist continue to work together in line with the most salient APQ items, yet Megan's view on how talking about herself affects her in the moment has

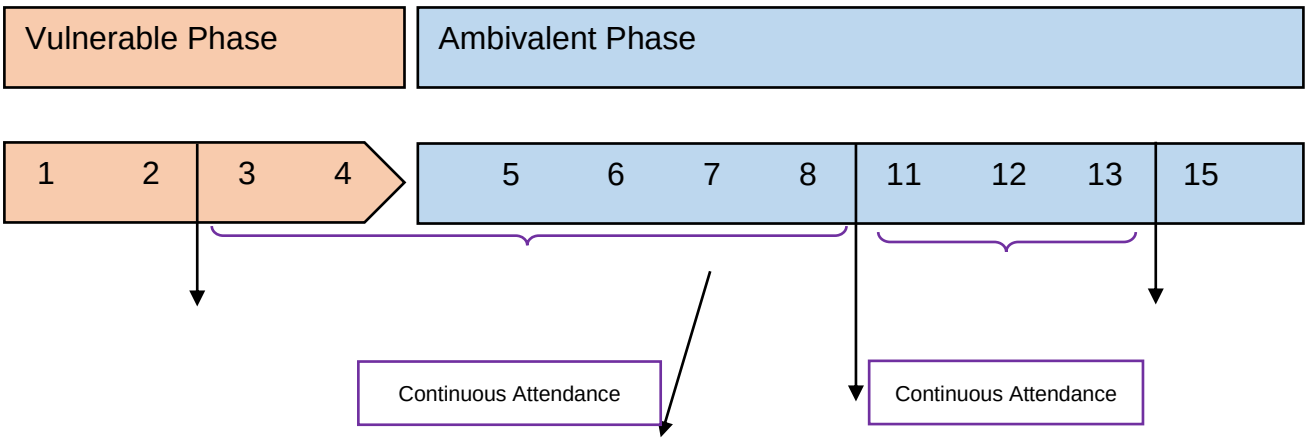
changed. Whilst in session two the idea of talking evoked a lot of feelings in Megan and made her feel vulnerable, she now reports that it leaves her emotionless and that she cannot be in touch with her experiences.

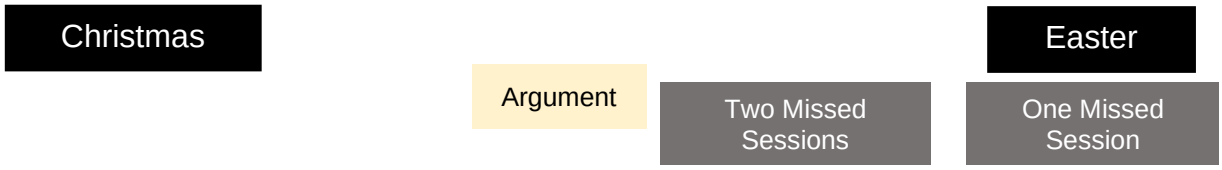
Two phases of therapy

A marked change in attitude towards therapy was identified in session five. Megan started the session by saying that there had been no change in her feelings of sadness, and she didn't see 'how talking about things helps'.

From here on, the idea of psychotherapy being useless was repeatedly expressed by Megan. Qualitative analysis identified two phases: phase one includes sessions one to four, and was dominated by a discourse focusing on Megan's emotional struggles, and how the process of therapy brings up emotions and makes Megan feel vulnerable, uncomfortable and overwhelmed. Phase two includes sessions five to 15, and focuses on an exploration of Megan's ambivalence and emotionlessness in therapy, with the dominant discourse of 'this isn't helping'. Figure 1 offers a visualisation of the therapy process including these phases.

Figure 1: *Phases, attendance, breaks, and missed sessions in Megan's therapy*





Differences in APQ items between phase one and phase two are presented in Table 4. The differences indicate trends as no inferential statistics were performed.

Table 4: Phase averages for sessions one – four and sessions five – 15 and the ten highest mean differences (change) between phase one and phase two means

Item number	**Item description**	**Sessions 1 – 4**	**Sessions 5 – 15**	**Change**
		M_1	M_2	
8	YP expresses feelings of vulnerability	8.75	5.75	-3.00
68	T encourages YP to discuss assumptions underlying experience	4.75	7.63	+2.88
17	T actively structures the session	3.25	6.13	+2.88
42	YP rejects comments and observations	5.75	7.88	+2.88
41	YP feels rejected or abandoned	6.25	3.75	-2.50
64	Feelings about love and relationship are a topic	8.25	5.75	-2.50
95	YP feels helped by the therapy	5.50	3.13	-2.38
93	T refrains from taking position in relation to YP's thoughts and behaviour	5.25	3.00	-2.25

14	YP does not feel understood by T	2.00	4.13	+2.13
72	YP expresses lively engagement with thoughts and ideas	5.75	7.88	+2.13

Note: T=Therapist; YP=Young Person. Items are ranked in order of size of change, starting with largest change

Phase 1

When looking at the mean APQ ratings for the most/least characteristic items, the item differences highlight that Megan talking about love and relationships (64) and about feelings of vulnerability (8), rejection and abandonment (41) was indeed more prominent in phase one of therapy. At times, romantic relationships were talked about as stabilising and fulfilling, as in session three, where she spoke about a previous boyfriend as someone who she could 'cry in front of', and he could respond in a supportive way.

Yet feelings of having a reliable other and enjoying emotional and physical intimacy could quickly change into feelings of dependency (session three):

> ***Therapist:*** *You're saying something about really wanting something close and intimate and you're not sure whether you will find it, really.*
> ***Megan****: Yea but it's also, like, I'm not sure whether I <u>want</u> to find it. (...) Like, for everything not to bother me in the way it does now, I'd have to have someone to lean on. Like, which insinuates that the whole, the only way I can be, like, happy in life is if I have someone else I'm with. Which is like, ridiculous.*
> ***Therapist:*** *You'd hate that.*

Megan: *Yeah.*

Therapist: *You hate the idea of having to depend on somebody.*

Megan: *Yeah.*

In phase one, talking about rejections (41) was also more prominent. Maybe because of this fear of rejection (41) and feeling vulnerable (8), Megan reports struggling to show her emotions to others. In session one, Megan spoke about how she didn't like her friends to see her cry, as she didn't like 'getting emotional', as it made her feel 'uncomfortable'. Feeling 'vulnerable' (8) seems to also become something that related to how Megan felt in therapy. The early sessions of phase one are characterised by Megan describing how she would hold back talking about certain things, as she was worried she would not be able to hold herself together emotionally. This example is from session four:

Megan*: It's kinda hard to think about something, like, things to say that aren't going to upset me to the point where I'll cry but are also still kind of relevant in the conversation.*

Therapist: *So, it almost sounds like you're saying there are things that you might talk about, which might make you cry. (...) But you prefer not to, you kind of move away from them.*

Megan*: Yea, I guess so. Like, they won't definitely make me cry, but they might. So, it's easier not to risk getting that upset, [laughs].*

Phase 2

Megan's readiness to admit that talking about her emotions in therapy makes her feel vulnerable drastically changes as she arrives in session five, when she

announces '*I'm not sure how it's supposed to help. (...) I don't know what I'm supposed to get out of it*'.

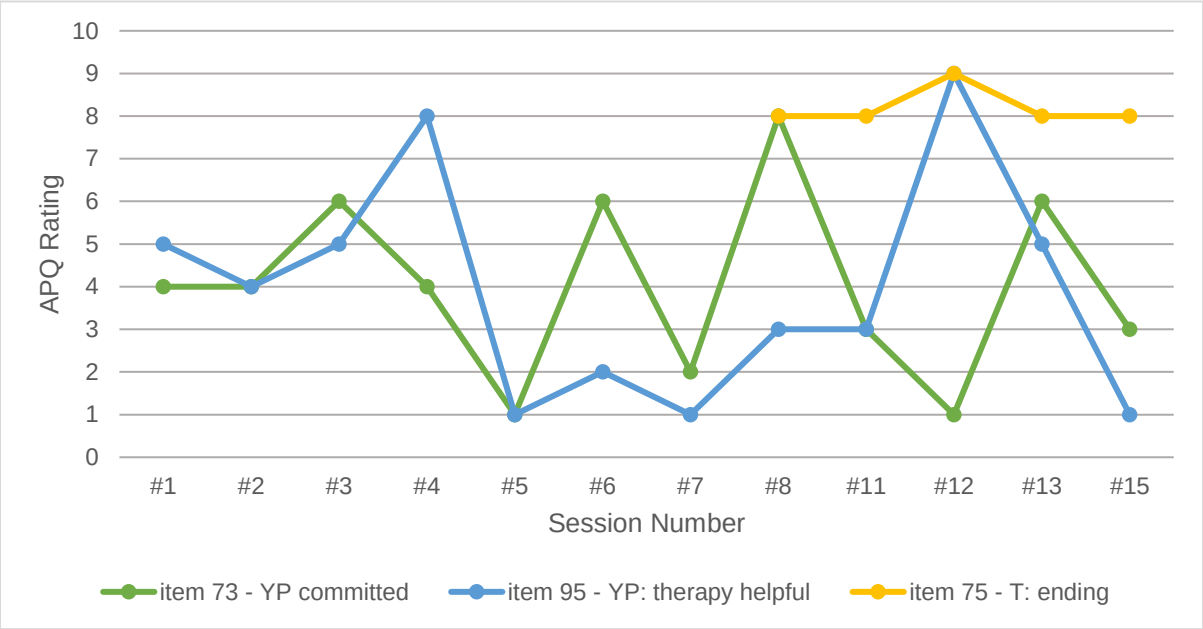
Although Megan and her therapist continue to discuss experiences that she talks about spontaneously, over much of phase 2, Megan voices her doubts and ambivalence, which the therapist tries to engage with in increasingly lively discussions (72). As table 4 shows, in this phase, ratings on the APQ indicated that the therapist's actions are comparatively more marked by being active in the discussions (17), challenging Megan's assumptions (68), and taking a position (93). Within these exchanges, Megan rejecting the therapist's comments (42) becomes a more dominant feature than before, whilst feeling understood (14) and feeling that therapy is helping (95) become less typical of the sessions.

Increasingly, Megan insists that therapy is not helping her (95) and that she cannot understand its mechanisms. In session seven, she asserts:

> ***Megan****: I just can't really think of this as anything more than what it is, like. Me just sitting here talking to you and you just saying what might be wrong with me and me saying 'no, that's probably not it', [laughs]. I don't know, I just can't see it as anything more, or, like, more helpful, or, like, deeper.*

As sessions progress, Megan becomes increasingly explicit about wanting to leave therapy. The APQ item cluster 'disengagement process' visualises this process in Figure 2.

Figure 2: *Select APQ items relevant to the 'disengagement process': items 73 (YP committed to therapy) and item 95 (YP finding therapy helpful) tracked across all therapy sessions; item 75 (T focuses on ending) tracked across the last five therapy sessions*



Megan's sense that therapy is helping (95) and her commitment to return (73) fluctuate strongly and do not necessarily go in tandem. For example, in session eight Megan agrees with her parents who are sceptical about therapy ('helping' rating '3') yet states that she will continue to attend despite this ('commitment' rating '8'). The opposite happens in session 12, in which Megan's lack of commitment to therapy (rating '1') and her expression of therapy having been helpful (rating '9') stand out, with Megan telling her therapist that 'it doesn't bother me either way if I have to stop or not because I feel like you helped me be better and that was pretty much the aim'.

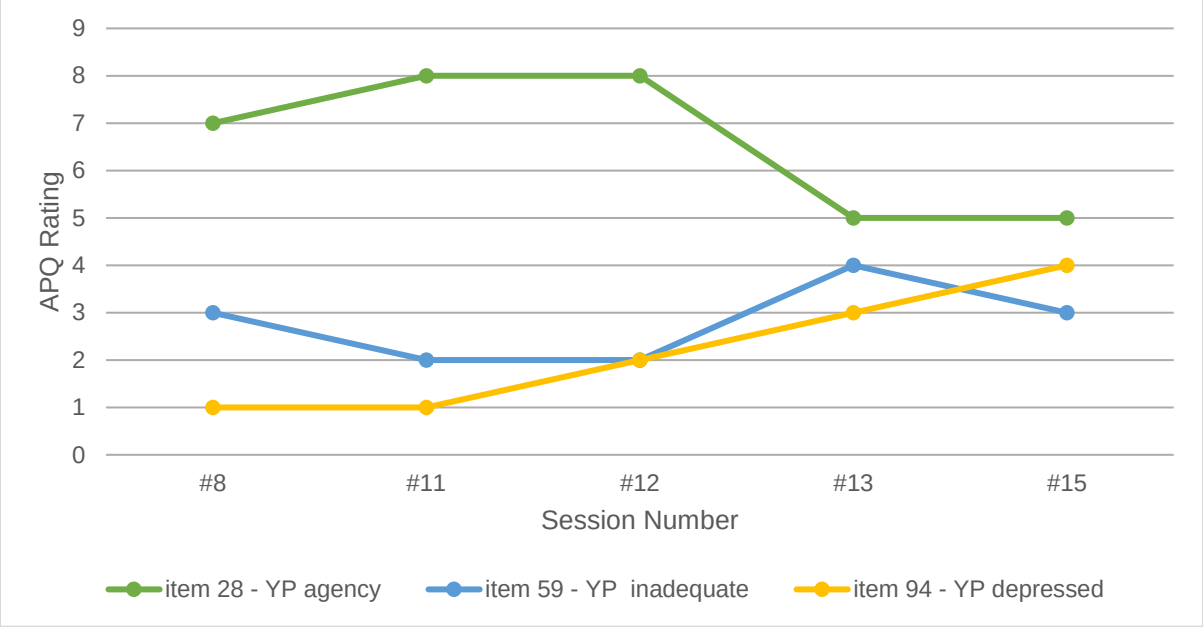
The therapist responds by exploring whether it is Megan's feeling of dependency that makes her want to leave therapy:

Therapist: *I think that's the really hard thing, to know that (...) you might need somebody else to kind of work things out a bit.*

Yet Megan expresses that she believes therapy has helped her to be more comfortable to talk to people, including new friends at school, but that she still wanted to stop going. It appears that Megan's increased determination to leave therapy coincides with her noticing a change in herself and her help-seeking outside of therapy. In session 11, after two missed sessions and in line with her intent to leave therapy, she reflects on having in fact 'trialled' a period without therapy, reporting that she had felt 'pretty good' over the two weeks in which she had not had therapy.

As therapy moves closer to the last session that Megan attends, she not only talks about perceived change in her help-seeking, but also a greater sense of well-being. The APQ item cluster 'sense of wellbeing' is visualised in Figure 3.

Figure 3*: Select APQ items relevant to a 'sense of wellbeing': Items 28 (YP communicates sense of agency), 59 (YP feels inadequate) And 94 (YP feels depressed) tracked across the last five therapy sessions*



Sessions eight, 11, and 12 stand out by Megan reporting a sense of confidence (28), effectiveness (59) and happiness (94). In session 12, for example, after Megan and the therapist disagreed on her feelings around leaving therapy, Megan explains:

> ***Megan**: In the last couple of weeks, I really, kind of, like, set out what I need to do in the next couple of years. (...) Like, things just seem a little bit more optimistic and (...) getting my grades back and whatnot was, I don't know, I think I just kind of...*
>
> ***Therapist**: [warm tone] You thought there was a future for you.*

In this interaction, Megan formulates the changes she has seen in herself. Moreover, it also shows Megan elaborating on topics spontaneously (item 15) and the therapist continuing to try and understand her experience (9) in a caring manner, consistent with the overall item descriptors identified by the APQ.

The lively explorations of Megan's ambivalence around therapy took up a large part of phase two of the therapy. After session 15, Megan stopped attending her sessions. As she explained in her IMPACT-ME interview after the therapy ended, she phoned the therapist and informed him of her decision.

Discussion

This study aimed to explore in-treatment therapy processes leading up to a young person with depression dropping out from STPP. It sought to identify therapeutic processes, techniques or interactions potentially associated with the premature ending.

Overall therapy process descriptors

When looking at the therapy using the most and least characteristic items on the APQ, it appears that the therapist and Megan were consistently engaged in collaborative therapeutic work focused on Megan's way of dealing with emotions in her interactions. This strong early therapeutic alliance, combined with Megan's consistent attendance in the early sessions is surprising as dropout has previously been linked to weaker therapist-rated and youth-rated alliance (O'Keeffe et al., 2018; Ormhaug & Jensen, 2016) and a pattern of early missed sessions (O'Keeffe et al., 2018). However, scores of therapeutic alliance decreased from early to late sessions over the course of the treatment, consistent with previous findings on the therapeutic process prior to dissatisfied dropout (O'Keeffe et al., 2020).

With regards to techniques used, the therapist's dominant techniques in this case study closely mirrored the 'psychodynamic-interpersonal' techniques used by STPP therapists in the IMPACT study (Midgley et al., 2018) and interaction

structures observed in STPP sessions (Calderon et al., 2018). This suggests that overall the treatment was delivered with adherence to the STPP approach.

The process of dropout

The analysis revealed two distinct phases of engagement. Phase one was marked by Megan's discussions about relationships, feelings of vulnerability and rejection. Phase two was marked by a discourse whereby therapy left Megan emotionless, alongside her ambivalence about continuing therapy.

In her sessions Megan made her doubts about the usefulness of therapy very clear to her therapist. As such, her dropout from treatment was certainly not unexpected. The therapist engaged in discussion of Megan's doubts. The STPP manual, in fact, states that the emergence of doubts about therapy shows the young person's sufficient trust in the therapist to work with their resistance (Cregeen et al., 2016). This case highlights the opportunity for therapists to demonstrate they can bear the young person's doubts (Cregeen et al., 2016) and, if necessary, to adjust therapeutic technique.

In the current case, comparing mean APQ ratings during the first and second phases of therapy revealed that when faced with Megan's intention to leave therapy, the therapist's reliance on active, structuring and challenging techniques increased. Conversely to the overall therapy process descriptors identified, all three of these items are ones that have been previously identified as characteristic of the interaction structures of CBT treatments, as delivered in the IMPACT study (Calderon et al., 2018). It appears that faced with Megan's doubts, the therapist increasingly uses techniques more associated with CBT and less characteristic of STPP (Midgley et al., 2018). Interestingly, Calderon and colleagues (2018) found

that when faced by challenge or resistance, STPP and CBT therapists alike are pulled into actions that seek to engage the young person but depart from their therapeutic model. In this therapy, it could also be the case that the therapist's anxiety of losing Megan's commitment to therapy created a slightly more argumentative and defensive stance in their exchanges. The argumentative exchanges appear to also mirror findings that in 'dissatisfied dropout' therapies there are more confrontational and withdrawal ruptures, more ruptures to which the therapist contributes and more unresolved ruptures (O'Keeffe et al., 2020). Although it cannot be said whether the confrontational interactions identified in treatment phase two were responsible for dropout, the findings might highlight the need for a non-defensive engagement in the face of a young person's expressed wishes to end therapy, especially since working with 'resistance' is a key part of STPP treatment (Cregeen et al., 2016).

Megan became livelier in her discussion and more rejecting of the therapist's comments in phase two. These 'battles' might highlight the prominence of ambivalence in adolescence around endings (Cregeen et al., 2016) and the difficulty of Megan pulling away whilst also attempting to get something helpful from her therapist (c.f. Della Rosa & Midgley, 2017). Indeed, Megan's commitment and her expressions of finding therapy helpful both oscillated from session to session. This fluctuating profile arguably made it harder for the therapist to anticipate Megan's final dropout, rather than a linear process of increased dissatisfaction.

Differences in the therapeutic process between phases one and two provide further opportunity to understand Megan's dropout. Her discussions with the therapist about relationships, painful rejections and vulnerability in phase one might have been the early signs of just how ambivalent Megan would feel about a

therapeutic relationship. Indeed, her predominant assertion in phase two, that talking about emotional experiences leaves her disconnected from her feelings, the opposite of the phase one narrative, allows her to gradually disengage and disinvest from therapy. Psychoanalytically, this was interpreted by the therapist, as a defence against closeness, emotionality, vulnerability and dependency. This interpretation would be in line with conceptualisations of treatment dropout as the adolescent's way of avoiding engagement with depressed feelings by leaving behind therapy and its potential exploration of these feelings (Blotcky & Friedman, 1984). Salzberger (1963) agreed that resistance to further therapeutic work can be a young person's way of avoiding anxiety whilst preserving mental stability. Just as vehemently as the therapist might have voiced his interpretations, Megan denies any avoidance despite her earlier assertions about her fears of dependency and intimacy. This finding highlights the importance of careful timing and wording of 'defence interpretations' (Cregeen et al., 2016) as they easily can leave patients feel accused and misunderstood, mobilising further resistance (Jones, 2000).

Dropout and outcome

For Megan, the ending of treatment seemed logical in the face of her increased feelings of agency, confidence and wellbeing. She reports feeling more upbeat and hopeful for the future, mirrored by her depression scores, which continued to improve beyond the end of therapy through to the one-year follow-up. In this way, Megan's hopes and confidence for the future might have become reality.

Despite dropout, Megan's improvement with regards to depression severity was greater than the mean improvement of her study cohort. For this reason, we may question the categorisation of Megan as a necessarily 'dissatisfied' dropout –

which was based on her report of how therapy ended (O'Keeffe et al., 2019) - as opposed to a young person who dropped out after she 'got-what-she-needed' as her outcome scores reflect a steady improvement in Megan's wellbeing in the long-term. After all, Megan herself asserted the changes she could attribute to therapy, namely allowing herself to 'need' people, e.g. to draw on friends to talk about difficulties. One might argue that by allowing others to deal with her needs, Megan has successfully internalised the psychotherapist's ability to deal with her level of conflict and disturbance, one treatment aim of STPP (Cregeen et al., 2016, p. 58). As such, we may consider Megan as having features of having 'got what she needed' from therapy, another distinct type of therapy dropout (O'Keeffe et al., 2019).

Implications for clinical practice and future research

Elucidating interactions between therapist and patient, as well as the overall lengthy ending process of therapy, the study provides thought-provoking material. It raises questions about how therapists can optimally respond in cases such as this, where the adolescent is explicitly ambivalent about the therapy process. In this case, the therapist challenged the adolescent's ambivalence, yet the therapeutic processes identified raise the question whether there was an alternative way to respond to the young person's expressed wish to end treatment. Even if understood as resistance, the young person's intention to leave treatment could have been responded to by inviting the young person to think together where this wish came from, overall showing a more accepting stance. An alternative technique could be the therapist sharing and owning the view that it might not be the right time to end treatment and inviting the young person to explore those thoughts in a non-argumentative fashion. The young person's ambivalence could also have been acknowledged more openly,

i.e. the idea of being in two minds about something. It could have been reflected to the young person that it was ‘okay’ to be unsure about psychotherapy, whilst continuing to engage with it and see whether it could hold some benefits. This might have modelled to the young person that it does not have to be ‘one or the other’, demonstrating that leaving is not the only response to feeling frustrated with therapy.

Conversely, one could argue that the therapeutic dyad’s argumentativeness held something beneficial for Megan. As described, Megan did not share her mental health difficulties with her parents for a long time, maybe feeling she would burden them or overwhelm them. In therapy, by contrast, Megan voiced her adolescent struggles and struggles with depression and found in the therapist a responsive adult. Her ability to be outspoken and argumentative might imply that she thought the therapist robust enough to withstand her strong and conflictual feelings. As has been shown, there was indeed evidence of Megan having made positive gains prior to stopping treatment. Perhaps in such cases giving young people agency to support them in deciding whether to continue, rather than trying to persuade them to continue in therapy –may lead to more mutually agreed endings and spare resources for other young people in need of treatment.

Strengths and limitations

The current study’s strength lies in studying an entire course of therapy with a young person who dropped out of therapy, using a validated therapy process measure. The study used the APQ measure and benefitted from supplementary data including outcome and interview data. Qualitative analysis illustrated how changes in attitude manifested and how a young person conceptualised her own changes in therapy.

There are however limitations to the current study. Whilst the APQ describes therapy processes in one session and can detect variation across several sessions, within-session complexity and ambivalence are more difficult to capture due to the one-item-per-session design. To understand within-session processes and the direct effect of therapist intervention on Megan's response and vice versa, moment-by-moment analyses are better suited (Elliott, 2010). Furthermore, aspects of the therapy can only be captured if they are covered by the existing items on the APQ; the absence of items accounting for an argumentative couple, symbolism in session, and the therapist interrupting the client were notable in this case study. Elucidating the therapeutic processes leading to dropout in the current case could have been enhanced by the integration and triangulation of a wider variety of sources and perspectives (Iwakabe & Gazzola, 2009), which has been described as systematic methodological pluralism (Elliott, 2010). Notably, the APQ misses the intersubjective dimension to the processes identified through APQ items, i.e. the inclusion of retrospective patient and therapist report (Elliott, 2010).

Conclusions drawn from single-case studies can be limited due to a range of methodological disadvantages. Findings from this single-case study are not necessarily generalisable to the larger group of 'dissatisfied dropouts'. However, the study showed that conclusions drawn from big data can also face generalisability problems: the perusal of pre-treatment and in-treatment characteristics in themselves could not have predicted Megan's dropout. Single-case studies, through systematic replication, cumulatively contribute to a more fine-grained, detailed, practice-based cluster of evidence. As such, they can aid bottom-up theory creation through the engagement of clinicians and researchers alike (Midgley, 2006).

Biographies

Jasmin Meier is a child and adolescent psychotherapist. She completed the Independent Child Psychotherapy training, jointly run by IPCAPA, the Anna Freud Centre and UCL. The published study is part of her doctoral thesis. She currently works as a child and adolescent psychotherapist in a CAMHS service in North West London.

Nick Midgley is a child and adolescent psychotherapist and Professor of Psychological Therapies with Children and Young People at UCL. He is also the Academic Director of the Independent Child Psychotherapy training, a collaboration between IPCAPA, the Anna Freud Centre and UCL. As well as his work on the IMPACT study, Nick's recent research includes the development and testing of an internet-based psychodynamic therapy for depressed teens (the D:OTS study) and the NIHR-funded Reflective Fostering Study, a randomised clinical trial to evaluate the impact of a mentalization-based support programme for foster carers. He is also the chief investigator for the ERiC (Emotion Regulation in Children) Study, a clinical trial evaluating the effectiveness of mentalization-based treatment for school-age children with mixed emotional and behavioural difficulties, funded by the Kavli Trust, and due to launch in CAMHS early in 2023.

Sally O'Keeffe is a post-doctoral research fellow at City, University of London. She conducted mixed methods research and her work focuses on developing the evidence base for psychological interventions for mental health problems. Her current work focuses on brief interventions to improve hospital care for self-harm.

Lisa Thackeray is a post-graduate research tutor at the Anna Freud Centre where she supervises MSc and doctoral students. She specialises in qualitative research methods, particularly Interpretative Phenomenological Analysis, working in the field of child, adolescent and family mental health.

Ethical considerations

Ethical approval for the IMPACT and IMPACT-ME studies was granted by the Cambridgeshire 2 Research Ethics Committee (reference 09/H0308/137). Written informed consent was obtained from all participants in the IMPACT and IMPACT-ME studies. To ensure anonymity, identifiable details in the data have been removed or disguised and a pseudonym has been assigned to the participant.

Funding

The current study was carried out without funding but involved secondary analysis of data from the IMPACT study, which was funded by the National Institute for Health Research (NIHR) Health Technology Assessment (HTA) programme (project number 06/05/01). The views expressed in this publication are those of the authors and do not necessarily reflect those of the NIHR.

Disclosure of Interests

The authors report no conflict of interest.

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Appendix 1

Internal validity - the extent to which the observed results represent the truth in the population studied, i.e. not obtained through methodological errors.

Intraclass correlation coefficient - a numerical measure that describes how strongly units in the same group resemble each other; a higher value denotes higher resemblance of units.

Longitudinal data - data collected from the same participants within a study over time.

Mean - an average obtained by dividing the sum of several quantities by their number.

Q-sort - a set of statements about a phenomenon that are ranked in order of importance or applicability to form a distribution describing said phenomenon.

Qualitative research - research focusing on the nature of phenomena, including their quality, the context in which they appear or perspectives from which they can be perceived.

Quantitative research - research focusing on data that is quantifiable, i.e. in numerical form, often using statistical analysis.

Randomised controlled trial - a study in which participants are randomly assigned to either the intervention or control group.

Standard deviation - a measure indicating variability within data for a group as a whole; a high standard deviation denotes high variability in the data, a low standard deviation denotes more uniform data.