Time-limited psychotherapy for depressed adolescents: examining cases of therapeutic ‘failure’ and ‘success’

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Thesis submitted for the degree of Doctor of Philosophy

University College London

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Declaration

I, Guilherme Fiorini, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm this has been indicated in the thesis.

Signed:

Date: 31st August 2023

Abstract

Background: Time-limited psychotherapies have demonstrated effectiveness in treating adolescents suffering from major depressive disorder (MDD). However, up to a third of young people may still present clinical symptoms after treatment. Considering this background, the present thesis aimed to examine therapy 'success' and 'failure' with this population. **Methods:** All data presented in this thesis was derived from a randomised controlled trial, namely the IMPACT study, and its qualitative branch, the IMPACT-ME study. Computational analyses were performed to investigate different trends of symptom change over time among adolescents diagnosed with MDD from baseline to one year after therapy ended. The Adolescent Psychotherapy Q-Set (APQ) was then used to assess patient and therapist in-session interaction, comparing cases of therapeutic 'failure' and 'success'. Lastly, a descriptive-interpretative approach was employed to investigate how young people who remained clinically depressed after therapy, their therapists, and parents made sense of the experience of psychotherapy. **Results:** This thesis identified that adolescents who started therapy with higher symptom levels were more likely to show poorer outcomes at a one-year follow-up. By analysing transcripts of psychotherapy sessions, it was possible to identify interaction patterns associated with 'successful' and 'unsuccessful' cases. Finally, by employing qualitative methods, it was found that the understanding of psychotherapy 'failure' is nuanced. This included some evidence that adolescents with poor outcomes do not necessarily describe 'negative experiences' of psychotherapy. **Conclusions:** This thesis' findings highlight the importance of assessing young people's symptoms at baseline to inform treatment planning and prognosis. They also point to some in-session features that might be associated with therapeutic 'success' or 'failure', potentially helping clinicians to identify if psychotherapies are on the 'right track'. The findings also indicate that having a positive experience of therapy does not necessarily reflect 'effective therapy' and that the understanding of outcomes may vary across stakeholders.

Impact Statement

The current thesis has examined cases of therapy 'failure' and 'success' when treating adolescents with major depressive disorder (MDD). By adopting different research methods and including different stakeholders (i.e., young people, their parents, and therapists), its methods bring contributions that can be applied in research and clinical practice.

First, it provides further indication that narrow-band symptom scores on outcome measures provide a limited understanding of young people's suffering. This was evidenced by some adolescents having their depressive symptom levels reduced after therapy, but still presenting high levels of anxiety and/or obsessions and compulsions, for instance. Additionally, it indicates that adolescents who start psychotherapy with more severe symptoms are less likely to benefit from the time-limited psychological treatments studied in this thesis (i.e., Short-term psychoanalytic psychotherapy, Cognitive-behavioural therapy, and a Brief Psychosocial Intervention).

This thesis' other findings focused exclusively on short-term psychoanalytic psychotherapy (STPP). By analysing STPP sessions, it is suggested that there are some in-session interactions associated with differential outcomes when comparing adolescents with equivalent baseline symptoms. For instance, young people who were open to exploring and discussing their inner thoughts and feelings during sessions, and worked collaboratively with a therapist that would help them make sense of their experience, were more likely to achieve better outcomes. Conversely, adolescent in-session anger was a feature more prominent in the poor outcome cases. It is worth mentioning that the analyses included in this volume did not allow for causal inferences but they raise key questions that can be addressed in future research. For instance, were some adolescents more prone to work collaboratively than others, or were there session features, including therapist behaviours that fostered this openness and collaboration?

Were there any specific causes for the expression of angry feelings? And how did therapists handle those affects?

The analysis of psychotherapy sessions also indicated that when working with depressed adolescents, psychoanalytic psychotherapists tend to work in a more directive and controlling way with young people with fluctuating emotional state. This type of process, however, was seen both in good and poor outcome cases. Nevertheless, as with the other session features, we do not know if the adolescents' emotional fluctuation made the therapists more directive and controlling or vice-versa.

Finally, this thesis' findings also indicate that adolescents, their parents, and therapists who had a 'poor outcome' therapy make sense of their experiences in a nuanced way. Most participants regarded and appreciated therapy as a 'safe space' for young people, indicating that a 'good experience' of psychotherapy might not be the same as good outcomes. However, there were some discrepancies between how adolescents perceived the impact of psychotherapy in comparison to therapists and parents. While the former had a more negative view of the outcomes they achieved, parents and therapists reported noticing some improvement. Taken altogether, these findings confirm that the assessment of psychotherapy outcomes may differ according to the informant being consulted. Furthermore, it also suggests that outcome measures should be examined with caution, alongside exploration of the adolescents' own views of therapy.

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Abbreviations

Abbreviation	Definition
ACP	Association of Child Psychotherapists
AIC	Akaike Information Criterion
APQ	Adolescent Psychotherapy Q-Set
BC	Behaviours Checklist
BDI	Beck Depression Inventory
BIC	Bayesian Information Criterion
BPD	Borderline Personality Disorder
BPI	Brief Psychosocial Intervention
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive-behavioural Therapy
CFA	Confirmatory Factor Analysis
CFI	Comparative Fit Index
CI	Confidence Interval
DBT	Dialectical Behaviour Therapy
DSM	Diagnostic and Statistical Manual of Mental Disorders
EFA	Exploratory Factor Analysis
FEST-IT	First Experimental Study of Transference Work - In Teenagers
FIML	Full Information Maximum Likelihood
FP	Free parameters
GMM	Growth Mixture Modelling
ICC	Intraclass Correlation
IPT	Interpersonal Psychotherapy
IS	Interaction Structure
K-SADS	Kiddie Schedule for Affective Disorders and Schizophrenia
LCGA	Latent Class Growth Analysis
LGCA	Latent Growth Curve Analysis
LOI	Leyton Obsessions Inventory

MBT	Mentalization Based Treatment
MDD	Major Depressive Disorder
MFQ	Mood and Feelings Questionnaire
NHS	National Health System
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health and Care Research
NST	Nondirective Supportive Therapy
OR	Odds Ratio
PDT	Psychodynamic Psychotherapy
PQS	Psychotherapy Process Q-Set
PTSD	Post-traumatic Stress Disorder
RCMAS	Revised Children's Manifest Anxiety Scale
RCT	Randomised Controlled Trial
RMSEA	Root Mean Square of Error Approximation
SRMR	Standardised Root Mean Square Residual
SSRI	Selective Serotonin Reuptake Inhibitor
STPP	Short-term Psychoanalytic Psychotherapy
TLI	Tucker-Lewis Index
VLMR-LRT	Vuong-Lo-Medell-Rubin Likelihood Ratio Test
WAI	Working Alliance Inventory

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Introduction

Currently there is a growing evidence-base indicating that different types of talking therapies are effective for the treatment of adolescent depression (Cuijpers, Karyotaki, Eckshtain, et al., 2020; Midgley et al., 2021; NICE, 2019), suggesting that adolescents who go to therapy achieve better outcomes compared to the ones who do not. Despite this promising context, there are still young people who do not benefit from psychotherapy, with studies reporting non-response rates of up to 36% even in established treatment modalities (e.g., Goodyer et al., 2017b; TADS Team, 2004; Weitkamp et al., 2017).

Besides learning from cases where therapy 'works', some authors have highlighted the importance of also understanding psychotherapy 'failure'. Learning from cases on both sides of this spectrum could provide valuable information to critically appraise and improve current practices (Goldberg, 2012). Addressing those specific cases could indicate what patients' and therapists' characteristics, attitudes and behaviours are associated with better and worse outcomes, as well as providing tools to identify when treatments are developing in the 'right' or 'wrong track' (De Smet et al., 2019; Lampropoulos, 2011).

Furthermore, some authors have identified that besides assessing psychotherapy efficacy and effectiveness (i.e., *if* therapy works), it is crucial to investigate *how* and *why* psychotherapy works for children and adolescents (Kazdin, 2003; Palmer et al., 2013; Weisz & Kazdin, 2017). Along similar lines, one can also argue that understanding what does *not* work for the treatment of adolescent depression might be key to promoting more effective and informed practices. For instance, practitioners could foster the use of techniques and behaviours that are associated with better outcomes and prevent or stop actions that are associated with worse ones.

Considering this context, and that most research on 'unsuccessful' treatments addressed adult treatments, the current thesis aimed to aimed to examine therapeutic 'success' and 'failure' in the context of psychotherapy for depressed adolescents.

Thesis overview

Given the array of variables related to this topic, this thesis' chapters employ diverse research methods and address multiple perspectives. In order to present the main concepts and evidence on this theme, Chapter 1 encompasses a narrative literature review addressing treatment 'success' and 'failure'. In its sections, it explores how different treatment modalities define 'success' and 'failure', how this is assessed in research, and what variables have been found to be predictors and mediators of therapy outcomes.

After describing the background literature and the main gaps in the current knowledge, Chapter 2 provides a general context for the empirical chapters of this thesis. Since all data presented here is drawn from two larger investigations, namely the IMPACT (Goodyer et al., 2011, 2017b) and IMPACT-ME (Midgley et al., 2014) studies, this chapter describes their sample, the treatments offered, the data collection involved, among other information.

Following the presentation of this thesis' research context, Chapter 3 to Chapter 5 are reports of empirical investigations on different aspects of talking therapies with depressed young people. These chapters follow a process of 'zooming in' into the sample: they start from a large-scale outcome investigation (n=465), which is followed by a psychotherapy process investigation, comparing 'successful' and 'unsuccessful' cases (n=10), and then finally reaching a qualitative investigation of a small sample of 'unsuccessful' cases (n=4). This format was used to carry out a detailed

examination of the different processes involved in psychotherapy for depressed adolescents and their implications with treatment 'failure' and 'success'. By adopting numerous angles and perspectives, each chapter aims to fill gaps left unanswered by the previous ones.

Delving into the specific empirical sections, Chapter 3 addresses how 465 depressed young people who attended one out of three short-term interventions changed over the course of therapy and one year after it ended. Given that most studies address change in terms of narrow-band depressive symptoms, this chapter uses computational analyses to assess adolescents in terms of their general psychopathology levels. It then uses this analysis to investigate what variables could be associated with differential response.

While Chapter 3 points to some baseline indicators that are, on average, associated with differential response, its findings do not explain why some adolescents with equivalent baseline presentations may still achieve different outcomes. To address this question in more depth, the following chapters focus specifically on short-term psychoanalytic psychotherapy (STPP) cases, justified by the under-representation of this modality in relation to cognitive-behavioural therapy (CBT; see Chapter 1 for more details).

Chapter 4 investigates and compares the STPP processes of 5 'successful' cases with 5 'unsuccessful' ones who shared similar baseline presentations. In this chapter, 100 sessions from all phases of the patients' treatments (i.e., 'early' and 'late' treatment) were assessed with the Adolescent Psychotherapy Q-Set (Calderon, 2014; Calderon et al., 2017) and submitted to an exploratory factor analysis. This section then provides a description of the interactional patterns observed in this sample and then investigates how they associate with outcomes.

Despite the original contributions presented in Chapter 3 and Chapter 4, they focus only on young people and their therapists, and their findings are

overall based on self-report questionnaires and measured through the perspective of external examiners. In this scenario, Chapter 5 also includes parents in its analysis, as they are key actors in adolescent psychotherapy. Furthermore, this chapter also positions the stakeholders' perspectives in the foreground by adopting qualitative research methods. Since the literature pays more attention to therapeutic 'success', this last empirical chapter focuses specifically on four cases of 'unsuccessful' STPP. It then uses a generic descriptive-interpretative approach (Elliott & Timulak, 2005; Timulak & Elliott, 2019) to examine interviews with young people, their parents and therapists and to understand how these stakeholders make sense of their experience of therapy.

Following the empirical investigations, the thesis' General Discussion and Conclusions narrates the thesis' 'journey'. This includes the thought process justifying each chapter, as well as how each one of them informed the following ones. These accounts incorporate the relevant literature on the topic, putting this thesis' findings into the broader debate of therapy 'failure' and 'success' with depressed adolescents. Finally, it draws potential clinical implications for the treatment of depressed young people and presents suggestions for future research.

Chapter 1 Psychotherapy for Depressed Adolescents: A Narrative Review Examining Treatment 'Success' and 'Failure'

The global prevalence of Major Depressive Disorder (MDD) in adolescents is estimated at one in five, with up to one in three reporting elevated levels of depression (Shorey et al., 2022). These already significant rates appear to have worsened during the COVID-19 pandemic (Racine et al., 2021). Coupled with the association of adolescent depression with heightened psychiatric issues (Pine et al., 1998; Rao et al., 1995), an increased risk of suicide (Nock et al., 2013), and substantial public expenditure during adulthood (Alaie et al., 2021), there is an urgent imperative to research effective treatments for this demographic.

Current evidence suggests that talking therapies serve as 'evidence-based treatments' for adolescents with depression. A systematic review and meta-analysis conducted by the National Institute for Health and Care Excellence (NICE, 2019), which included studies from 70 randomised controlled trials (RCTs), endorsed the recommendation of five types of talking therapies for treating moderate to severe depression in adolescents in the United Kingdom. These treatments are: Cognitive-Behavioural Therapy (CBT) in either group or individual formats, Short-term Psychoanalytic Psychotherapy (STPP), Brief Psychosocial Intervention (BPI), Interpersonal Psychotherapy for Adolescents (IPT-A), and Family Therapy (either attachment-based or systemic; NICE, 2019). In instances of moderate or severe MDD, these modalities might be provided in conjunction with antidepressants (NICE, National Institute for Health and Care Excellence, 2019). Yet, it should be noted that the concurrent use of medication and talking therapies, both of which aim to alleviate symptoms, reduce suicidal ideation, and improve social and academic functioning (Oberlander & Miller, 2011), will not be discussed in detail in this chapter.

Whilst these RCTs generally show that depressed adolescents who engage in therapy are more likely to witness a reduction in their depressive symptoms and an improvement in their general functioning than those who do not, they also underscore some limitations of these interventions. For instance, these studies report remission rates spanning from 46% to 85% (Midgley et al., 2021; Oud et al., 2019; Pu et al., 2017). Although these remission rates are in line with other evidence-based treatments (Cuijpers et al., 2019; Cuijpers, Karyotaki, de Wit, et al., 2020), they suggest that a significant proportion of patients may not benefit from even the most established evidence-based interventions. Additionally, follow-up analyses from these studies typically only extend up to one-year post-treatment, which leaves unanswered questions about the longevity of these improvements throughout an individual's lifetime.

The evidence base garnered from RCTs prompts two interrelated questions: firstly, what factors contributed to the 'success' in certain cases and how these can be broadly applied?; secondly, what led to the 'failure' in other instances, and what measures should be adapted or avoided to foster more effective practices (Gazzola & Iwakabe, 2022; Goldberg, 2012; Kazdin, 2007, 2009)? Studies exploring these questions might, for instance, reveal which patients are more likely to benefit from a particular intervention or technique, and under which contexts specific therapy practices are most effective (Kazdin, 2000).

In light of this background, this chapter will provide a narrative review of the findings on psychotherapy 'success' and 'failure'. It will cover the following topics: (a) the conceptualisation of psychotherapy 'success' and 'failure' across different treatment approaches for depressed adolescents; (b) how research assesses psychotherapy 'success' and 'failure'; (c) which variables have been identified as predictors of psychotherapy 'success' and 'failure'; and (d) which variables have been found to act as mediators for psychotherapy 'success' and 'failure'.

1.1 Conceptualising Psychotherapy 'Success' and 'Failure' in Different Treatment Approaches

To understand how different treatments conceptualise psychotherapy 'success' and 'failure', it is essential to consider their core concepts, objectives, and the mechanisms they employ to achieve those objectives. Within this framework, one aspect of therapeutic 'success' is defined as the attainment of these objectives, while the inability to do so is associated with treatment 'failure', with both concepts seen as opposites on the same continuum (Norcross & Lambert, 2019). This chapter will discuss three out of the five treatment modalities currently recommended by NICE (2019), specifically STPP, CBT, and BPI. These three approaches were chosen as they are the focus of the following empirical chapters in this thesis, with all data drawn from the Improving Mood with Psychoanalytic and Cognitive Therapies (IMPACT) Trial (Goodyer et al., 2017a, 2017b). For a more comprehensive description of the IMPACT Trial, refer to Chapter 2.

1.1.1 Short-term Psychoanalytic Psychotherapy for Depressed Adolescents

Short-term Psychoanalytic Psychotherapy (STPP) is a treatment modality guided by psychoanalytic theory principles, tailored for treating depressed adolescents. In the version of STPP included in the NICE guidelines, 28 weekly individual sessions are offered to the adolescent, complemented by seven parallel sessions with their parents (Cregeen et al., 2017). STPP aims to address adolescents' difficulties concerning the developmental tasks of adolescence, with a core focus on helping the adolescent interpret their emotional experiences.

The STPP manual outlines intended outcomes including the adolescent (1) gaining an ability to manage depressive feelings and aggression, (2)

becoming less prone to guilt and self-devaluation, (3) making more realistic assessments of behaviour and understanding the underlying motivations of self and others, (4) developing a better sense of agency, (5) improving emotion regulation skills, (6) forming a more realistic perspective of their responsibilities and differentiating between internal and external phantasy and reality, (7) becoming less vulnerable to depression in the face of loss, disappointment, and criticism, and (8) gaining a better sense of their own identity (Cregeen et al., 2017). Therefore, while symptom relief is an important objective in STPP, it also intends to address a wider range of facets of the adolescent's life.

In order to achieve these aims, STPP utilises a range of techniques grounded in psychoanalytic principles. These may encompass the use of interpretation in various forms, clarification, validation, and mirroring, among others (for a comprehensive description of STPP's techniques, see Cregeen et al., 2017).

1.1.2 Cognitive Behavioural Therapy for Depressed Adolescents

Cognitive Behavioural Therapy (CBT) is another treatment modality for adolescent depression endorsed as an evidence-based treatment in the NICE guidelines and is included in this study. CBT is founded on a blend of cognitive and behavioural interpretations of depression (J. S. Beck, 2020). This particular CBT programme offers up to 20 sessions with the adolescent, with the option for parents to attend these sessions as well (IMPACT Study CBT Sub-Group, 2010).

This CBT model aims to enable the depressed adolescent to (1) alleviate their symptoms, (2) challenge their negative thoughts and beliefs, and (3) develop new strategies to enhance coping and resilience (IMPACT Study CBT Sub-Group, 2010).

In line with its theoretical underpinnings, the techniques used in CBT involve a combination of behavioural interventions, such as behavioural activation (i.e., assisting the adolescent in participating in pleasurable activities, Dimidjian et al., 2011), and cognitive interventions, such as aiding the adolescent in identifying and then challenging negative automatic thoughts (Shirk et al., 2013). For a more in-depth description of the CBT model, refer to the IMPACT CBT Treatment manual (IMPACT Study CBT Sub-Group, 2010).

1.1.3 Brief Psychosocial Intervention

Brief Psychosocial Intervention (BPI) is a non-specialist type of intervention. It was initially formulated in response to empirical evidence suggesting that the outcomes of sound clinical care may not markedly differ from those of established therapy approaches (Goodyer & Kelvin, 2023). BPI comprises up to 12 sessions, eight of which are individual and four are conducted with caregivers (Kelvin et al., 2010). This modality adheres to the principles of collaborative care, comprehensive assessment and understanding of the person and their mental state, active listening, providing information, offering advice, problem-solving, and educating about adolescent depression (Goodyer & Kelvin, 2023).

Unlike STPP and CBT, the BPI manual is less prescriptive in terms of intended outcomes. However, during the description of the tasks to be carried out in BPI's concluding phase, Goodyer and Kelvin (2023) suggest that therapists should assess and discuss with their patients how they can (1) 'move forward' following treatment, (2) improve their social skills, (3) enhance their personal performance, (4) accomplish their educational goals, (5) recognise signals indicative of potential depression or future mental health issues, and (6) cope effectively with any disturbances to their wellbeing.

To attain its objectives, BPI primarily employs psychoeducation, but also includes aiding the adolescent in engaging in a set of activities and gaining knowledge about mental states and overall wellbeing (Goodyer & Kelvin, 2023; Kelvin et al., 2010). Despite its practical overlaps with CBT and STPP, this approach does not involve any direct work on negative thoughts/cognitions (Goodyer et al., 2017a) nor the understanding of unconscious phenomena (Goodyer & Kelvin, 2023). For a more comprehensive description of the BPI model, see Kelvin et al. (2010) and Goodyer and Kelvin (2023).

1.1.4 Overview

In sum, all these treatment models acknowledge the remission of depressive symptoms as a critical component of treatment 'success'. These descriptions appear to reflect the robust influence of the biomedical model of mental disorders, adopting an individualistic understanding of the adolescents' conditions. In this context, it is worth noting that these models may not sufficiently consider the role of socio-political and economic factors in the onset and/or perpetuation of depression, a notion highlighted by the biopsychosocial model (for more information on the biopsychosocial model, see D. T. Wade & Halligan, 2017).

Aside from addressing depressive symptoms, these models share other common goals, such as fostering better coping skills among depressed adolescents. However, it is also notable that each manual aligns with its respective theoretical foundations. For example, STPP emphasises aspects like the reduction in guilt and self-devaluation and promoting the differentiation of internal and external fantasy and reality, which aligns with the psychoanalytic conceptualisations of adolescent depression (Freud, 1917; Radó, 1928). Similarly, the CBT manual focuses on reducing the adolescent's

negative thoughts and beliefs, consistent with the CBT theoretical understanding of depression's negative triad (Alloy, 1988).

Furthermore, it is essential to compare these models' collective aims with the perspectives of service users. In a study utilising data from a qualitative investigation of the experiences of depressed adolescents seeking treatment, Krause et al. (2020) identified the outcomes that mattered most to different stakeholders. Although symptom reduction was indeed reported as a significant outcome, the participants also highlighted other aspects such as improvements in self-esteem, confidence, relationships, and family functioning. Many of these elements were not explicitly addressed by the treatment manuals. Hence, there appears to be some incongruence between how treatment manuals, clinicians, and service users define indications of 'success'.

1.2 How psychotherapy 'success' and 'failure' is assessed in research

Following the discussion on the clinical treatment goals for each therapeutic modality, it's important to consider how research literature has been assessing treatment 'success' and 'failure' and how that relates to those clinical aims. The terms 'success', 'good', 'positive', and 'favourable' outcomes are often used interchangeably in the literature, alongside their respective counterparts 'failure', 'poor', 'negative', and 'unfavourable' outcomes (e.g., Goldberg, 2012; Mehta et al., 2023; Schilling et al., 2021; Werbart et al., 2019; Wilmots et al., 2020). This thesis adopts the terms 'good outcomes' and 'successful outcomes' as synonyms, as well as 'poor outcomes' and 'failure'. As will be discussed, defining these outcome categories is a challenging task due to the vast number of variables that they encompass and the measurement implications. Therefore, a nuanced understanding of what therapy 'success' and 'failure' entail is favoured over a rigid differentiation.

In a significant effort to identify what variables have been used to measure treatment outcomes for depressed adolescents, Krause et al. (2019) conducted a systematic review. Their study found that the most frequently assessed domain was the young people's symptoms, with over 90% of the research published between 2007 and 2017 focusing on this area. These studies assessed symptoms including depressive symptoms, suicidality, and self-harm, among others, making this domain considerably more studied than others.

The way these symptoms are assessed can vary across different studies. Some investigations utilise diagnostic interviews such as the Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADS; Kaufman et al., 1997), which assesses the presence or absence of various diagnoses from the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000, 2013) and their categorical severity (mild, moderate, or severe). Alternatively, and not mutually exclusively, some studies employ self-report scales to track patient symptoms, such as the Beck Depression Inventory (BDI; A. T. Beck et al., 1996) and the Mood and Feelings Questionnaire (MFQ; Daviss et al., 2006; Wood et al., 1995). These scales, despite encompassing a range of possible symptom raw scores, also have established cut-off points that indicate a patient's symptom severity.

Despite their widespread use, these different methods have limitations in terms of measuring therapy 'failure' or 'success'. For instance, cut-off points could be arbitrary and not reflect change in a clinically meaningful way (Davies et al., 2019). In this context, patients could still present symptoms ranked as within the clinical range before and after treatment, yet experience their symptoms differently, either for better or worse (Wolpert et al., 2016). Furthermore, these methods overlook current empirical findings suggesting that psychopathology should be measured as a continuum rather than as a series of discrete categorical variables (Caspi et al., 2014; G. T. Smith et al., 2020).

Indeed, an alternative to using cut-off points is to employ indices such as the Reliable Change Index (Jacobson & Truax, 1991). These indices examine change through statistical analyses that account for average changes in measurement within a sample. While these strategies are useful in demonstrating change that might be more significant than measurement errors, they may still not be clinically meaningful, as questionnaire scores may not necessarily capture individuals' subjective experiences.

Apart from identifying symptoms as the most examined outcome in the literature on treatments for adolescent depression, Krause et al.'s (2019) study also found that approximately 52% of studies assessing the treatment of adolescent depression also evaluated young people's functioning. This includes various academic domains, executive functioning, and communication skills. Very few studies included measures of patients' personal growth or interpersonal relationships. Thus, this review demonstrated that many outcome domains highlighted as goals by the selected treatment manuals are not typically researched.

This is especially relevant for STPP, for which several aim-related variables are under-studied, such as guilt and self-devaluation, affect regulation skills, agency, and sense of identity (Cregeen et al., 2017). While the most commonly used measures are more closely aligned with the CBT model, as with the adult literature (Barber & Sharpless, 2015), there are still key outcome domains targeted in CBT that are under-investigated in studies evaluating the treatment of adolescent depression. These include coping skills and resilience (IMPACT Study CBT Sub-Group, 2010), for example.

Undoubtedly, the intricacies of adolescent psychotherapy, such as the parents' role in treatments beyond the therapy dyad, add another layer of complexity to the issue of measuring outcomes. Studies have identified that there is often little agreement between young people, their parents, and therapists concerning which outcomes they prioritise (Garland et al., 2004).

And even when they address the same outcome domains, they may have differing opinions on how severe the young person's issues are. Notably, for internalising problems, young people often rate their issues as more severe compared to their parents (e.g., Makol & Polo, 2018; Orchard et al., 2017; Serafimova et al., 2021). This discrepancy could be because depressive symptoms, like other internalising problems, may not be as visibly noticeable from 'the outside' as externalising issues (Zahn-Waxler et al., 2000).

As previously mentioned, Krause et al.'s (2020) findings suggest that what clinicians, parents, and depressed young people consider relevant psychotherapy outcomes do not fully align with the stated aims of treatment manuals. In a similar vein, this qualitative study also indicates that these same perspectives do not correspond to what is being investigated in the empirical literature, with symptoms and functioning being prioritised, while other domains are neglected to varying extents.

Considering these factors together, it appears that the current empirical evidence base on treatment 'success' and 'failure' is narrowly focused. Therefore, the following findings on predictors and mediators of treatment outcomes should be interpreted with caution. They predominantly concentrate on symptoms as discrete categories and may overlook significant aspects of change (or lack thereof) in young people.

1.3 What variables have been found to be predictors of psychotherapy ‘success’ and ‘failure’

Predictors in psychological treatment studies are variables that indicate the possible likelihood or risk of treatment 'success' or 'failure', as they are associated with the direction and strength of outcomes (Vousoura et al., 2021). The studies that investigate predictors among depressed adolescents have

primarily focused on Cognitive Behavioural Therapy (CBT), although some patterns have emerged from clinical trials.

For instance, certain features of an adolescent's baseline clinical profile appear to significantly predict their treatment outcomes. Adolescents who exhibit higher levels of depression and anxiety symptoms, antisocial behaviour, suicidal ideation, and hopelessness at the outset seem to be at greater risk of achieving poorer outcomes (Curry et al., 2006; Goodyer et al., 2017b; Wilkinson et al., 2009; Young et al., 2006). These findings are based on trials offering Short-term Psychoanalytic Psychotherapy (STPP), CBT, a Brief Psychosocial Intervention (BPI), and Interpersonal Therapy (IPT).

It is worth noting, however, that the findings on baseline symptoms should be taken with caution, as this field is less developed concerning adolescents in comparison to adults. In an umbrella review (i.e., a systematic review that gathers data from previous systematic reviews on a given topic) focusing on outcome predictors of psychotherapy for adults with MDD (Tanguay-Sela et al., 2022), it was identified that baseline depressive symptoms were associated with better CBT outcomes in some reviews (Johnsen & Friborg, 2015; Sim et al., 2016) and worse outcomes in others (Chen et al., 2019; Furukawa et al., 2017). Among adults with MDD, the predictors most consistently found in the literature are comorbidity, with patients with more comorbidities less likely to benefit from treatments (Härter et al., 2018; Tanguay-Sela et al., 2022; Tunvirachaisakul et al., 2018), and social support, with individuals with less perceived social support less prone to improve after therapy (Chen et al., 2019; Tanguay-Sela et al., 2022).

Only a few studies have investigated the role of a young person's baseline motivation to change and treatment outcomes, and their results have been mixed. One RCT comparing fluoxetine, CBT, a combination of the two, and a placebo found that higher patient motivation to change at baseline was associated with better outcomes (Lewis et al., 2009). However, another trial

comparing group-based CBT, bibliotherapy CBT, and a brochure control group found no significant associations between baseline motivation and outcomes for depressed adolescents (Brière et al., 2016).

It is worth noting that these studies used different instruments to assess young people's motivation, and the discrepancies in results might be due to measurement effects. Also, these studies primarily focused on CBT compared to self-directed treatments or control groups. Therefore, motivation may play a different role in less directive types of psychotherapy for depression, such as STPP.

Linked with patient motivation, some studies have addressed adult patients' expectations about their psychotherapy outcomes and their own role in achieving these outcomes. While in general there is a small but significant association between expectations and outcomes (Delsignore & Schnyder, 2007), these seem to be more accurately scrutinised if examined in more detail. For instance, patients seem more likely to improve when they emphasise their own role in the treatment, in comparison to delegating it to the therapist or the treatment in itself (Craig et al., 1984; Timmer et al., 2006). Likewise, the relationship between expectations on specific outcomes (such as having reduction in a specific symptom) and actual outcomes seem to be stronger than the one between general expectations and outcomes (Antikainen et al., 1994; Borkovec et al., 2002; Persson & Nordlund, 1983; Safren et al., 1997). While some studies have addressed qualitatively depressed young people's expectations of psychotherapy (Midgley et al., 2016), this has not been investigated in terms of their predictive power in relation to outcomes with this population.

The role of demographic variables such as sex, gender, and ethnicity in predicting changes in depressive symptoms in CBT and Family Therapy for depressed adolescents has been investigated. Interestingly, these variables have not been found to be statistically significant predictors (Asaknow et al.,

2009; Curry et al., 2006; Rohde et al., 1994, 2006; Wilkinson et al., 2009). These findings, drawn from multiple studies, suggest that young people of various genders and ethnicities might achieve similar therapy outcomes regarding their symptoms. These findings are in accordance with the ones drawn from adult patients with MDD, with gender and baseline age presenting inconsistent associations with outcomes in previous reviews (Tanguay-Sela et al., 2022). However, it is important to note that sex, gender, and ethnicity are constructs with contextually built meanings (Diekman & Eagly, 2000; Phinney & Ong, 2007) and are not necessarily fixed. As such, their understanding within a dynamic and contextual framework, such as through a therapist's cultural competence (H.-T. Lo & Fung, 2003), is currently underexplored for this population and warrants further investigation.

Regarding the studies' geographical location, most were conducted in North America and Europe (Courtney et al., 2022), which could potentially reinforce the bias in psychology and psychotherapy research towards 'WEIRD' samples (i.e., samples drawn from Western, Educated, Industrialized, Rich, and Democratic societies; Henrich et al., 2010). As a result, findings about predictors might differ in other populations. Furthermore, most of the predictor analyses focused on CBT, which means that the findings might not be transferable to other types of treatments, such as psychoanalytic psychotherapies.

In conclusion, current evidence on predictors for the treatment of adolescent depression is still in its early stages. The latest findings suggest that young people who start psychotherapy with more severe symptoms are less likely to achieve positive outcomes after treatment. Conversely, sex and ethnicity do not seem to play a role in predicting therapy 'success' or 'failure' for this population, and the evidence on the role of patient motivation remains inconclusive.

1.4 Variables found to be mediators for psychotherapy 'success' and 'failure'

While predictors identify what types of treatment work for what type of patient, mediators are variables that statistically explain the relationship between a specific intervention and one (or more) outcomes (Kazdin, 2007). Identifying mediators is henceforth a key component in detecting what are the mechanisms of change (i.e., the variables that define a causal relationship between an intervention and patient change) in the treatment of depressed adolescents (Kraemer et al., 2002).

1.4.1 The therapeutic alliance

The therapeutic alliance, often conceptualised as the bond and collaborative relationship within the therapeutic dyad (Bordin, 1979), stands as one of the most extensively investigated mediators in the context of psychotherapy. Meta-analytic findings have indicated that with adults the association between patient-therapist alliance and outcomes is significant but modest (Horvath et al., 2011), however, it is unclear how this can be transposed to patients of other age groups. In the domain of youth psychotherapy, for instance, the alliance assumes a particularly intricate character as it must encompass not only the patient-therapist relationship but also the interaction between *parents* and therapist. These dyads/triads may not always share identical therapeutic goals or understanding of the therapeutic process (Hawley & Garland, 2008). Despite these complexities, meta-analytical findings have identified a significant, albeit small-to-medium, positive effect between the alliance and treatment outcomes across varied conditions in child and adolescent therapy. This effect accounts for both patient-therapist and parent-therapist alliances (Karver et al., 2018; B. D. McLeod, 2011; Shirk et al., 2011).

The matter of whether the therapeutic alliance bears more significance for particular groups of patients has also been subject to study, though findings in this area have proven somewhat mixed. While some research suggests that the alliance may play a more pivotal role in relation to treatment outcomes for female and younger patients (B. D. McLeod, 2011; Shirk et al., 2011), other studies have not been able to corroborate these findings (Cirasola et al., 2021; Karver et al., 2018). Similarly, the body of evidence presents some inconsistency regarding the alliance-outcome relationship in the treatment of young people with different conditions. While certain reviews have identified a stronger association between alliance and outcome for patients presenting with externalising conditions as opposed to internalising ones, such as depression (Karver et al., 2018; Shirk & Karver, 2003), other research has found no significant differences (B. D. McLeod, 2011; Shirk et al., 2011).

Moreover, the role of the therapeutic alliance in determining 'success' or 'failure' of therapy may also differ amongst various treatment modalities for adolescent depression. Cirasola et al. (2021), through examining a sample of 223 young people diagnosed with MDD participating in an RCT that offered STPP, CBT and BPI, discovered that the alliance-outcome association was stronger in CBT compared to STPP. These findings suggest that nurturing a positive therapeutic alliance might be more crucial for promoting favourable outcomes in CBT compared to STPP, potentially because there is a greater emphasis in CBT on encouraging patient engagement with therapeutic tasks, especially those related to their life outside of therapy. However, it is important to critically examine the existing instruments for measuring therapeutic alliance. Measures such as the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989; Tracey & Kokotovic, 1989), by focusing on therapy 'goals', may overemphasise core aspects of behavioural therapies and neglect key relational features of other modalities (Cirasola & Midgley, 2023).

1.4.2 Ruptures and repairs of the therapeutic alliance

In addition to the direct relationship between alliance and outcomes, recent studies have highlighted the importance of understanding the therapeutic alliance as a dynamic construct, subject to fluctuations throughout the therapy process. This perspective emphasises not merely how 'high' or 'low' global alliance scores are, but also what happens when ruptures in the alliance occur (Eubanks-Carter et al., 2010; Safran & Muran, 2000). In a meta-analysis focusing on adult patients receiving a range of psychological interventions, including CBT, Psychodynamic, Integrative, Relational and Exposure therapy for a wide array of conditions, Eubanks et al. (2019) identified a moderate association between alliance rupture resolution and treatment outcome. This finding suggests that treatments in which ruptures in the therapeutic alliance were effectively resolved were more likely to result in better outcomes.

The body of evidence focusing on alliance ruptures with adolescents is still in its infancy, with preliminary findings predominantly concerning patients with Borderline Personality Disorder (BPD) and MDD. Taken together, these studies suggest that withdrawal ruptures (i.e., instances where the patient disengages from the session's content, including their own emotions, or from interaction with the therapist) appear to be more common in the treatment of adolescents (O'Keeffe et al., 2020; Schenk et al., 2019). Interestingly, Gersh et al. (2017) provided some evidence that early withdrawal ruptures might transition into confrontation ruptures (i.e., instances where the patient explicitly expresses discontent, anger, or resentment towards the therapist) in later stages of therapy with BPD adolescents. In a mixed-methods case study on STPP, Cirasola et al. (2022) highlighted that the resolution of withdrawal ruptures was considered a mechanism of change promoting positive outcomes in treating a young person with MDD.

In summary, the domain of alliance rupture and repair appears to be a promising and clinically meaningful area of study, though further research involving larger sample sizes and directly associating alliance rupture-resolution with outcomes in young people is needed. Moreover, research examining the consequences when ruptures are not addressed or resolved in the therapeutic setting could hold significant clinical relevance.

The more extensive studies on alliance ruptures could also be enriched by insights from existing qualitative findings on 'unsuccessful' treatments. For instance, Mehta et al. (2023), analysing interviews with depressed adolescents who received either STPP, CBT, or BPI, identified reports of patients feeling mistrustful, emotionally disconnected, or feeling patronised or pitied by their therapists, which they described as obstacles to progress. These aspects could have precipitated withdrawal or confrontation ruptures in the therapeutic process, thereby contributing to poorer outcomes.

In fact, characteristics such as forming an emotional connection with and trusting the therapist have been widely described in the qualitative literature as being valued by young people receiving psychological treatments (e.g., Fiorini et al., 2024; Herring et al., 2022; Housby et al., 2021; Løvgren et al., 2020; MacKean et al., 2023). However, these factors have not been thoroughly explored in their association with outcomes in this population, particularly using standardised measures.

1.4.3 Therapist's adherence, competence, and integrity when delivering manualised treatments

Another feature of therapy that has been examined with respect to its role as a mediator is the implementation of specific therapeutic techniques by therapists. Within this domain, three aspects have been identified in the literature: adherence, competence, and integrity (Power et al., 2022; Waltz et

al., 1993). 'Adherence' refers to the extent to which a therapist implements techniques that are prescribed in their chosen modality, whilst 'competence' denotes how skilfully a therapist applies these techniques in specific contextual scenarios (Waltz et al., 1993). 'Integrity', also referred to as 'fidelity', is a construct that incorporates both adherence and competence, in addition to treatment differentiation (i.e., ensuring that a particular treatment does not employ features of other treatments; Perepletchikova et al., 2007).

In an attempt to understand the extent to which adherence, competence, and integrity contribute to outcomes in adult psychotherapy, Power et al. (2022) carried out a meta-analysis concerning psychotherapy for patients with a range of mental health disorders. Their findings revealed that treatment adherence did not have a significant relationship with outcomes, indicating that the simple implementation of prescribed techniques does not necessarily result in better support for adult patients. However, this study did unveil that both competence and integrity had a significant association with outcomes, suggesting that the skilful application of these techniques plays a crucial role in achieving therapeutic 'success' (Power et al., 2022).

In the treatment of children and adolescents, however, adherence, competence, and integrity appear to play varying roles. In a meta-analysis carried out by Collyer et al. (2020), which assessed different treatments for children, adolescents, and families, it was found that treatment adherence had a significant yet small relationship with outcomes. This suggested that providing specific prescribed therapeutic components might play a role in improving symptoms and/or functioning in children and adolescents. Conversely, in the same investigation, therapist competence and integrity (considered here as a combination of adherence and competence, without including treatment differentiation) did not have a significant association with outcomes. The authors postulated that in the treatment of children, adolescents, and families, perhaps overall competence might be more important than specific competence in applying particular techniques (Collyer

et al., 2020). It's worth noting, however, that the studies included in this meta-analysis primarily focused on the treatment of behavioural/externalising problems, and the treatments examined were almost exclusively based on cognitive and/or systemic approaches. Therefore, despite some moderation analyses being performed considering treatment modality and symptoms, we still know very little about how adherence, competence, and integrity might impact outcomes in other types of treatment and for adolescents with depression.

In one of the few studies addressing specific psychoanalytic techniques and their association with outcomes, it was identified that the context in which they are used is crucial for promoting therapeutic 'success' in children (Halfon, 2021). In this particular investigation, the author analysed 359 sessions from the treatments of 79 children receiving outpatient care for different conditions in Turkey. Through multilevel modelling, the results showed that the implementation of psychoanalytic techniques such as transference work, defence analysis, and play interpretations, in the context of an unstructured setting, was associated with positive outcomes when there was a well-established alliance between therapist and patient. However, the use of the same techniques was associated with worse outcomes when occurring in poor-alliance contexts. These findings suggest that recommending a higher usage of 'psychoanalytic techniques' is not always the ideal approach in psychodynamic therapies for children. Moreover, they also suggest that some therapeutic interventions might lead to negative outcomes depending on the relational context in which they are implemented (Halfon, 2021).

1.4.4 Specific treatment components

Relating to adherence, competence, and integrity, some studies have also explored the role of specific components in promoting better or worse psychotherapy outcomes. To investigate this, certain trials deliver the same

intervention to two groups, with the only distinction being that one group has a specific feature of the treatment added or removed (Ahn & Wampold, 2001).

Much like in other areas, research on psychotherapy components is more established with regard to CBT for adults than other therapeutic approaches or for different age groups. In this respect, some studies have compared the effects of CBT alone versus CBT in conjunction with a specific technique such as hypnosis (e.g., Alladin & Alibhai, 2007), or mindfulness (e.g., Manicavasagar et al., 2012; Omidi et al., 2013; Tovote et al., 2014), while others have 'disassembled' CBT features, such as providing only behavioural activation or cognitive restructuring (e.g., Jacobson et al., 1996; Taylor & Marshall, 1977) for the treatment of adult depression. Overall, these studies have found no superiority between these approaches in alleviating the patient's depressive symptoms, suggesting that the use of these specific techniques, including some identified as central elements of CBT, does not play a significant role in achieving therapeutic 'success'.

The FEST-IT (First Experimental Study of Transference Work - In Teenagers) study, conducted by Ulberg et al. (2021), represents one of the limited number of investigations that have considered the use of psychotherapy components in treating adolescent depression. In this trial, 69 adolescents were randomised to receive STPP either with or without transference work. The authors' analysis revealed that those adolescents who were randomised into the transference-work group experienced a greater reduction in their depressive symptoms, as assessed by both self-report and clinician-rated measures. Interestingly, in the same study, both groups showed equivalent outcomes in terms of their psychodynamic functioning, including domains such as the quality of family relations, quality of friendships, affect tolerance, insight, and problem-solving capacity. These initial findings suggest that transference work might be a key component in reducing adolescents' depressive symptoms, but not overall functioning.

However, some studies involving young people have expressed caution regarding transference work. This is based on theoretical assumptions that adolescence is a phase where individuals are simultaneously distancing themselves from parental figures and developing their sense of identity, while still trying to develop their capacity for self-regulation (Laufer, 1997). In a qualitative study by Della Rosa and Midgley (2017), they examined young people's reactions to direct transference interpretations. They analysed four sessions from four STPP cases from the IMPACT study in which therapists linked the anxieties the patients mentioned in the session to potential anxiety about ending therapy. Their analysis showed that the young people's responses to these interventions fell into two categories: 'dramatizing' and 'down-playing'. 'Dramatizing' reactions were characterised by general catastrophising about the self, their future, and the therapy relationship, and fluctuating emotionality in the session. On the other hand, those patients who displayed a 'down-playing' response were dismissive about the therapy ending, stating their problems were already solved and they had enough of therapy. In light of these results, the authors suggested that in some contexts, general conversations about relationships (such as indirect interpretations) might feel less threatening or mobilising to young people than direct transference interpretations (Della Rosa & Midgley, 2017).

Indeed, the theoretical and empirical suggestions regarding the role of transference can seem particularly perplexing when contrasted with the findings of the FEST-IT study. It's possible that the 'dramatizing' and 'down-playing' responses noted by Della Rosa and Midgley (2017) are typical reactions in the treatment of adolescent depression and constitute parts of the patients' individual processes of growth or improvement. Consequently, it's worth bearing in mind that Della Rosa and Midgley did not examine outcomes in their study. Therefore, while the adolescents in their study might have been reacting in these specific ways, they could still have been making clinical progress.

With regard to studies that focus on specific features of treatment, it's important to recognise that by selecting specific features, these studies might not control for other aspects of the therapy process that could impact outcomes. They may not even include these additional aspects in their primary analyses. For instance, some studies have proposed that the active ingredients of certain treatments are, in fact, characteristics associated with other treatment modalities. Ablon and Jones (1998), in a pioneering study, developed what they called psychotherapy 'prototypes'. These are empirically validated 'models' of psychotherapy that are created by expert clinicians and can be used to compare how closely 'real life' sessions adhere to prescribed models of various treatment modalities. Ablon and Jones then examined how three types of treatment—psychodynamic psychotherapy (PDT), PDT for post-traumatic stress disorder (PTSD), and CBT—compared to the PDT and CBT prototypes and how the similarity between sessions and prototypes was related to outcomes. Interestingly, although all interventions had similar outcomes in their final assessments, the authors found that features of PDT were significantly associated with better outcomes in both PDT and CBT cases. This suggests that psychodynamic elements within CBT could account for some of the positive changes observed in patients' symptoms.

While psychotherapy prototypes specific to the treatment of adolescents have already been developed (Goodman et al., 2021), no research to date has investigated the congruence between these prototypes and actual therapy sessions, nor their correlation with outcomes. Some preliminary evidence, gleaned from sessions within the IMPACT study, suggests that STPP, CBT, and BPI are empirically distinguishable as treatment modalities (Calderon et al., 2017; Midgley et al., 2018), and that therapists within the study generally adhered to their respective treatment guidelines. Additional evidence indicates that these levels of adherence should be understood within a relational context, with therapists implementing STPP and CBT adhering more closely to their models when working with open and engaged young individuals, as opposed to those who were disengaged or

hostile (Calderon et al., 2018). Despite these enlightening results, the area of exploring treatment adherence and its relationship with outcomes in adolescents, particularly in relation to psychodynamic treatments, remains relatively uncharted.

Collectively, these findings underscore the dynamic and contextual nature of psychotherapy techniques. Analogous to the understanding of the therapy alliance and its ruptures, these findings suggest that the application of techniques could be more precisely scrutinised when the context in which they are utilised is taken into account (e.g., Calderon et al., 2018; Halfon, 2021). In this vein, these studies reveal certain gaps in our comprehension of the psychotherapy process, specifically 'what occurs' during treatment sessions, and highlight the necessity for more integrated or holistic evaluations.

1.4.5 Other cognitive mediators

In addition to alliance features and how therapists employ specific techniques, other studies have also investigated the role of specific cognitive features as mediators for the treatment of adolescent depression. For example, three studies (Gladstone et al., 2014; P. Smith et al., 2015; Topper et al., 2017) have identified that reductions in negative and ruminative thinking mediated the effect of CBT, including an Internet-based prevention programme. Likewise, changes in hopelessness seemed to mediate the effects of CBT (Brent et al., 1998) and Dialectical behaviour therapy (DBT; Mehlum et al., 2019), and higher levels of perfectionism seem to hinder the effects of CBT (Jacobs et al., 2009) for depressed adolescents. Also in the context of mediators that are associated with better outcomes, it was identified that young people’s problem-solving skills mediated the effect of CBT, systemic CBT and nondirective supportive therapy (NST; Dietz et al., 2014). Similarly, adolescent emotional self-awareness mediated the effects of a self-monitoring intervention for depression (Kauer et al., 2012), and changes in

mentalization and interpersonal relationships mediated the effects of Mentalization Based Treatment for Adolescents (MBT-A) for patients who self-harm (Rossouw & Fonagy, 2012).

These mediation studies point to some explanations on what pathways make some specific treatments 'work'. However, it is worth re-stating that all of them assessed treatment effects exclusively in terms of reduction in depressive symptoms. Furthermore, it is noted that this body of research overwhelmingly focused on the delivery of CBT and on cognitive processes and characteristics (Taubner et al., 2023). In that sense, there are significant gaps in the knowledge about how these same mediators influence the outcomes of other treatments such as STPP, BPI, and family therapies. Consequently, there is a paucity of studies addressing psychodynamic features and mediators, including – but not limited to – the use of more or less adaptive defence mechanisms, levels of guilt, and identity integration, as well as systemic features, such as family cohesion, warmth, and competence.

1.5 Final Considerations

Research examining determinants of 'success' and 'failure' in psychotherapy for adolescent depression is varied and multifaceted. Several factors, encompassing individual patient characteristics, therapy-related aspects, and the broader treatment context, have been implicated in therapy outcomes.

Starting with patient characteristics, several studies indicate that the severity of baseline symptoms and the presence of comorbid disorders can significantly impact the effectiveness of psychotherapy. More severe depression and higher levels of comorbidity are associated with poorer treatment outcomes (Curry et al., 2006; Goodyer et al., 2017b; Wilkinson et al., 2009; Young et al., 2006). Nonetheless, it is important to note that most of this evidence base has been derived from studies utilising narrow-band

measures, thereby leaving substantial gaps in our understanding of how change might transpire when considering broader outcome domains and the potential impact of different treatment modalities within those domains.

In terms of therapy-related factors, the therapeutic alliance is often highlighted as a key determinant of therapy success (B. D. McLeod, 2011). This alliance, however, is dynamic and can be marked by ruptures and resolutions that can impact therapy outcomes (Shirk et al., 2011). This also applies to our understanding of the role and impact of psychotherapy techniques: while very few studies have tackled this issue (e.g., Calderon et al., 2018; Halfon, 2021; Midgley et al., 2018), existing findings underscore the need for understanding these techniques within a more contextual and holistic framework.

Moreover, it is also noted that the current literature predominantly focuses on symptom reduction as the main outcome of interest, potentially overlooking some domains that are relevant according to key stakeholders (Krause et al., 2020). In that sense, recent qualitative research has provided an opportunity for young people, their parents, and therapists to voice their experiences with psychotherapy, offering clinically meaningful insights (Fiorini et al., 2024; Løvgren et al., 2019; Marotti et al., 2020; Midgley et al., 2014). However, very few of these studies have correlated these experiences with specific treatment outcomes. Among the few that have done so, more attention has been paid to cases of therapy 'success' (e.g., Cirasola et al., 2022; Goodyer & Kelvin, 2023; Housby et al., 2021) as compared to 'failure' (e.g., Mehta et al., 2023). This suggests a relative lack of focus on instances when therapy 'does not work' (see also Krivzov et al., 2021).

With this backdrop and considering the questions left unanswered by the current literature, the empirical chapters of this thesis aim to fill some of these gaps by drawing data from the IMPACT (Goodyer et al., 2017a, 2017b) and IMPACT-ME (Midgley et al., 2014) studies. The inquiry begins broadly in

Chapter 3, examining all three different treatment modalities (i.e., STPP, CBT, and BPI), and then narrows its focus to STPP exclusively on Chapter 4 and Chapter 5. This is justified by the current literature, that has paid more attention to CBT processes and cognitive features in comparison to psychoanalytic ones, and to allow for a deeper understanding of the specifics of this modality.

The forthcoming chapters encompass an investigation into changes in general psychopathology levels among depressed adolescents (a dimension-based variable), examining how different types of treatment may influence this over time. Building on these findings, the chapters then delve deeper into STPP, examining the psychotherapy process in selected 'successful' and 'unsuccessful' cases in a holistic manner, comparing in-session interactions across cases. Finally, an exclusive focus on 'unsuccessful' therapy is presented, examining how different stakeholders (i.e., young people, their parents, and therapists) interpret their experiences of STPP.

Chapter 2 Context for the current thesis: the IMPACT and IMPACT-ME studies

This thesis' empirical studies (Chapters 3 to 5) draw on data from the IMPACT (Goodyer et al., 2017b) and IMPACT-ME (Midgley et al., 2014) investigations. The present chapter presents an overview for these studies, in order to provide a clearer context to the reader.

2.1 The IMPACT study

The IMPACT study was an NIHR-funded multicentre, pragmatic, randomised controlled trial (RCT) that investigated the effects of short-term treatments in reducing depressive symptoms and preventing relapse in adolescents with moderate to severe depression. 465 participants were randomised to receive either short-term psychoanalytic psychotherapy (STPP), cognitive-behavioural therapy (CBT), or a brief psychosocial intervention (BPI; all described in more detail below). Fifteen child and adolescent mental health services (CAMHS) were involved in this study, being located in three regions in England: East Anglia, the North West, and North London.

2.1.1 Recruitment and eligibility criteria

The recruitment phase for the IMPACT study took place from July 2010 to December 2012 through CAMHS. The study ended in 2016, and the main study report was published the following year. Young people aged between 11- and 17-years old meeting diagnostic criteria for major depressive disorder (MDD; American Psychiatric Association, 2000) were eligible for participating

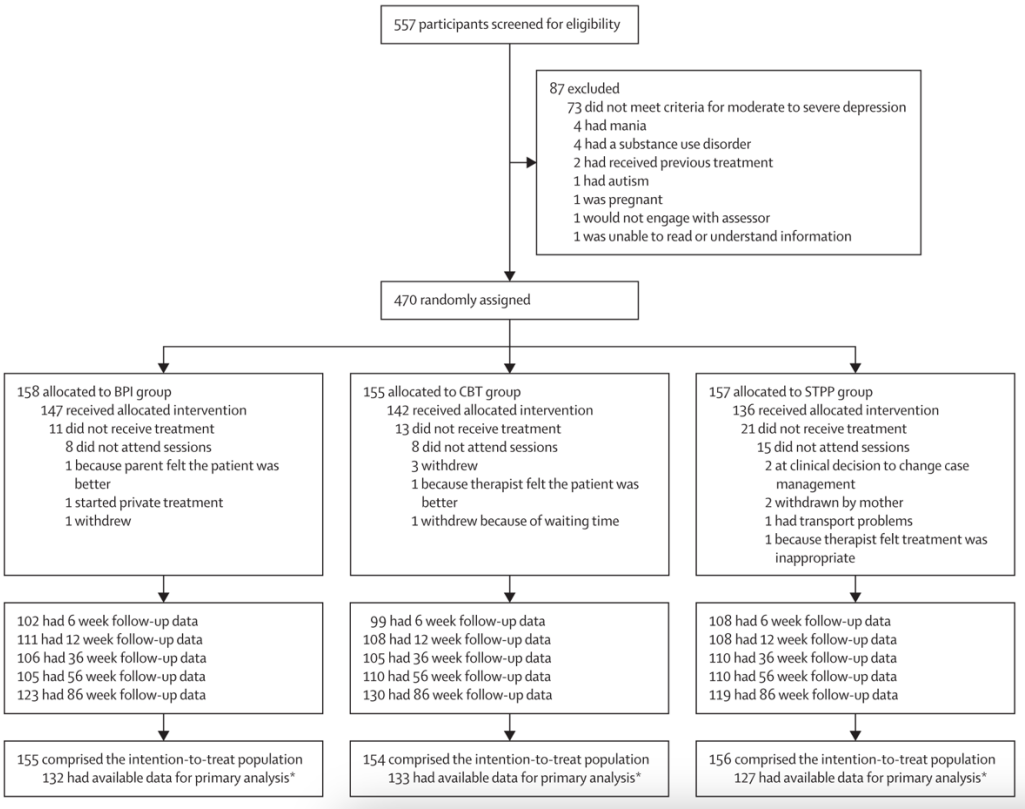
in the IMPACT trial. The diagnosis was assessed by the Kiddie schedule for affective disorders and schizophrenia (K-SADS-PL; Kaufman et al., 1997).

The exclusion criteria were (1) having generalised learning difficulties, (2) having a pervasive developmental disorder, (3) being pregnant, (4) taking a medication that could interact with selective serotonin reuptake inhibitor (SSRI) and being unable to stop taking it, (5) substance abuse, and (6) a primary diagnosis of bipolar type I, schizophrenia or eating disorders. These exclusion criteria were less strict than in other RCTs in order to make the sample as representative as possible of the cases that would seek assistance in CAMHS.

2.1.2 Participants

557 participants went through the initial screening phase. Out of those, 87 cases did not meet the eligibility criteria and 5 withdrew their consent to participate in the study. The remaining 465 young people represent the overall IMPACT sample (See the CONSORT diagram below on Figure 2-1). The mean age of this group was 15.61 years (*SD*=15.61, range=11.30-17.99), and the sample was 75% female. Concerning ethnic groups, 82.2% of the sample was White, 3.4% Black, 1.9% Asian, 7% mixed. 2.4% reported belonging to 'other' ethnic group (i.e., a group not listed in the demographic form), and this information was missing for 3.2% of participants. 156 patients were randomised into STPP, 154 to CBT and 155 to BPI. While Chapter 3 includes all this sample in its analyses, Chapter 4 and Chapter 5 used selected purposive case selection, as described in their respective methods section.

Figure 2-1: *The CONSORT diagram of patient ascertainment in the IMPACT trial*



Note: BPI=brief psychological intervention. CBT=cognitive behavioural therapy. STPP=short-term psychoanalytical psychotherapy. Five patients withdrew consent before starting treatment (n=3 in the BPI group, n=1 each in the CBT and STPP groups) and requested their data be deleted. Source: Goodyer et al. (2017b).

2.1.3 Treatments

The treatments offered as part of the IMPACT study are described below:

- **Short-term psychoanalytic psychotherapy** (STPP; Cregeen et al., 2017): STPP is an intervention aimed at helping the patients to give meaning to their emotional experiences, attachment patterns, and developmental tasks. STPP also includes reflections on the therapeutic relationship and uses supportive and expressive strategies

to help the young person. Therapists in this modality should keep a non-judgemental and enquiring stance (also called a 'psychoanalytic stance'), trying to convey through words what the adolescent is communicating consciously and unconsciously. STPP included up to 28 individual sessions plus seven parent/guardian sessions offered by a different clinician. All STPP therapists were Child and Adolescent Psychotherapists working in the NHS services who were part of the study, and they were accredited by the Association of Child Psychotherapists (ACP).

- **Cognitive-behavioural therapy** (CBT; IMPACT Study CBT Sub-Group, 2010): CBT is an intervention focused on behavioural activation (i.e., helping the patient to engage in activities they no longer do) and in the identification and modification of dysfunctional thoughts processes. Treatments were designed to include up to 20 individual sessions plus four family/parent/guardian sessions to be delivered within 30 weeks. CBT therapists were staff from the National Health System (NHS) from different professional backgrounds, including clinical and counselling psychology, nursing, and occupational therapy. All of them had received specialist training in CBT.
- **Brief psychosocial intervention** (BPI; Kelvin et al., 2010): BPI is a generic action-oriented, goal-focused psychoeducational program on depression, delivered in this study as the control intervention. These treatments were designed to offer up to 12 sessions, delivered within 20 weeks. BPI therapists were intended to be drawn from different backgrounds (e.g., mental health nursing, clinical psychology, psychiatry and mental health social work), however, more than 80% were child psychiatrists. All therapists were experienced mental health professionals working in the NHS services involved in the study and received training on the BPI manual.

Although the treatments were designed to be of different lengths, in practice they were generally shorter, with a median between 6 to 11 sessions. There was no statistically significant difference in treatment dose between the three arms of the study. Following the NICE guidelines (2019), if a clinician from any treatment arm considered that the young person was not benefiting by the psychological intervention by itself, they could recommend the prescription of fluoxetine, a type of SSRI. The methods for prescribing SSRI did not differ between groups, but the reasons for prescribing medication or the patients' compliance to it was not controlled for in the overall study (Goodyer et al., 2017b).

2.1.4 Data collected in the IMPACT study

The data that was used in this thesis and their respective measures are described below. For the complete list of measures used in the IMPACT trial please see Goodyer et al. (2017b).

- **Sociodemographic data:** sociodemographic data was collected through a questionnaire at baseline. It included age, sex, ethnicity, caregivers' occupation, family income, among others.
- **Psychotherapy sessions:** psychotherapy sessions in all arms were audio recorded to be used in studies examining the process of therapy.
- **Depressive symptoms:** depressive symptoms were measured through the Mood and Feelings Questionnaire (MFQ; Daviss et al., 2006; Wood et al., 1995). The MFQ is a self-report measure as experienced in the past two weeks from the assessment date. It includes 33 items on a 0-2 scale. Higher scores reflect a higher severity of depressive symptoms. The MFQ has good test-retest reliability (r=.78; Wood et al., 1995) and Cronbach's α of .82 (Kent et al., 1997);

- **Anxiety symptoms:** anxiety symptoms were assessed by the Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1985). The RCMAS measures current general anxiety, including physiological anxiety, worry/oversensitivity and social concerns. It comprises a 28-item questionnaire on a 4-point scale. Higher scores indicate severer anxiety levels. In the current sample, the RCMAS presented a Cronbach's α <.80 (Goodyer et al., 2017b);
- **Obsessions and compulsions:** obsessions and compulsions were measured by the short Leyton Obsessional Inventory (LOI; Bamber et al., 2002). The LOI is comprised by 11 items to be answered on a 4-point scale, whereas higher scores indicate acuter obsessional thinking and compulsive behaviour. Considering the IMPACT sample, the LOI had a Cronbach's α = .86 (Goodyer et al., 2017b);
- **Antisocial behaviour:** antisocial behaviours were assessed by the behaviours checklist (BC; Goodyer et al., 2017b). The BC is a measure designed specifically for the IMPACT trial and is based on DSM-IV criteria for conduct and oppositional disorders. It comprises 11 items to be filled on a 4-point scale, where higher scores reflect greater proneness to antisocial behaviours. In the present thesis, the BC presented an internal consistency of α = .972.

All symptom measures (MFQ, RCMAS, LOI, and BC) were collected at baseline, weeks 6 and 12 (treatment phase), week 36 (in which >95% of young people had completed their treatments), and weeks 52 and 86 (follow-up period).

2.1.5 IMPACT study main findings

By the end of the IMPACT trial, there was no significant difference in the mean levels of depressive symptoms between the treatment modalities (i.e., STPP, CBT, and BPI). On average, considering the whole sample,

participants presented a 49-52% reduction in their symptom levels at a one-year follow-up. In addition to that, MFQ scores higher than 25, which indicate clinical caseness for depression, were reduced from 96% of participants at baseline to 38% at the last assessment. There were no differences in terms of costs or quality-of-life scores between groups, neither in prescription of SSRI. For more information on the IMPACT trial's findings, see Goodyer et al. (2017b) and Loades, Midgley et al. (2023).

2.2 IMPACT-ME study

The IMPACT-My Experience (IMPACT-ME; Midgley et al., 2014) study was a qualitative investigation embedded into the overall IMPACT trial, which aimed to explore the experience of young people, their parents/carers and the therapists who were taking part in the IMPACT trial. It included separate interviews with young people, their therapists, and their parents following semi-structured protocols. While young people and their parents were invited for interviews in three time points (namely Time 1: before treatment started, focused on expectations of therapy, Time 2: end of treatment, and Time 3: a 1-year follow-up), therapists were interviewed only at the end of the treatment (Time 2). Since this thesis did not focus on expectations of therapy, Time 1 interviews were not included henceforth.

2.2.1 Participants

Only London patients took part into the Times 2 and 3 interviews. Out of the overall IMPACT sample, 112 young people, 72 parents, and 79 therapists were interviewed at T2 and/or T3.

2.2.2 Data collected in the IMPACT-ME study

The IMPACT-ME interviews took place between the years 2011 and 2014. The interviewers were all post-graduate psychologists working on the IMPACT-ME study. They followed a series of semi-structured interview schedules, having received a half-day training session for conducting them.

For T2, the interview schedules were named *Experience of Therapy Interview*, and they were carried out separately with young people, parents, and (where the young person gave permission) therapists. They addressed the participants' perspectives on (a) what were the difficulties of the young person that led them to seek a CAMHS; (b) how they understood these difficulties; (c) any perceived changes within the last calendar year; (d) the 'story' of therapy, including the participants' impressions on the therapy relationship, and any subjectively meaningful moments; their evaluation of psychotherapy including their understanding if therapy was helpful or unhelpful, and it what aspects; (f) their experience of involvement in taking part in a clinical trial.

The *Thinking back about therapy interview* (T3) schedule was used with YP and parents, and most of its items were a review of the ones addressed in T2. It encompassed the participants' perception of (a) how was life since the last interview; (b) their current understandings on what were the difficulties that led the young person to seek help from CAMHS; (c) 'thinking back about therapy', focusing on the participants' recollection about the experience of therapy; (d) any links between therapy and change/no-change; and their experience of taking part in a clinical trial.

The interviews took place at a location of choice of the participants, which was generally in CAMHS or their residence, and took, on average, one hour each (*M* and *SD* for purposefully selected interviews are provided on Chapter 5). They were audio-recorded and transcribed verbatim, hiding any

identifying information such as names, or places. Young people were invited to choose a pseudonym for themselves to be used in any publications.

The full interview schedules for young people in T2 and T3, Therapists in T2, and Parents in T2 and T3 are presented in Appendices 1 to 5, respectively.

2.2.3 IMPACT-ME Study main findings

Since the IMPACT-ME was a qualitative investigation, it did not address *a priori* hypotheses. However, many influential papers analysing its data have contributed to the understanding of adolescent depression and its treatment. That includes the participants' subjective understanding or experience of depression (Midgley, Parkinson, et al., 2017; Parkinson et al., 2016; Weitkamp et al., 2016) and their perspective of what outcomes 'matter' in their treatments (Krause et al., 2020). Regarding the treatment, this data was also used to understand young people's expectations about therapy (Midgley et al., 2016) and their perspective on dropping out of therapy (O'Keeffe et al., 2019), and experiences of 'unsuccessful' treatment (Mehta et al., 2023). For a review of more findings from the IMPACT and IMPACT-ME studies, see Loades, Midgley et al. (2023).

2.3 Ethical procedures

The IMPACT and IMPACT-ME protocols were approved by the Cambridgeshire 2 Research Ethics Committee (reference: 09/H0308/137; Appendix 6). Young people and their parents provided fully informed consent (Appendices 7 and 8), which also covered the use of session recordings for research purposes. While being informed by the studies, adolescents and their parents were given the opportunity to ask any questions and to discuss any

concerns that they had about participating in the investigations. Participants were informed that they had the right to withdraw from the study at any time. UCL and Anna Freud data protection and confidentiality policies were followed.

Chapter 3 Trajectories of change in general psychopathology levels among depressed adolescents in short-term psychotherapies

3.1 Introduction

Despite the increasing appreciation of the effectiveness of talking therapies as treatment of choice for adolescents with depression (Cuijpers, Karyotaki, Eckshtain, et al., 2020; NICE, 2019), we still do not understand enough about differential response, and in particular how different sub-groups of young people respond to psychotherapies. The 'personalised medicine' initiative is based on the suggestion that treatment outcomes can be improved even further by identifying which intervention has the greatest chance of obtaining the best outcome for any one individual (Khoury & Galea, 2016). Psychological therapies, even those with the best evidence base, are not always beneficial with perhaps as many as a third of individuals offered treatment showing either no benefit or a deterioration in symptoms, with large variability in outcomes across individuals (Cuijpers et al., 2019). If studies can identify clusters of individuals who can be predicted to benefit from a therapy based on information gathered before the treatment starts (including demographic and self-reported symptom data) we might be able to make more evidence based clinical and policy decisions (Saunders et al., 2019). Adopting a person-centred approach circumvents the limited success of correlational techniques to identify aggregated patient characteristics used in most past investigation to predict outcomes on the basis of sample co-variance of sample characteristics and treatment outcome (Saunders et al., 2020). Further, attention to such typologies could improve our mechanistic understanding of how different patients are affected by psychotherapy and therefore improving the treatments we offer.

In this context, investigating trajectories of change (i.e., detecting different patterns of change among patients in a given variable over time) can

offer a range of clinical and research contributions. While some investigations focus on the description of mean intervention outcomes, this type of analysis throws light onto heterogeneity in symptom course, identifying possible group trends and allowing for the identification of common trajectories that reveal how early-stage changes can predict final outcomes and such group membership may be predicted by attributes collected prior to initiating treatment (Brière et al., 2016; Saunders et al., 2019). Knowing more about common patterns of therapeutic change could also provide data to policy makers and healthcare providers for planning treatment strategies, and also offer empirical data to develop and guide theories on why patients change (Owen et al., 2015). Furthermore, this approach provides a further dimension in the understanding of what constitutes good or poor outcome, which is often treated in a rather arbitrary way, using *a priori* cut-off points for clinical and non-clinical classifications (Davies et al., 2019).

Different studies drawn from randomised controlled trials have already unveiled trajectories of change in depressive symptoms among adolescents with major depressive disorder (MDD). Maalouf et al. (2012) and Scott et al. (2019), for instance, have investigated the trajectories of change of depressed adolescents who received either drug treatment, cognitive-behavioural therapy (CBT) or a combination of both. Both studies have found three main patterns of change: one that indicated rapid and persistent improvement across time-points, one that had slow but steady improvement across assessments and a third group that had limited response to the treatments offered. The patients in the third 'limited response' groups encompassed 24.9% and 13% of those studies' samples, respectively. Analysing the symptoms from depressed adolescents who received different types of CBT, Brière et al. (2016) have found four trajectories of change. Two of them encompassed patients who had their symptoms improved across time-points, one of them with high baseline scores and the other one low. The other two trajectories were considered 'unsuccessful': one of them presenting high symptom levels across all time points and the other one showing an initial response – up to 6 months after

baseline – but with resurgence of symptoms after this point. Together, the 'unsuccessful' trajectories of this study represented 16% of this sample. Davies et al. (2019) were the first to analyse trajectories of change among depressed adolescents who received talking therapies other than CBT. Re-analysing data from the IMPACT trial, which offered teenagers either CBT, Short-term Psychoanalytic Psychotherapy (STPP) or a manualised Brief Psychosocial Intervention (BPI), the authors have identified two trajectories of change in depressive symptoms: 'continued improvers', who showed steady and persistent improvement across time points, up to a one-year follow-up, and 'halted improvers' (15.9% of the IMPACT sample), who showed improvement up to the 18th week of treatment, which was not sustained and levelled out over the following assessments.

The aforementioned studies are important contributions concerning how adolescents diagnosed with MDD change with treatments, but a limitation among all of them is that they only looked at the outcomes through a single and predefined measure of depressive symptoms, a narrow-band indicator. MDD is frequently associated with other conditions, especially anxiety and behavioural disorders (Avenevoli et al., 2015), as evidenced in the IMPACT study, with 48% of the participants meeting diagnostic criteria for at least one comorbid psychiatric disorder. In this specific study, 21.3% of the sample presented with comorbid generalised anxiety disorder (GAD), 9.5% oppositional defiant disorder and 2.2% obsessive compulsive disorder (Goodyer et al., 2017b). Therefore, focusing only on trajectories of change in depressive symptoms may not give the full picture, and considering change from a multidimensional perspective might provide more clinically meaningful information on the benefits of treatment (Aitken et al., 2020; Caspi et al., 2014; Midgley et al., 2014).

Recently, researchers have begun challenging the traditional diagnostic categorisation of psychopathology and approached change by examining a statistically derived construct of general psychopathology in patients receiving

interventions (e.g., Aitken et al., 2020; Constantinou et al., 2019; M. Wade et al., 2018). General psychopathology – also called the *p* factor – is a concept popularised by Caspi et al. (2014) that represents one's general proneness to suffer from mental disorders. *P* is a robust construct that has been extensively studied in adolescent samples (Castellanos-Ryan et al., 2016; Snyder et al., 2017) and is based on empirical data that suggests psychopathology to be a continuum rather than pre-set categories assumed by diagnostic classification systems (G. T. Smith et al., 2020). Addressing mental suffering as a developmental phenomenon – where different types of symptoms may appear at the same time but also sequentially, provides a more holistic, naturalistic and reliable view when compared to narrow-band perspectives (Kotov et al., 2017; G. T. Smith et al., 2020). In clinical terms, high *p* individuals tend to have more life impairments, regulation and control difficulties when dealing with others, the environment and the self, and worse development histories (Caspi et al., 2014; Selzam et al., 2018).

The incorporation of *p* in tracking patients' change has been made through bifactor modelling in several clinical contexts, such as multisystemic therapy for adolescents with antisocial behaviour (Constantinou et al., 2019), children who received foster care intervention (M. Wade et al., 2018), and depressed adolescents who were randomised into three types of short-term therapies (Aitken et al., 2020). A common finding across those studies was that a range of modalities of treatment promoted a reduction in *p* for patients with a variety of psychopathologies, even when the intervention was supposedly developed for a specific psychiatric condition. More specifically in the study performed by M. Wade et al. (2018), which included a control group, the patients who received foster care intervention had lower *p* scores at the final follow-up than the children who were received care as usual. Those consistent findings indicate that the reduction in general psychopathology might be a common factor modified by numerous modalities and forms of intervention, reflecting a global improvement in the functioning of patients.

Specifically concerning the study of *p* in adolescent psychotherapy research, Aitken et al. (2020) have reported an investigation on the change in general psychopathology among depressed young people who participated in the IMPACT Trial (Goodyer et al., 2017b). Trying to understand how specific and general psychopathology factors changed over time across treatments with similar outcomes, the authors performed a Confirmatory Factor Analysis (CFA) gathering data from a set of narrow-band instruments, including specific measures for depression, anxiety, obsessive-compulsive and conduct disorders. The best-fit model found in this study encompassed six dimensions: one general *p* factor and five specific factors representing symptoms domains when *p*'s variance is taken into account. While the specific factors (namely melancholic features, depressive cognitions, anxiety, obsessions-compulsions and conduct problems) presented inconsistent change over time, the general factor decreased constantly throughout treatments, including the follow-up assessments. Those findings suggested that *p* was the factor that responded most consistently to psychological therapy across three different treatment approaches and that the improvement in the individual levels (such as depression and anxiety) might be best explained by the reduction in *p* itself, rather than in terms of the supposed discrete focus of therapy (Aitken et al., 2020).

In this context, while previous research has investigated both trajectories of change in narrow-band measures and general psychopathology among aggregated groups of depressed adolescents with depression, no investigations have so far explored the potential existence of different trajectories of change *defined* by general psychopathology. If the assumption is correct that psychological therapies have their impact via a broad concept of disorder such as general psychopathology, then the understanding of change in psychological therapy is probably also most effectively scrutinised in terms of common patterns of change in *p* factor scores rather than arbitrarily selected pre-defined narrow-band symptom severity. Aiming to fill this conceptual and empirical gap, this chapter aim was to identify and describe

trajectories of change in general psychopathology and specific symptom domains and among depressed adolescents who received one of three types of short-term psychological therapies. In addition to that, it had two additional aims (1) to investigate how different treatment arms (i.e., STPP, CBT, and BPI) are associated with specific trajectories of change; and (2) to investigate if demographic or clinical characteristics available at baseline including levels of general psychopathology, depressive symptoms, anxiety, obsessions-compulsions and behaviour problems predict membership of a specific trajectory group.

3.2 Method

3.2.1 Study design

The present study is based on secondary data analysis on the Improving Mood with Psychoanalytic and Cognitive Therapies (IMPACT) trial (ISRCTN83033550; Goodyer et al., 2017b). This trial evaluated the treatment and relapse prevention of depression in adolescents, offering three types of manualised short-term therapies for adolescents diagnosed with MDD. The patients were randomised into the following treatments: Short-term Psychoanalytic Psychotherapy (STPP), Cognitive-behavioural therapy (CBT), and a Brief Psychosocial Intervention (BPI). For further information on the design of the trial, see Chapter 2 and Goodyer et al. (2017b).

3.2.2 Participants

465 adolescents aged between 11 and 17 years (*M*=15.6, *SD*=1.4) who met diagnostic criteria for MDD (American Psychiatric Association, 2000). 348 individuals (75%) were female and 82.2% were White, 3.4% Black, 1.9% Asian, and 7% mixed. After an initial assessment, the participants were randomised to one of three treatments. All patients and parents provided informed consent to participate in the trial.

3.2.3 Treatments

- Short-term psychoanalytic psychotherapy (STPP; Cregeen et al., 2017): an intervention aimed at helping the patients to give meaning to their emotional experiences, attachment patterns, and developmental tasks. These treatments were designed to include up to 28 individual sessions plus seven parent/guardian sessions to be delivered within 30 weeks. All therapists were accredited by the Association of Child Psychotherapists (ACP).

- Cognitive-behavioural therapy (CBT; IMPACT Study CBT Sub-Group, 2010): an intervention focused on behavioural activation (i.e., helping the patient to engage in activities they no longer do) and in the identification and modification of dysfunctional thoughts processes. Treatments were designed to include up to 20 individual sessions plus four family/parent/guardian sessions to be delivered within 30 weeks. CBT therapists were staff from the National Health System (NHS) from different professional backgrounds, including clinical and counselling psychology, nursing, and occupational therapy. All of them had received specialist training in CBT.

- Brief psychosocial intervention (Kelvin et al., 2010): a generic action-oriented, goal-focused psychoeducational program on depression, delivered in this study as the control intervention. These treatments were designed to offer up to 12 sessions, delivered within 20 weeks. BPI therapists were intended to be drawn from different backgrounds (e.g., mental health nursing, clinical psychology, psychiatry and mental health social work), however, more than 80% were psychiatrists. All therapists were experienced mental health professionals and received training on the manual for BPI.

All interventions were offered in 15 Children and Adolescent Mental Health Services (CAMHS), located in London, Northwest England and East Anglia, and in practice the median length of treatments was shorter than planned, with no statistical difference in treatment duration between the three groups (Goodyer et al., 2017b). The treatments' delivery were found to be empirically distinguishable (Calderon et al., 2017; Midgley et al., 2018).

3.2.4 Instruments

In order to determine the general and specific symptoms trajectories, the following self-report Likert-scale questionnaires were used, administered at six time-points: baseline, 6, 12, 36, 52, and 86 weeks post-randomisation. (1) the Mood and Feelings Questionnaire (MFQ; Wood et al., 1995): a 33-item measure of depressive symptoms (test-retest reliability, r=.78 (Wood et al., 1995) and Cronbach's α of .82 (Kent et al., 1997)); (2) the Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1985): a 28-item measure for general anxiety (Cronbach's α <.80 (Goodyer et al., 2017b)); (3) the short Leyton Obsessional Inventory (LOI; Bamber et al., 2002): an 11-item measure for obsessive-compulsive symptoms (Cronbach's α =.86 Goodyer et al., 2017b); and (4) a Behaviours checklist (BC; Goodyer et al., 2011): an 11-item measure based on DSM-IV criteria for conduct and oppositional disorders. In all scales, higher scores reflected higher symptom levels.

Furthermore, other baseline characteristics were examined in terms of their potential predictive value for class membership. They were gender, age, serotonin reuptake inhibitors (SSRI) prescription, treatment modality, and comorbidity – the latter assessed by the Kiddie-Schedule for Affective Disorder and Schizophrenia (K-SADS; Kaufman et al., 1997), a semi-structured diagnostic interview.

3.3 Statistical methods

3.3.1 Confirmatory Factor Analysis (CFA)

The narrow-band instruments described above were used to extract the patients' general psychopathology and lower-level factor scores at each time-point. Since this step was a replication of findings previously described by Aitken et al. (2020), a CFA specifying an orthogonal bi-factor model was performed, comprised of a general *p* factor and five lower-level factors: melancholic features, depressive cognitions, anxiety, obsessions-compulsions and conduct problems. For further information on this model, see Aitken et al. (2020). As done by Aitken et al. (2020) and Goodyer et al. (2017b), 'mostly' and 'almost always' responses in the RCMAS, LOI and BC were collapsed.

3.3.2 Latent growth curve analysis

After extracting the factor loadings, the general psychopathology and specific factor scores were submitted to latent growth curve (LGC) analyses to investigate how each factor changed over time. The present analyses started with a linear modelling, which was subsequently compared to a quadratic model in terms of their model fit indices. The best fit solution informed the analyses of trajectories of change.

The model fit indices used to compare the different growth curves were the Comparative Fit Index (CFI) and the Tucker-Lewis Index (TLI). Values above .95 on both would suggest good model fit (Schermelleh-Engel et al., 2003). In addition, the root mean square of error approximation (RMSEA) and the standardised root mean square residual (SRMR) were examined. For these metrics, values below .05 would indicate good fit (Hu & Bentler, 1999).

3.3.3 Trajectories of Change

To determine the trajectories of change in *p* and specific symptom factors, the factor scores for each patient at each time point were used to perform a Latent Class Growth Analysis (LCGA). LCGA is a type of Growth Mixture Modelling (GMM) used to identify latent subgroups of patients that share similar trajectories in a determined variable over time (Andruff et al., 2009; Lutz et al., 2014). By fixing the slope and intercept among participants in each class to zero, it differentiates itself from traditional GMM (Berlin et al., 2014), allowing for clearer class-identifications (Jung & Wickrama, 2008).

For comparing the models, their values for the Vuong-Lo-Medell-Rubin Likelihood Ratio test (VLMR-LRT; Y. Lo et al., 2001), the Akaike Information Criterion (AIC), the Bayesian Information Criterion (BIC) and entropy were analysed. The VLMR-LRT is a comparison between the current K model (a model with K number of classes) and the K-1 model (i.e., the model with one less class). A p-value <.05 indicates that the current model is a better fit than the K-1 model, whereas p-values ≥.05 suggest that the K-1 model should be preferred over the K model. Lower AIC and BIC of one model compared to another also indicates better fit, while higher entropy levels suggest best model fit. Furthermore, it is common practice that all classes should contain at least 5% of the sample for them to be considered numerically stable and clinically meaningful (Gueorguieva et al., 2011; Saunders et al., 2019).

After determining the best fitting solution for the data, Chi-square and one-way ANOVA tests were used to investigate if there were any significant differences between groups concerning their demographic characteristics, treatment arms and baseline symptoms.

3.3.4 Predictors of class membership

Regression models were examined to identify potential predictors of trajectory membership. The specific model would be dependent on the number and type of classes identified - i.e., binary, ordered or multinomial logistic.

3.3.5 Software

The CFA, the latent growth curve analysis and the LCGA were performed using M*plus* 8.4 (Muthén & Muthén, 2017). The analyses exploring demographic differences between groups and predictors of class membership were performed using IBM SPSS v26. To handle missing data, Bayesian methods equivalent to full information maximum likelihood (FIML) for the CFA, LGCA and LCGA and Multiple Imputation for the regression analyses were used.

3.4 Results

As expected, the CFA generated the same model fit indices as described by Aitken et al. (2020) (FP=148, c^2=3,13.42, RMSEA=.045, CFI=.979) and the same factor loadings, as presented in Appendix 9.

Regarding the latent growth curve analysis for the general psychopathology model, the current findings indicated that a linear LGC offered a poor fit, with CFI and TLI scores <.90 (CFI=.839, TLI=.849) and RMSEA and SRMR>.05 (RMSEA=.088, SRMR=.065). Adding a quadratic curve showed improvement in the model fit, with an excellent CFI (.973), good TLI (.967) and both RMSEA and SRMR below .05 (.041 and .0035, respectively).

Concerning the specific factors, linear models presented excellent fit for Conduct Problems (CFI=.97, TLI=.97, RMSEA=.03, SRMR=.04), Depressive Cognitions and Obsessions-compulsions. For the two latter, however, a quadratic model showed a slightly improved fit (CFI=1, TLI=1, RMSEA=.0, SRMR=.02 for both factors). The factors of melancholic features and anxiety did not present good model fit in the LGCAs, presenting CFI and TLI indices below the .95 threshold (CFI=.904 and .852, and TLI=.880 and .815, respectively) and non-significant RMSEA (RMSEA=.063 and .060, respectively), indicating that it was not possible to identify clear patterns of change in those lower-level factors in this sample. The model fit stats for the LGCAs are presented in Table 3-1.

Table 3-1: Latent Growth Curve Analysis for General Psychopathology and Specific Factors

		CFI	TLI	RMSEA	SRMR
General Psychopathology					
	Linear	0.839	0.849	0.088	0.065
	Quadratic	**0.973**	**0.967**	**0.041**	**0.035**
Melancholic features					
	Linear	0.833	0.843	0.072	0.063
	Quadratic	0.904	0.880	0.063	0.048
Depressive Cognitions					
	Linear	0.984	0.985	0.021	0.033
	Quadratic	**1.000**	**1.000**	**0.000**	**0.024**
Anxiety					
	Linear	0.808	0.820	0.060	0.055
	Quadratic	0.852	0.815	0.061	0.047
Obsessions-compulsions					
	Linear	1.000	1.000	0.000	0.026
	Quadratic	**1.000**	**1.000**	**0.000**	**0.022**
Conduct Problems					
	Linear	**0.972**	**0.974**	**0.033**	**0.040**
	Quadratic	0.965	0.956	0.042	0.039

Note. CFI = Comparative Fit Index; TLI = Tucker-Lewis Index (TLI); RMSEA = Root Mean Square of Error Approximation; SRMR = Standardised Root Mean Square Residual.

Where the LGCA indicated that a quadratic curve explained the best the change in that specific factor, LCGAs specifying quadratic curves were run to identify the trajectories of change in those factors over time. Likewise, where the LGCA indicated linear curves, the following analyses would match the same specification. As this investigation did not have any *a priori* hypotheses

concerning the number of latent classes, LCGAs from two-classes upwards were performed, comparing VLMR-LRT values until they became non-significant, whilst also considering the AIC and BIC values.

Concerning the *p* factor, the VLMR-LRT was statistically significant until the 4-class model (*p*=.117), with lower AIC and BIC values for the 3-class model compared to the 2-class model. Therefore the 3-class solution was selected (Table 3-2).

Table 3-2: Latent Class Growth Analysis for General Psychopathology

classes	AIC	BIC	Adj-BIC	VLMR-LRT (p=)	Entropy	% individuals/class
2	7535.85	7589.70	7548.44	0.002	0.76	78/22
3	**7445.55**	**7515.97**	**7462.01**	**0.016**	**0.73**	**12/19/69**
4	7420.07	7507.06	7440.41	0.117	0.77	67/5/10/17
5	7402.60	7506.15	7426.80	0.248	0.72	10/23/9/4/54

Note. AIC = Akaike Information Criterion; BIC = Bayesian Information Criterion; VLMR-LRT = Vuong-Lo-Medell-Rubin Likelihood Ratio test.

The first trajectory of change in *p* encompassed a group of 57 (12.7%) adolescents who had a sharp and fast decrease in their *p* levels over time ("GO"), which was sustained in subsequent assessments. The second class was formed by a group of 322 (66.4%) young people who had a significant and steady decrease in *p* across the study assessments ("SLOW"). The remaining patients (n=86, 20.9%) encompassed a group whose *p* did not decrease significantly after the 12th week ("NO"; Figure 3-1). The class names were paraphrased from Maalouf et al. (2012), who found similar trajectories of change in depressive symptoms among adolescents. A summary of the baseline demographic and diagnostic information for each group is presented in

Table 3-3. The groups were equivalent in their age, ethnicity, treatment modality and SSRI baseline prescription. However, the groups differed concerning sex, baseline symptoms and comorbidity. The 'NO' group included

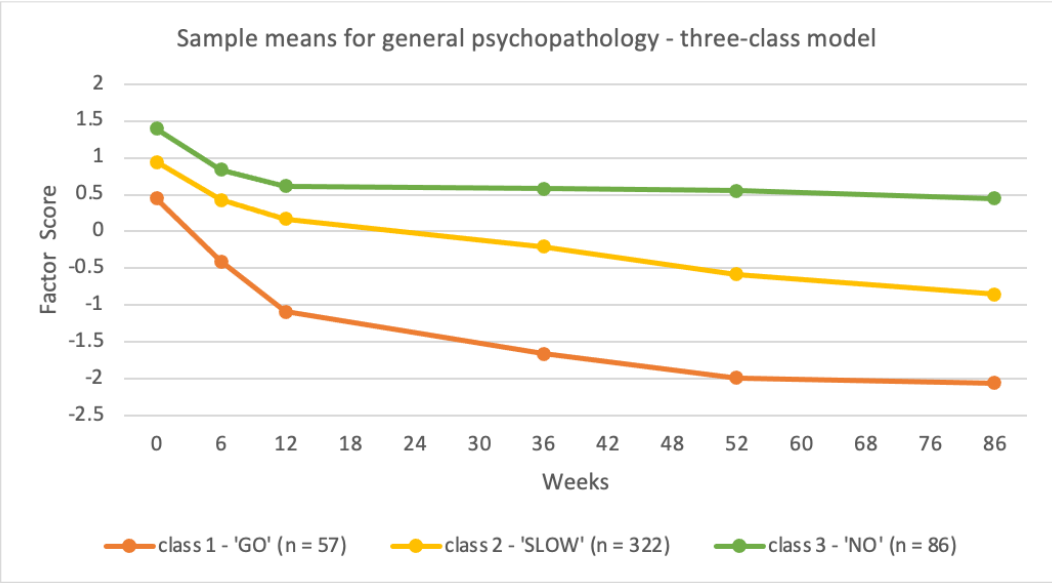
proportionately more females than the overall sample, while the 'GO' group was more male (F=8.203, *p*=.017). Consistent with the overall concept of *p*, the 'NO' group also had higher levels of baseline symptoms of depression (F=39.893, *p*<.001), anxiety (F=14.209, *p*<.001), obsessions-compulsions (F=16.730, *p*<.001), antisocial behaviour (F=5.159, *p*=006), and comorbidity levels than the 'GO' and 'SLOW' groups (c^2=5.385, *p*=.005).

Table 3-3: Characteristics of patients in each latent trajectory of change in general psychopathology

	Class 1: GO (*n*=57)		Class 2: SLOW (*n*=322)		Class 3: NO (*n*=86)		Comparison	
	Mean (*n*)	SD (%)	Mean (*n*)	SD (%)	Mean (*n*)	SD (%)	c^2/F	*p*
Demographics								
Female	35	61.4%	242	75.2%	71	82.6%	8.203	.017
Age	15.46	1.33	15.63	1.42	15.64	1.33	.364	.695
Ethnicity (white)	46	80.7%	252	78.3%	65	75.6%	.548	.760
Treatment arm							.658	.956
BPI	17	29.8%	111	34.5%	27	31.4%		
CBT	20	35.1%	105	32.6%	29	33.7%		
STPP	20	35.1%	106	32.9%	30	34.9%		
Baseline symptoms								
MFQ	38.11	12.13	45.51	9.82	52.83	7.71	39.893	.000
RCMAS	37.33	10.35	40.82	6.66	43.73	5.72	14.209	.000
LOI	7.72	5	9.73	5.09	12.52	5.14	16.730	.000
BC	2.70	2.89	3.17	2.96	4.25	3.87	5.159	.006
Comorbidity							5.385	.005
0	35	61.4%	156	48.4%	32	37.2%		
1	18	31.6%	85	26.4%	32	37.2%		
2	1	1.7%	45	14%	15	17.4%		
3	3	5.3%	23	7.1%	8	9.3%		
Baseline SSRI prescription	11	19.3%	62	19.3%	16	18.6%	1.309	.860

Note. BPI = Brief Psychosocial Intervention; CBT = Cognitive-Behavioural Therapy; STPP = Short-term Psychoanalytic Psychotherapy; MFQ = Mood and Feelings Questionnaire; RCMAS = Revised Children's Manifest Anxiety Scale; LOI = Leyton Obsessions Inventory; BC = Behaviour Checklist.

Figure 3-1: *Latent class growth analysis for general psychopathology*



Regarding the lower-level factors, a two-class solution presented the best fit for obsessions-compulsions (p=.006), whereas three-class solutions were the best fit for depressive cognitions (p=.020) and conduct problems (p<.001). The model fit information for all lower-level factors' LCGAs is presented in Table 3-4. The baseline characteristics for each lower-level factors' trajectories are presented in Appendices 10 to 12. The factors of melancholic features and anxiety did not present significant values for the two-class models (p=.438 and .349, respectively). Hence, free loadings on the LCGAs for the melancholic features and anxiety factors were run, but they also led to non-significant results. Taken altogether, this indicates that it was not possible to identify significant trajectories of change for these two specific symptoms factors after extracting *p*'s variance from them.

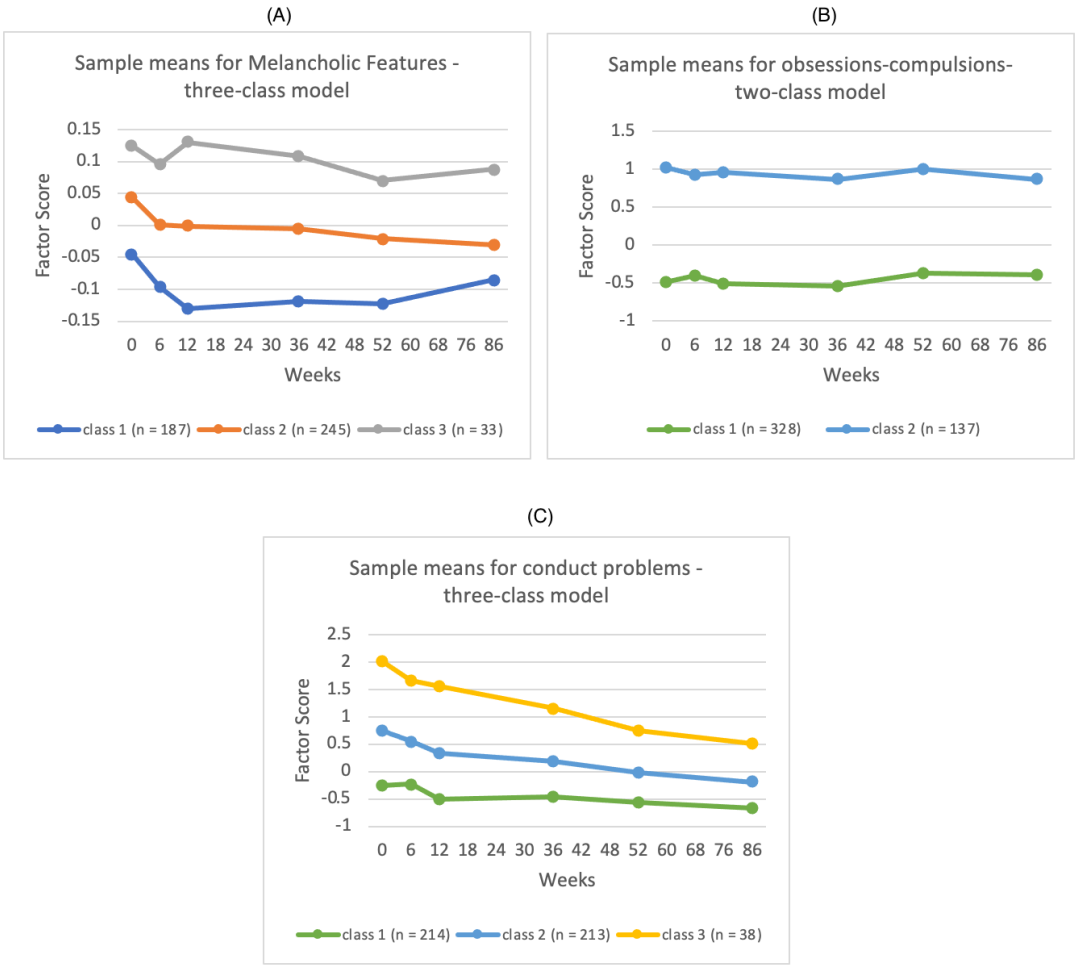
Table 3-4: Latent Class Growth Analysis for Lower-level Factors

	classes	AIC	BIC	Adj-BIC	VLMR-LRT (p=)	Entropy	% individuals/class
Melancholic features (quadratic)							
	2	-4562.66	-4508.81	-4550.07	0.438	0.56	31/68
Depressive Cognitions (quadratic)							
	2	8393.23	8447.07	8405.81	0.000	0.61	31/68
	3	**8364.51**	**8434.93**	**8380.98**	**0.020**	**0.59**	**50/41/8**
	4	8359.19	8446.17	8379.52	0.217	0.56	9/29/47/12
Anxiety (quadratic)							
	2	-3398.760	-3344.914	-3386.173	0.349	0.463	38/61
Obsessions-compulsions (quadratic)							
	2	**8903.55**	**8957.39**	**8916.13**	**0.006**	**0.73**	**69/30**
	3	8763.74	8834.15	8780.20	0.148	0.74	54/38/7
Conduct Problems (linear)							
	2	7608.41	7653.97	7619.06	0.000	0.70	29/70
	3	**7545.72**	**7603.71**	**7559.28**	**0.000**	**0.68**	**8/46/46**

Note. AIC = Akaike Information Criterion; BIC = Bayesian Information Criterion; VLMR-LRT = Vuong-Lo-Medell-Rubin Likelihood Ratio test.

The LCGA for depressive cognitions and obsessions-compulsions evidenced different trajectories where symptom levels were constant throughout all time points. In the conduct problems trajectories, however, three trajectories of decreasing symptoms were identified. Although two of those groups presented marginal symptom decrease over time, a small one (n=38, 8.2%, class 3) showed a more accentuated lowering in their behaviour problems. Figure 3-2 contains the graphs on lower-level factors' trajectories.

Figure 3-2: *Latent class growth analysis for (A) Depressive Cognitions, (B) Obsessions-compulsions, and (C) Conduct Problems.*



Since the *p* trajectories ranged from better-to-worse outcomes, ordinal logistic regression was chosen to identify potential predictors of trajectory membership. When controlling for gender, age, SSRI prescription, treatment arm, comorbidity, *p*, MFQ, RCMAS, LOI, and BC scores, only baseline *p* significantly predicted class membership (Table 3-5). Higher *p* levels at the beginning of treatment increased the odds (Odds ratio [OR]=0.41, 95% confidence interval [95%CI]=0.19 to 0.88) of a patient belonging to unsuccessful trajectories. Surprisingly, when controlling for other variables, treatment arm did not predict trajectory of *p*. Predictors for lower-level factors trajectories are presented in Appendix 13.

Table 3-5: Baseline predictors of general psychopathology trajectory class membership: clinical characteristics

	OR	95% CI
Gender	0.65	0.40—1.07
Age	1.02	0.88—1.18
SSRI	1.00	0.99—1.01
Treatment modality	0.98	0.77—1.26
P-factor	**0.41***	**0.19—0.88**
MFQ	0.97	0.93—1.02
RCMAS	1.02	0.98—1.06
LOI	0.97	0.93—1.02
BC	0.98	0.91—1.05
Comorbidity	0.89	0.74—1.06

*p<0.05

Note. OR = Odds Ratio, CI = Confidence Interval, SSRI = baseline intake of selective serotonin reuptake inhibitors, MFQ = Mood and Feelings Questionnaire, RCMAS = Revised Children's Manifest Anxiety Scale; LOI = Leyton Obsessions Inventory; BC = Behaviour Checklist.

3.5 Discussion

The present study aimed to identify and describe patterns of change in general psychopathology and lower-level factors among depressed adolescents who received one of three types of short-term talking therapies, as well as exploring potential predictors of membership to the different trajectories. To address these questions, this chapter was built on findings of a primary study on *p* in depressed adolescents, running computational analyses to identify trajectories of change in their *p* levels.

Concerning the first and main aim of the present study, the best fitting model revealed three distinct trajectories, which were named 'GO' (12.7%), 'SLOW' (66.4%), and 'NO' (20.9%), paraphrasing Maalouf et al. (2012). As found in previous research (Davies et al., 2019; Maalouf et al., 2012; Scott et al., 2019), one group (20.9% of the sample) scoring in clinical range at the last assessment was identified, encompassing limited responders, non-responders and patients who deteriorated in their *p* levels. In the current analyses, the three groups showed decrease in *p* up until the 12th week,

however, this was not maintained for the 'NO' group in the subsequent evaluations.

The change patterns identified for *p* appear similar to those examined in narrow-band depressive symptoms (using the symptom measure, not the lower-level factors presented in the current study). As in previous literature, the present results support the idea that it is only possible to predict a patient's outcome from at least 6 to 12 weeks after baseline (Davies et al., 2019; Maalouf et al., 2012; Scott et al., 2019).

However, it was also noted that the 'GO' and 'SLOW' groups had significantly different *p* levels at the last assessment (week 86), suggesting that some patients (in this study, 12.7% of the sample) may have a significantly higher improvement at follow-up when compared to other 'improvers'. This contrasts with previous studies examining depressive symptoms' trajectories: even when a 'fast improvement' and a 'steady improvement' trajectory were found, the groups' outcomes at the last assessment were equivalent (Maalouf et al., 2012; Scott et al., 2019). This chapter's findings thus indicate that *p* offers a new layer in the understanding of patients' response to psychotherapy: when taking a more holistic look at the patients, some seemed to achieve a 'higher' or more global improvement.

Directly comparing our findings with Davies et al.'s (2019), who examined trajectories of change in depressive symptoms in the same sample, the *p* trajectories suggest that the number of patients who did not benefit from treatments might be larger than previously found. While the trajectories of change in depressive symptoms shed light on a group of 74 'halted-improvers' (15.9% of the IMPACT sample), examining *p* levels showed that this group was larger (86 teenagers, 18.5% of the total sample). In *post hoc* examinations it was also noticed that six patients of the 'NO' group (6.9% of this trajectory) had non-clinical scores for depression at the last assessment, but clinical scores in other narrow-band instruments for anxiety, obsessions-compulsions

and/or behaviour problems. Taken altogether, these findings indicate that including *p* evidenced more parsimonious results, also reinforcing the view that focusing on depressive symptoms alone may offer a limited view of the patients' sufferings.

Concerning the lower-level factors, it was found that most trajectories demonstrated stable symptom levels across all assessment points. These findings suggest that the psychotherapies offered may not have promoted significant change in the specific features of depressive cognitions, obsessions-compulsions and behaviour problems when *p*'s variance was removed. One possible conclusion that could be drawn is that the factors that are not part of the overall *p* factor may encompass the patients' trait-like characteristics or features that are less responsive to psychotherapies, as pointed out by Aitken et al. (2020). However, is it worth noting that the discussion of what psychopathology factors *mean* when *p* is taken from them is still being broadly discussed in the literature (G. T. Smith et al., 2020). One exception among the patterns was the decreasing-symptom trajectory on the behaviour problems factor, being the only factor where symptoms significantly declined throughout the study's assessments. This finding indicates that the patients who presented antisocial behaviour levels over and beyond what is included in *p* in this sample had a decrease in this factor, even though these problems were not the primary focus of any of the interventions offered.

A curious finding is that it was not possible to identify patterns of change in the melancholic features and anxiety lower-level factors. These findings may indicate that there were no typical patterns of change within these features, or that the current sample size was not big enough to model them. Further investigation is advised for understanding how the multiple lower-level factors of psychopathology, beyond what is included in general psychopathology, respond to psychotherapy.

After identifying the trajectories of change, two other additional aims were addressed, both concerning predictors of class membership. The first step was defining how each treatment arm was associated with the different trajectories of change. According to the current findings, receiving a particular type of intervention did not predict class membership in terms of change in *p* nor in the lower-level factors. This indicates that STPP, CBT and BPI did not differ in terms of promoting faster, slower or limited change in general psychopathology. These results also suggest that the different approaches did not present differences in how they promote change in lower-level factors.

Finally, concerning the third aim, it was analysed which baseline indicators could predict trajectory class membership (if any). In this analysis, only baseline *p* predicted class membership when controlling for the other variables. This finding suggests that patients with lower baseline *p* are more likely to be fast responders ('GO' group), whilst higher *p* young people are more prone to present with poorer outcomes ('NO' group). Similarly, a previous study examining a youth sample participating in a trial on the treatment of anxiety disorders found equivalent results, with *p* consistently predicting long-term outcomes (Cervin et al., 2021). Since *p* is a construct that reflects global impairment and proneness to mental suffering, it is expected that high *p* patients would face difficulties in multiple domains, thus increasing their overall mental health burden (Caspi et al., 2014; G. T. Smith et al., 2020). These findings emphasise the importance of early screening of young people with high levels of general psychopathology, who may be less responsive to traditional talking therapies and may require more targeted treatment strategies, including more intensive or multidisciplinary support.

3.6 Limitations

Because this study was based in UK NHS clinics, the current findings may not be generalisable to populations from differing contexts, especially the

ones who are disadvantaged and/or discriminated against when attempting to access mental health services. Also, being 82% of our sample white, the findings presented here do not necessarily apply to ethnic-minority youth. This investigation also did not control for any therapist factors in this study. Further investigations in this paradigm could address therapists' characteristics that may impact the patients' trajectories of change.

Furthermore, the *p* and specific factors values used in this study were drawn from a CFA based on self-report narrow-band measures for depression, anxiety, obsessions-compulsions, and behaviour problems. With this framework, it is noted that the present model is skewed towards internalising symptoms in comparison to previous studies examining the *p* factor and may carry the issues related to using narrow-band measures. This is an important limitation of performing secondary data analysis, as the instruments could not be changed for the present study. Future studies including the perspectives of multiple informants and other symptoms dimensions of *p* into the analysis – such as substance use – could make the model more reliable.

Finally, only initial *p* scores were associated with trajectory membership from the available participant characteristics. However, it is crucial to highlight that the prediction tests were drawn without a replication sample (or a 'test set'). Therefore, this chapter's findings might encompass an overfit model (Simmons et al., 2011). Future analyses might consider additional characteristics which might have more predictive value, and therefore further increase the utility of these trajectories in clinical practice. Additionally, clinicians cannot easily identify the patients' *p* scores from the measures alone, as they were based on computational analysis, so transpositions of these findings to a clinically trained population are needed.

3.7 Conclusions

In summary, this study identified different patterns of change in general psychopathology and lower-level factors among depressed adolescents who received one of three types of short-term psychotherapy. By converting narrow-band scores into a general index of psychopathology, two trajectories of treatment response characterised by positive outcomes and one trajectory with limited response were found. By looking at differences between class membership in depressive symptoms and general psychopathology, it is proposed that *p* might be a more parsimonious indicator for understanding patients' change. Furthermore, the lower-level factors fit into globally stable trajectories, indicating some trait-like characteristics that did not change significantly with psychotherapy.

This study's findings still raise questions about why the patients in the 'NO' group did not respond to psychotherapy as expected, and how clinicians and researchers could help them to benefit from these treatments. Further research addressing these treatment processes could contribute to the understanding of these phenomena.

Chapter 4 Short-Term Psychoanalytic Psychotherapy with Depressed Adolescents: Comparing In-Session Interactions in Good and Poor Outcome Cases

4.1 Introduction

Despite the growing evince of effectiveness of psychoanalytic psychotherapies for the treatment of adolescent depression (Cuijpers, Karyotaki, Eckshtain, et al., 2020; NICE, 2019), no response and even deterioration is still an issue that affects up to a third of patients (Cuijpers et al., 2019). In this context, investigating the therapeutic processes associated with successful and unsuccessful treatments can contribute to the promotion of more effective interventions (Weisz & Kazdin, 2017).

Considering the current body of empirical literature on what contributes to change in adult psychotherapy, Norcross and Lambert (2019), examining a series of outcome studies and meta-analyses, drew some general conclusions regarding what is associated with treatments that work and that *do not* work. Firstly, the authors estimated that the patient's characteristics account for around 30% of the variance in treatments' outcomes, indicating that patients who are more motivated or engaged in their psychotherapy process and have less severe mental health difficulties are more likely to achieve better outcomes. This was followed by the therapy relationship, accounting for 15% of the variance in outcomes; and then the treatment method or techniques, accounting for 10% of the variance. Specific relational features such as therapeutic alliance, collaboration, goal consensus, empathy, and positive regard and affirmation have all been found demonstrably effective through correlational studies, ranging from small to medium effect sizes. Conversely, the authors stated that ineffective treatments contained the reverse of what was identified as beneficial through meta-analyses, such as poor alliance and

low levels of collaboration, as well as the therapist not adapting to the patient's feedback or comments, as well as ignoring the alliance ruptures.

Most of the research on what contributes to change in therapy has been conducted with adults, but it is unclear to what degree these findings may or may not transfer to therapy with young people. For these specific populations, while some demographic variables seem to impact outcomes, such as the patient's age (Baskin et al., 2010; Lin & Bratton, 2015; Target & Fonagy, 1994), and ethnicity (Lin & Bratton, 2015; Nilsen et al., 2013; van der Stouwe et al., 2014), the current body of literature has not reached consistent findings on what factors are associated with change (Hayes, 2017). In addition to that, most evidence does not address *how* or *why* these variables impact outcomes. Moreover, some in-session features appear to contribute to outcomes, such as the patient's commitment and openness (Lilliengren et al., 2019; Watsford & Rickwood, 2014), and the techniques used by therapists (Fonagy & Moran, 1990; Halfon, 2021; Luzzi et al., 2015). Within this complex framework, paying attention to the factors directly related to the therapy hour may be especially valuable in informing researchers and clinicians on what are the most effective techniques to be adopted in each case, and what patient behaviours may signal a need for adaptations in the setting.

Considering the context of psychoanalytic psychotherapies, one should bear in mind its specific aims and methods. Psychoanalytic psychotherapies are treatments that intend to reduce patients' symptoms but also help them to improve their insight capacity, foster better relationships, and resume their normal course of development (Romanowski et al., 2015; Shedler, 2010). To achieve that goal with depressed patients, effective psychoanalytic therapies are expected to work with the therapist-patient relationship as a way to unfold the patient's unconscious feelings and anxieties related to depression and their overall problems (Cregeen et al., 2017). From this examination, as pointed out by Cregeen et al. (2017), psychotherapists should then interpret those feelings, making room for discussions and their subsequent understanding.

Previous research examining the relationship between psychoanalytic techniques and outcomes has indicated that the effect of those techniques depends on the context in which they take place. Halfon (2021), for instance, by examining the treatments of 79 children in outpatient care for different conditions in Turkey, found that the employment of psychoanalytic techniques such as transference work, defence analysis, and play interpretations, in the context of an unstructured setting was associated with positive outcomes when there was a well-established therapeutic alliance. However, the employment of the same psychoanalytic techniques was associated with worse outcomes when taking place in the context of a therapy characterised by poor alliance. These findings indicate that the prescription of greater use of 'psychoanalytic techniques' is not always the gold standard in psychodynamic psychotherapies. Furthermore, they also provide empirical hints that some therapeutic interventions may be more effective in certain relational contexts, while in others may lead to worse outcomes (Halfon, 2021).

Trying to understand and describe how patient-therapist interactions occur in an integrated way – i.e., considering altogether the therapist, the patient, and the climate of the sessions – Enrico Jones developed the Psychotherapy Process Q-Set (PQS; Jones, 1985, 2000b). The PQS is an ipsative measure used to assess dyadic interactions from full-length session audio or video recordings with adult patients, and previous research employing it has shed light on possible in-session patterns that might be associated with different outcomes.

The first study using the PQS was published by Jones (2000a), who examined three cases of long-term psychoanalytic psychotherapy with adults diagnosed with major depressive disorder (MDD). In this investigation, the session ratings from each case were submitted to separate factor analysis, and for each case, a different set of factors described what took place in the treatments. The only poor outcome case presented three identifiable factors: (1) Collaborative Exploration, (2) Resistance and Withdrawal, (3) Angry

Interaction. According to the author's analysis, even though there were collaborative moments between the dyad in this treatment (Factor 1), the Angry Interaction factor (Factor 3), characterising competitive and tense encounters, was also consistent over time. Furthermore, the Angry Interaction factor was positively associated with the patient's outcome measures over time: in the sessions when the patient presented higher symptom levels, higher levels of the factor 'Angry Interaction' were also identified.

In contrast, one of the good outcome cases in Jones' (2000a) study evidenced the following three identifiable interaction patterns: (1) Collaborative Exploration, (2) Ambivalence/Compliance, (3) Provoking Rescue (comprised of items describing a patient with depressive mood, a sense of inferiority and low self-esteem and with prolonged silences). In this case, a collaborative exploration factor was found (Factor 1) as in the poor outcome case, alongside a factor where the patient presented themselves silent and in low mood (Factor 3). Through time-series analysis, Jones identified that the decline of Factor 3, Provoking Rescue, was associated with improvement in symptoms of depression and overall functioning. The interaction patterns in the other good outcome case examined in this same study were described by four factors: (1) Therapist Neutral Acceptance, (2) Therapist Suppresses the Patient's Negative Self Representations, (3) Psychodynamic Technique, and (4) Patient Dysphoric Affect. In this latter case, higher factor 2 scores were associated with lower symptom levels, indicating that therapist's stances of actively challenging and suppressing the patient's negative views about themselves appeared to be beneficial.

Overall, Jones' (2000a) findings suggest that in both successful and unsuccessful cases one can identify interactions where the dyad works collaboratively. However, other factors such as tension between the dyad and the presentation of the patients' symptoms within the sessions may be associated with different outcomes. Beyond describing interactions that may unfold in the treatment of adults diagnosed with MDD, these findings also

signal the importance of understanding the treatments in a longitudinal perspective: the prevalence of specific interactions over time may be an indication of the patient's symptoms progression, as well as the therapist's reactions facing them (or vice versa). Perhaps what Jones (2000a) referred to as working on reducing tense interactions or helping the patient overcome withdrawal is related to the growing literature indicating the therapeutic effects of resolving alliance ruptures (Eubanks et al., 2019).

Considering the design employed by Jones (2000a), it is worth noting this study's limitations. Firstly, by being based on three treatments, these findings have limited generalisability, and they do not inform the prevalence of those factors in the wider population. Furthermore, the author only presented the full item description for the factors more significantly associated with symptom change. That left other factors that could be crucial in other cases without a thorough description, allowing for comparisons in further studies. In addition, although some interaction patterns identified were similar across cases (e.g., 'Collaborative Exploration'), no case comparisons were drawn.

Addressing some of the limitations identified in Jones' (2000a) study, Lilliengren et al. (2019) used the same instrument (the PQS) to compare how these interactions patterns unfold in successful versus unsuccessful treatments. To do so, the authors assessed 845 sessions from 20 cases of Cognitive-Behavioural Therapy (CBT) and Short-Term Psychoanalytic Psychotherapy (STPP) for adults with cluster C personality disorders. According to their findings, which were drawn from examining which individual PQS items differentiated good and poor outcome cases, successful cases across both treatment modalities were characterised by an active and committed patient who was open for introspection. Conversely, the unsuccessful cases were associated with higher controlling and directive therapeutic stance, regardless of the therapy approach. It is noteworthy that in this study all items significantly related to better outcomes were patient items, and as indicated by Jones (2000a), these results signal the importance of

paying attention to how patients present themselves in the therapy hour, as this may inform the necessity of working on the promotion of patient engagement. In the opposite direction, all items associated with worse outcomes were therapist items, suggesting that, for those patients, therapist excessive directedness may be counterproductive. Nevertheless, Lilliengren et al.'s (2019) analyses did not examine if there were any specific contexts associated with therapists acting in this manner.

Compared to the treatment of adults, only a small amount of research has examined in-session interactions with adolescents. In the context of the short-term treatment of adolescent depression, Calderon et al. (2018) used the adolescent version of the PQS, the Adolescent Psychotherapy Q-Set (APQ; Calderon, 2014; Calderon et al., 2017), to assess 70 sessions of 70 different psychotherapy cases, also divided into patients who received CBT and STPP. In this study, all sessions were submitted to an Exploratory Factor Analysis (EFA), which generated three distinct factors. Out of those, two factors captured the sessions under the STPP modality: the first one described dynamics where the young people were emotionally connected with the session's material, while their respective therapists helped them reflect on their experiences and to develop their self-understanding. The second one, in contrast, evidenced interactions where the patients were disengaged in the session, with their therapists taking a more active approach, such as asking questions or actively structuring the sessions. Calderon et al.'s (2018) findings indicate that when depressed adolescents work collaboratively with their psychoanalytic therapists, the therapy process takes a more 'traditional' psychoanalytic framework, focusing on the patient's internal states and interpersonal relationships. Conversely, these findings suggest that when the patient is disengaged, psychoanalytic psychotherapists tend to adopt a more directive approach, distancing themselves from classic psychoanalytic techniques, maybe trying to engage the patients in a more active or structured way to try to encourage them to participate more fully in the therapy session.

Beyond describing how depressed adolescents may present themselves in psychotherapy sessions, Calderon et al.'s (2018) results also shed light on how therapists may behave in these settings. However, one limitation of this study is that it did not carry out any analysis of the relation between the interactions and the patient's outcomes, hence we still do not know if these different types of interactions are associated with successful or unsuccessful treatments. Furthermore, neither Lilliengren et al. (2019) nor Calderon et al. (2018) examined dyadic interactions longitudinally, and both studies ran joint analyses with STPP and CBT sessions. Consequently, we also do not know if there were any meaningful identifiable fluctuations in these interaction patterns over time, or if any specifics of these treatment modalities were 'washed out' in their analyses.

Understanding that psychotherapies characteristically encompass non-linear processes, where one can find 'ups-and-downs' in the therapy relationship and outcomes over time, as well as sudden and late gains (Luyten et al., 2012), it is fundamental to examine treatments as longitudinal phenomena. Considering this dimension could allow for a more accurate appraisal of what is associated with therapeutic success or failure, what is expected in better or worse treatments, and inform researchers and clinicians on more effective ways to deliver the available interventions.

Therefore, the current study had the following aims: (1) To identify and describe interaction patterns between psychoanalytic therapists and young people diagnosed with major depressive disorder; (2) To examine the association of these interaction patterns with the therapeutic process of good and poor outcome cases; and (3) to assess how these interaction patterns changed over time in good and poor outcome cases.

4.2 Methods

The treatments examined in this study were part of the Improving Mood with Psychoanalytic and Cognitive Therapies (IMPACT) trial (Goodyer et al., 2017b). All psychotherapies took place in Child and Adolescent Mental Health Services (CAMHS) in London, following the STPP manual (Cregeen et al., 2017). For more information on the IMPACT Trial see Chapter 2 and Goodyer et al. (2017b) , and on the STPP manual see Cregeen et al. (2017).

4.2.1 Participants

In order to address this study's aims, a subsample of patients who participated in the IMPACT study (Goodyer et al., 2017b) was selected. Selecting a subsample from this larger investigation allowed for the in-depth analysis of the patients' STPP process as well as the assessment of possible changes in the psychotherapy process over time.

The participants selected for this study were 10 adolescents diagnosed with Major Depressive Disorder (MDD; American Psychiatric Association, 2000) randomised to the IMPACT study STPP arm and their respective psychotherapists. Selection criteria included being randomised into the STPP IMPACT arm and having a minimum of 8 session recordings available. After applying the treatment arm and session availability criteria, only 22 participants were eligible from the overall sample. Out of those, the 5 with the highest likelihood of experiencing a 'poor outcome' trajectory of change in general psychopathology (as described in Chapter 3) were selected and grouped as the 'poor outcome' subsample. The likelihood of belonging to the 'poor outcome' trajectory was a calculation already embedded in the LCGA presented in Chapter 3. This approach was preferred over simply selecting the 5 cases with the highest symptom scores at the last assessment as it accounts for changes over time. Therefore, these 5 patients were the ones who were

the most likely to have had poor change over time. Since baseline symptoms predicted patient improvement in the IMPACT study (see Table 3-5), the SPSS Case Control Matching Tool was used to select 5 patients for the good outcome group with equivalent baseline Mood and Feelings Questionnaire (MFQ; Wood et al., 1995) scores to avoid confounds. The MFQ was used for the case matching because it was more intuitive to set tolerance levels that were clinically meaningful than with the p-factor loadings. The patients' mean baseline age was 15.80 years old (*SD*=1.38, range: 13.13-17.67), and 70% (n=7) of the sample was female. 70% (n=7) of the adolescents were white, while 1 was Asian (10%), one was from a mixed ethnic background (10%), and one did not state their ethnicity (10%). The groups did not differ at baseline in terms of their depression scores (t=.000, p<.001), as calculated by t-tests for paired samples, meaning they had equivalent symptom levels at the beginning of their treatments. By the end of their latest assessments, however, the patients in the 'poor' outcome group had significantly higher depression scores, as measured by the MFQ ($t(8)$= 3.823, p=.005). A summary on the 'poor outcome' patients' demographic and symptom information is presented in Table 4-1, and on the 'good outcome' ones in Table 4-2.

Table 4-1: 'Poor outcome' group information

IMPACT ID	**2101**	**2113**	**2134**	**2349**	**2321**
MFQ baseline	29	61	51	56	48
MFQ week 6	20	n/a	45	n/a	40
MFQ week 12	43	41	37	39	45
MFQ week 36	41	48	38	40	57
MFQ week 52	46	45	49	25	62
MFQ week 86	29	n/a	36	43	n/a
Baseline age	16.13	16.17	14.78	17.52	13.13
Sex	♂	♀	♂	♀	♀
Ethnicity	White	White	Mixed	White	White

Table 4-2: 'Good outcome' group information

IMPACT ID	2312	2133	2360	2209	2336
MFQ baseline	41	54	50	56	44
MFQ week 6	40	43	34	45	39
MFQ week 12	37	43	52	44	n/a
MFQ week 36	9	14	18	26	23
MFQ week 52	30	12	14	28	22
MFQ week 86	23	28	11	18	15
Baseline age	14.84	17.67	15.34	16.76	15.50
Sex	♀	♀	♂	♀	♀
Ethnicity	White	Missing	White	Asian	White

4.2.2 Session recordings

100 psychotherapy sessions were examined in this study, equally divided between the groups (50 for the good outcome group and 50 for the poor outcome group). The selection of 100 sessions was the minimum required for the factor analysis employed, as described below.

In order to select the sessions to be analysed, the first and last sessions from each case were excluded, as it was expected that they would not reflect typical therapy processes. Afterwards, the remaining sessions were divided into ‘early’ and ‘late’ treatment. Since session recordings availability was not even across cases, the distinction between early and late phases was drawn from the middle point available in each treatment. From the available recordings, 8 to 11 sessions were selected for each case, with half of them being randomly drawn from the early treatment strata and the other half from the late treatment strata.

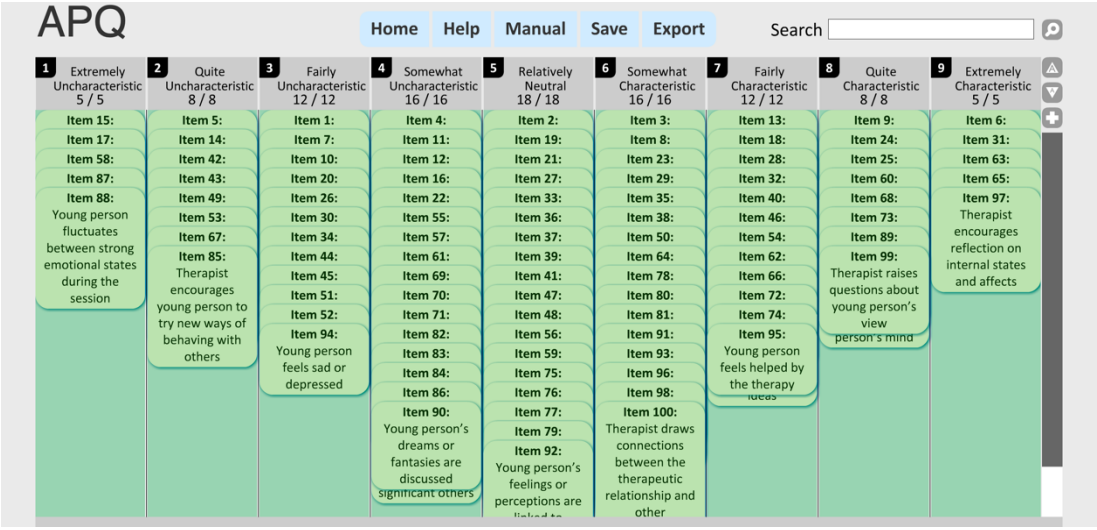
The sessions’ duration ranged from 15 to 57 minutes (*M*=45.56 minutes, *SD*=7.49). Although the time offered in each session was roughly the same, some recordings were shorter due to the circumstances of those specific sessions (the most usual reason was the patient being late).

4.2.3 Measure: The Adolescent Psychotherapy Q-Set

The Adolescent Psychotherapy Q-Set (APQ; Calderon, 2014; Calderon et al., 2017) is an ipsative measure that is used to describe and classify the psychotherapy process of treatments with young people aged between 12 and 18 years old. It is comprised of 100 items that describe (a) the therapist's techniques and attitudes, (b) the patient's feelings, behaviours, or experience, and (c) the nature of the dyad's interaction, including the climate or atmosphere of the session. While its adult version (PQS; Jones, 1985) has a greater focus on psychoanalytic processes, the APQ adopts a jargon-free language and encompassed in its development a review on different treatment modalities, allowing for its items to capture key features from numerous approaches, such as Cognitive-behavioural Therapy, Interpersonal Therapy, Psychoanalytic Psychotherapy, and Mentalization-based Treatment (Bychkova et al., 2011; Calderon et al., 2014).

The APQ is traditionally used for the assessment of whole sessions. After listening or watching a psychotherapy session, the rater sorts the 100 items in a forced way (i.e., with a predetermined number of items in each column), forming a normal distribution ranging from scores between 1 (least characteristic) and 9 (most characteristic). An example of a completed APQ rating is presented in Figure 4-1. In previous studies, the APQ has demonstrated good to excellent levels of inter-rater reliability (Benetti et al., 2017; Calderon et al., 2017, 2018), and good convergent and discriminant validity (Calderon, 2014). The APQ manual is presented in Appendix 14.

Figure 4-1: *Example of completed Q-sort*



4.2.4 Raters

In this study, eight qualified raters contributed to the sessions' assessments. All of them underwent training with the developers of the measure involving the rating of at least 10 sessions meeting agreement levels of .70 or above as measured by intraclass correlation (ICC). When assessing the sessions, the raters were blind concerning the group that each session belonged and at what time point of the psychotherapy they took place (e.g., early, or late phases). In this study, the mean ICC for the double-rated session ratings was .735, ranging from .536 to .856 (Median=.745). The different assessments for the same session were averaged for the factor analysis, while the resulting factor scores (see 'Data Analysis' below) for each session were used in the subsequent analyses.

4.2.5 Data Analysis

To assess the consistency levels across raters, 30% of the sessions in this study (n=30) were double coded and submitted to ICC, following a two-

way random consistency model (Koo & Li, 2016). The remaining 70 sessions (70% of the total sample) were single coded by me.

Addressing the first aim, which consisted of identifying and describing interaction patterns between dyads, a series of EFAs with direct oblimin rotation were performed. This oblique (nonorthogonal) rotation was chosen since it is understood there was no theoretical reason APQ items could not load into multiple theoretically meaningful factors (Watts & Stenner, 2012). The number of factors to be extracted was defined by a combination of statistical criteria (such as examining the scree plot, percentage of variance explained, and including factors with at least two significantly loaded items) and the factors' theoretical and clinical meaningfulness (Brown, 1980). An item was considered significant if it presented a factor loading ≥.40 to its respective factor (Howard, 2016). Cronbach's alpha was used to assess the internal consistency of each factor. The weighted factor loadings extracted were then used in the subsequent analyses.

The factors' convergent validity was assessed in relation to other measures addressing psychopathology (General psychopathology (p-factor); Aitken et al., 2020; Short Leyton Obsessional Inventory for Children and Adolescents (LOI); Bamber et al., 2002; Behaviours Checklist (BC); Goodyer et al., 2017b; Revised Child's Manifest Anxiety Scale (RCMAS); Reynolds & Richmond, 1985; Mood and Feelings Questionnaire (MFQ); Wood et al., 1995), as patients' symptoms might have impacted their in-session behaviour. The factors' convergent validity analysis was also calculated in relation to the therapy alliance (Working Alliance Inventory - Short Form (WAI-S); Tracey & Kokotovic, 1989). Furthermore, the causal relationship between factors was examined through linear regression models, comparing the factors with each other and lagged values of themselves. Through the lagged values of the factors, it was possible to examine if the factors' scores at session X could be predicted by factors' scores at a previous session (X – 1) and so on.

Concerning the second aim, referring to the association of the interaction patterns with therapeutic processes of good and poor outcome cases, t-tests comparing the groups' factor loadings in each session were run.

Lastly, addressing the third aim, focusing on the assessment of changes in the factors over time, a series of Pearson correlations between each patient's factor scores for each session with time were run. The regression models were calculated using Mplus 8.4 (Muthén & Muthén, 2017), while all other analyses were performed using IBM SPSS v28.

4.3 Results

In relation to this chapter's first aim, which was identifying and describing in-session interaction patterns through exploratory factor analysis, a three-class solution was considered the best model for this dataset. Adding a fourth factor evidenced an interaction structure composed of eight items with poor theoretical and clinical meaningfulness. After defining the number of factors to be extracted, an iterative process was taken to identify the items that would contribute to the factor structure of the interaction patterns. In the first run, 42 items did not present a factor loading ≥.40 to any of the three factors and were thus excluded from the second iteration. In the second iteration, two items did not load significantly into any of the factors and were also excluded, and in a third iteration, one item was excluded. In the fourth iteration, all 55 remaining items presented factor loadings ≥.40 to at least one of the three factors, encompassing a solution that explained 47.01% of the variance of the 55 items. The three factors/interaction patterns are presented below, while the EFA iterations details are presented in Appendix 15.

Factor 1: 'Open, engaged young person working collaboratively with a therapist to make sense of their experiences'

The first factor identified included 29 APQ items, listed in Table 4-3. This factor characterised a young person committed to the work of therapy (APQ Item 73), and who demonstrated lively engagement with thoughts and ideas (72), connected with their feelings when discussing experiences and communicating with affect (40, 53). Added to those features, this factor described a young person open to discussing and exploring current interpersonal relationships (63), describing emotional qualities of the interaction with significant others (6), demonstrating a capacity to link mental states with action or behaviour (24), while not being provocative, nor resisting the therapist's attempt to explore thoughts, reactions, or motivations related to their problems (20, 42, 58). Furthermore, the young person would begin the session with ease (30) and initiate and elaborate topics (15), while the therapist would work with them to try to make sense of the experience being discussed in the session (9, 38), being directly reassuring (66). In the relationship between the dyad, they would use humour (74), the patient would feel trustful and understood by the therapist (14, 44) and express positive feelings towards them, seeking their approval, affection, or sympathy (1, 78), with few silences (12). The young person would present a sense of excitation or well-being during the session (13, 94), as well as a sense of being un-self-conscious and certain of themselves (7, 61). The patient would also appear not to try to manage or control the feelings they were experiencing (70), demonstrating feeling helped by the therapy (95), a sense of agency (28) and achieving new understandings (32). In sum, this factor seemed to describe an 'on model' psychoanalytic process, reflecting the work on exploring internal states and interpersonal relationships in the context of a good working alliance between therapist and young person.

Factor 1's internal consistency was excellent, with a Cronbach's α of .954, and it showed significant convergent validity with therapeutic alliance, measured by the WAI-S (r=.662, p=.007).

Table 4-3: Factor 1 'Open, engaged young person working collaboratively with a therapist to make sense of their experiences'

Item n	Item description	Factor Load
73	YP is committed to the work of therapy	0.843
72	YP demonstrates lively engagement with thoughts and ideas	0.826
32	YP achieves a new understanding	0.816
74	Humour is used	0.803
13	YP is animated or excited	0.773
95	YP feels helped by the therapy	0.749
40	YP communicates with affect	0.67
38	T and YP demonstrate a shared understanding	0.665
6	YP describes emotional qualities of the interaction with significant others	0.625
28	YP communicates a sense of agency	0.56
63	YP discusses and explores current interpersonal relationships	0.557
78	YP seeks T approval, affection, or sympathy	0.557
24	YP demonstrates capacity to link mental states with action or behaviour	0.534
9	T works with YP to try to make sense of experience	0.469
66	T is directly reassuring	0.448
Items with negative factor loading:		
15	YP does not initiate or elaborate topics	-0.862
58	YP resists T's attempts to explore thoughts, reactions, or motivations related to problems	-0.859
42	YP rejects T comments and observations	-0.769
7	YP is anxious/tense	-0.759
44	YP feels wary or suspicious of T	-0.713
12	Silences occur during the session	-0.706
30	YP has difficulty beginning the session	-0.669
94	YP feels sad or depressed	-0.662
14	YP does not feel understood by T	-0.615
53	YP discusses experiences as if distant from his feelings	-0.606
1	YP expresses negative feelings towards T	-0.599
61	YP feels shy or self-conscious	-0.456
20	YP is provocative, tests limits of relationship	-0.43
70	YP attempts to manage feelings or impulses	-0.414

Note: YP = young person; T = therapist.

Factor 2: 'Directive therapist with a young person fluctuating in emotional state and unwilling to explore'

The second factor identified was composed of 19 Items (Table 4-4). It evidenced a distinct type of interaction both concerning the therapist's and the

patient's features. Contrasting with Factor 1, this factor illustrated a young person who would not express feelings of vulnerability or loss (APQ Items 8 and 19), and who was not clear and organised in their self-expression (54) and would fluctuate between strong emotional states during the session (88). In their interaction, the adolescent would attribute their own characteristics or feelings to the therapist (51) and would try and be controlling over their interaction (87). The patient would also find it difficult to concentrate or maintain attention during the session (48). Concurrently, the therapist would adopt a generally more directive approach, by actively structuring the session (17), adopting a problem-solving approach with the patient (82), challenging their over-generalised or absolute beliefs (71), encouraging the patient to try new ways of behaving with others (85) and being more independent (67), also discussing activities and tasks for them to attempt outside the session (49). The therapist's remarks would be aimed at facilitating the young person's speech (3), but they would not restate or rephrase the patient's communications to clarify their meaning (65), would not encourage the young person to discuss assumptions and ideas underlying their experience (68), would not make definite statements about what was going in the adolescent's mind (89) and would not raise questions about the young person's view (99) on the subjects discussed within the session. In short, this factor describes interactions where the therapist took a directive stance, while the patient was fluctuating in their emotional state and unwilling to explore their feelings.

This interaction pattern had a good level of internal consistency (α=.859) and did not present significant convergence validity with the measures included in this study.

Table 4-4: Factor 2 'Directive therapist with a young person fluctuating in emotional state and unwilling to explore'

Item n	Item description	Factor Load
17	T actively structures the session	0.75
51	YP attributes own characteristics or feelings to T	0.7
82	T adopts a problem-solving approach with YP	0.641
49	There is discussion of activities and tasks for YP attempt outside the session	0.639

88	YP fluctuates between strong emotional states during the session	0.637
87	YP is controlling of the interaction with T	0.598
67	T encourages independence in the YP	0.518
71	T challenges over-generalised or absolute beliefs	0.517
48	YP finds it difficult to concentrate or maintain attention during the session	0.497
85	T encourages YP to try new ways of behaving with others	0.489
3	T remarks are aimed at facilitating YP speech	0.431
	Items with negative factor loading:	
65	T restates or rephrases YP's communication in order to clarify its meaning	-0.704
8	YP expresses feelings of vulnerability	-0.485
19	YP explores loss	-0.481
89	T makes definite statements about what is going on in the YP's mind	-0.478
68	T encourages YP to discuss assumptions and ideas underlying experience	-0.476
99	T raises questions about YP's view	-0.467
54	YP is clear and organised in self-expression	-0.452
35	Self-image is a focus of the session	-0.448

Note: YP = young person; T = therapist.

Factor 3: 'Young person expressing anger and irritation and challenging the therapist'

The third and final factor encompassed 14 items, as presented in Table 4-5. All items focused on the young people's behaviour or stance within the session. Overall, this factor described a young person who expressed anger, irritation, or aggressive feelings (APQ Items 10, 84), was connected with their feelings (53) and was provocative and demanding during the session, testing the limits of the relationship with the therapist (20, 83). This factor also described interactions where the young person would feel unfairly treated (55) and blame others or external forces for their difficulties (34). Furthermore, this factor's items defined an adolescent who would feel misunderstood by their therapist (14) and would express negative feelings towards them (1), not seeking their approval, affection, or sympathy (78). The young person also would not speak with compassion and concern (25) nor express feelings of remorse (22), would not attempt to manage their own feelings or impulses (70), nor feel shy or self-conscious (61).

This factor shared six items with Factor 1: item 1 'Young Person (YP) expresses negative feelings towards Therapist (T)' and item 78 'YP seeks T approval, affection, or sympathy' had reverse loads between factors (negative in Factor 3 and positive in Factor 1). Item 14 'YP does not feel understood by T' loaded positively into both factors, while Items 53 'YP discusses experiences as if distant from his feelings', 61 'YP feels shy or self-conscious', 70 'YP attempts to manage feelings or impulses', loaded negatively into both factors. Overall, these items describe a young person expressing anger and irritation and challenging the therapist.

The third factor showed good internal consistency (α=.825), but similarly to Factor 2, it did not have significant convergent validity with the other measures.

Table 4-5: Factor 3 'Young person expressing anger and irritation and challenging the therapist'

Item n	Item description	Factor Load
84	YP expresses angry or aggressive feelings	0.777
10	YP displays feelings of irritability	0.723
20	YP is provocative, tests limits of relationship	0.623
55	YP feels unfairly treated	0.615
1	YP expresses negative feelings towards T	0.549
83	YP is demanding	0.491
34	YP blames others or external forces for difficulties	0.486
14	YP does not feel understood by T	0.462
Items with negative factor loading:		
25	YP speaks with compassion and concern	-0.583
78	YP seeks T approval, affection, or sympathy	-0.563
70	YP attempts to manage feelings or impulses	-0.538
22	YP expresses feelings of remorse	-0.492
61	YP feels shy or self-conscious	-0.469
53	YP discusses experiences as if distant from his feelings	-0.406

Note: YP = young person; T = therapist.

In addition, through a regression model, two significant relationships between factors were identified. Firstly, lagged factor 1 scores significantly predicted higher factor 1 scores in subsequent sessions, indicating that higher levels of dyadic collaboration promoted high collaboration in the following sessions (Effect estimate= 0.25, *p*=.029, 95% confidence interval [95%CI]= -0.01 to 0.51). Conversely, lagged factor 2 scores significantly predicted lower

factor 3 scores in subsequent sessions, suggesting that interactions between a directive therapist and a young person fluctuating in emotional states reflected in lower levels of patient in-session anger in subsequent sessions (Effect estimate=-.026, *p*=.016, 95%CI= -0.47 to -0.03). All other regression scores between factors were non-significant. Table 4-6 presents the regression analysis between factors.

Table 4-6: Regression analysis between factors

Effect	Estimate	*SE*	95% CI		*p*
			LL	*UL*	
F1→F2	-0.04	0.14	-0.31	0.23	.388
F1→F3	0.19	0.14	-0.08	0.46	.078
F2→F1	-0.05	0.14	-0.28	0.18	.342
F2→F3	0.03	0.15	-0.22	0.26	.400
F3→F1	0.16	0.11	-0.04	0.38	.060
F3→F2	0.03	0.10	-0.16	0.24	.370
Lagged F1→F1	**0.25***	**0.13**	**-0.01**	**0.51**	**.029**
Lagged F2→F1	-0.19	0.12	-0.41	0.06	.058
Lagged F3→F1	-0.14	0.13	-0.39	0.12	.131
Lagged F1→F2	0.11	0.13	-0.16	0.37	.202
Lagged F2→F2	-0.10	0.12	-0.35	0.14	.205
Lagged F3→F2	0.01	0.14	-0.27	0.28	.479
Lagged F1→F3	0.08	0.13	-.015	0.34	.248
Lagged F2→F3	**-0.26****	**0.11**	**-0.47**	**-0.03**	**.016**
Lagged F3→F3	0.05	0.13	-0.20	0.31	.343

*p<.05, **p<.01.
Note: F1 = Factor 1; F2 = Factor 2; F3 = Factor 3; SE = Standardised Estimates; CI = Confidence Interval; LL = lower limit; UL = upper limit.

Addressing the second aim, a series of t-tests were carried out to investigate if there were any associations between the factors and the therapeutic processes of good and poor outcome cases. Factor 1 ('Open, engaged young person working collaboratively with a therapist to make sense of their experiences') scores were significantly higher in the good outcome group (t(98)=-3.568, p<.001, *d*=-.714, 95%CI= -1.12 to -0.31]). Conversely, Factor 3 ('Young person expressing anger and irritation and challenging the therapist') scores were higher in the poor outcome group sessions (t(98)=3.742, p<.001, *d*=.748, 95%CI= 0.34 to 1.15]). Lastly, no significant differences were found between groups concerning Factor 2 ('Directive therapist with a young person fluctuating in emotional state and unwilling to explore'; t(98)=-.356, p=.722, *d*=-.071, 95%CI=-0.46 to 0.32]).

Regarding the third aim, Pearson correlations were calculated to assess how the factors' loadings changed over time. Figure 4-2, Figure 4-3, and Figure 4-4 show the mean factor loadings for each group over time, while a full correlation matrix is presented in Table 4-7. In a first step, the aggregated patients' scores considering each group were analysed, to assess if there were any associations between factors and time considering their outcome classifications. Afterwards, the same test was carried out for each patient individually.

Table 4-7: Correlation matrix between Factors and Time

Case		F1	F2	F3	Case		F1	F2	F3
Good outcome (global)	*r* Sig. (p=)	.067 .644	.124 .391	.158 .273	**Poor outcome (global)**	*r* Sig. (p=)	.155 .284	-.070 .627	.222 .120
Good Outcome 1 (Patient A1)	*r* Sig. (p=)	.375 .285	.295 .409	.068 .853	Poor Outcome 1 (Patient B1)	*r* Sig. (p=)	.160 .638	-.010 .977	.040 .907
Good Outcome 2 (Patient A2)	*r* Sig. (p=)	**-.756*** **.011**	.269 .452	.538 .108	Poor Outcome 2 (Patient B2)	*r* Sig. (p=)	.092 .800	.005 .988	.521 .122
Good Outcome 3 (Patient A3)	*r* Sig. (p=)	.132 .716	-.400 .252	.043 .906	Poor Outcome 3 (Patient B3)	*r* Sig. (p=)	**.717*** **.013**	**-.725*** **.012**	.191 .574
Good Outcome 4 (Patient A4)	*r* Sig (p=)	**.692*** **.027**	-.007 .985	.101 .782	Poor Outcome 4 (Patient B4)	*r* Sig. (p=)	.393 .262	.479 .161	.171 .636
Good Outcome 5 (Patient A5)	*r* Sig. (p=)	**.820**** **.004**	.193 .594	.583 .077	Poor Outcome 5 (Patient B5)	*r* Sig. (p=)	.048 .910	.433 .283	.687 .060

*p<.05, **p<.01.
Note: F1 = Factor 1; F2 = Factor 2; F3 = Factor 3.

Figure 4-2: *Mean Factor Loadings for IS1: 'Open, engaged young person working collaboratively with a therapist to make sense of their experiences'*

Figure 4-3: *Mean Factor Loadings for IS2: 'Directive therapist with a young person fluctuating in emotional state and unwilling to explore'*

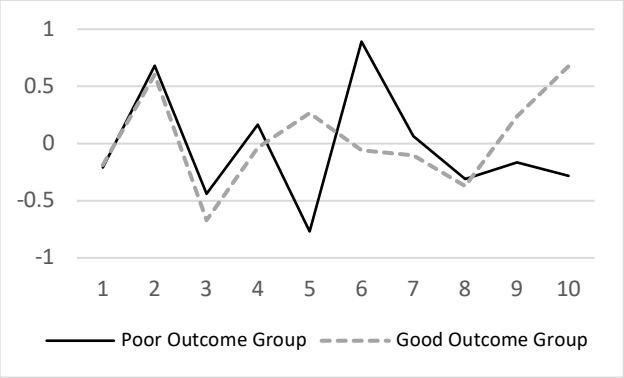


Figure 4-4: *Mean Factor Loadings for IS3: 'Young person expressing anger and irritation and challenging the therapist*

For the aggregated analysis, there were no significant associations between factor loadings and time for the good outcome group (Factor 1: *r*=.067, p=.644, Factor 2: *r*=.124, p=.391, Factor 3: *r*=.158, p=.273) nor the poor outcome group (Factor 1: *r*=.155, p=.284, Factor 2: *r*=-.070, p=.627, Factor 3: *r*=.222, p=.120).

When examining the cases individually, two good outcome cases showed a significant increase in Factor 1 loadings over time (Patient A4, *r*=.692, p=.027, Patient A5, *r*=.820, p=.004), while one showed a significant decrease over time (Patient A2, *r*=-.756, p=.011). The other two cases did not have any significant associations between factors and time.

Concerning the poor outcome group, four patients did not present any significant associations between factors and time. The only exception was Patient B3, which showed a significant increase in Factor 1 scores and decrease in Factor 2 scores over time (Factor 1: r=.717, p=.013; Factor 2: r=-.725, p=.012).

4.4 Discussion

The present chapter aimed to identify and describe interaction patterns in the STPP for ten adolescents diagnosed with MDD, as well as investigate how these interaction patterns changed over time, comparing cases that achieved good and poor outcomes.

Concerning the first aim, three factors were identified through a joint analysis of all ten treatments. The first factor described a collaborative young person with a therapist helping them to make sense of their experiences, and the second one described an STPP therapist working in a more directive way, with a patient fluctuating in their emotional state and unwilling to explore. A third factor including only patient's items was also found, describing a young person expressing anger, irritation, and challenging the therapist.

Factor 1, named 'Open, engaged young person working collaboratively with a therapist to make sense of their experiences', described a young person committed to the work of therapy, able to engage with thoughts and ideas, alongside a therapist helping them make sense of their experience, and exploring subjects related to the patient's problems. Previous studies using the PQS and its versions for children and adolescents have found similar factors for psychoanalytic psychotherapy across different age groups (e.g., 'Collaborative Exploration' in two adult cases from Jones (2000a), 'Strong working relationship between an emotionally involved young person and a therapist who invites the young person to reflect on experiences and develop

self-understanding' in 30 adolescent cases from Calderon et al. (2018), and 'Connected Child, attached to Therapist, expressing mental contents and fantasies, with a supportive Therapist' from a single case with a child described by Ramires et al. (2020)). Overall, these factors seem to describe the psychoanalytic process taking place 'as intended', reflecting the work on exploring internal states and interpersonal relationships in the context of a good working alliance, as also indicated by its convergent validity with the ratings of these same cases on the WAI-S.

Factor 2, 'Directive therapist with a young person fluctuating in emotional state and unwilling to explore', on the other hand, seems to be less 'on model' with the psychoanalytic approach, with therapists employing 'CBT-ish' techniques, such as actively structuring the session, challenging dysfunctional beliefs, and discussing activities to be attempted outside the session for patients presenting themselves more volatile or projective. Previous studies focusing on the psychotherapy process with children, either by analysing actual psychotherapy recordings (Goodman, 2015; Ramires et al., 2020) or evaluating prototypes (Fiorini & Ramires, 2019), found similar patterns for children with externalising disorders and for patients presenting impaired mentalising capacity. This chapter's findings suggest that in the psychoanalytic treatment of adolescents, these features can also be found in the treatment of patients with internalising conditions, with therapists adopting this stance perhaps trying to provide some structure both to the therapy setting and to a more disorganised, non-mentalising or reactive patient. Along similar lines, Midgley et al. (2018) examined treatment adherence in STPP and CBT for depressed adolescents using the Comparative Psychotherapy Process Scale (Hilsenroth et al., 2003, 2007). According to their findings, both STPP and CBT showed relatively low adherence levels to their respective levels, reinforcing the empirical evidence base that therapists tend to adapt their techniques when working with depressed adolescents.

The third and final factor encompassed only patients' items and described a young person expressing anger and irritation and challenging the therapist. This factor shared six items with Factor 1, all of which addressed the young person's affective expression or their behaviour in relation to the therapist. For two items (APQ items 1 and 78), the valence between factors was reversed, whilst for items 14, 53, 61, and 70 it was the same between factors. The shared items indicate that even though factors 1 and 3 both describe a young person seemingly connected with their feelings, the nature of those emotions in each factor seems to differ. For factor 1, the items seem to describe an emotional connection encompassing some degree of collaboration and elaboration, while in factor 3 these emotions seem to describe confrontation ruptures in the alliance (Safran & Muran, 2000) or negative transference (Cregeen et al., 2017).

Further exploring these factors to address our second aim, we performed t-tests to examine if the factors related to different types of outcomes. As expected, higher Factor 1 scores were significantly associated with the good outcome group, indicating that higher levels of in-session patient collaboration, with a therapist helping the patient to make sense of their experiences, were more characteristic in successful treatments than unsuccessful ones. As in previous studies (e.g., Lilliengren et al., 2019; Watsford & Rickwood, 2014), our results reinforce that collaboration between patient and therapist is associated with successful psychodynamic treatments. This factor overall seemed to bridge different variables that account for positive outcomes, such as patient engagement, a positive therapy relationship, and certain specific therapy techniques (Norcross & Lambert, 2019). Furthermore, lagged Factor 1 scores predicted higher Factor 1 scores in subsequent sessions, indicating that this collaboration between therapist and patient fostered higher subsequent collaboration, forming a type of 'virtuous cycle' in the therapy process.

Curiously, signs of the therapists being directive, accompanied by patients presenting fluctuant emotional states and unwillingness to explore, found on Factor 2, were equally present in good and poor outcome cases. While previous studies focusing on different types of therapy for adults found that being directive or controlling in the setting related to poor outcomes (e.g., Lilliengren et al., 2019), this chapter's results may indicate that these actions can be seen in both successful and unsuccessful cases of adolescent psychotherapy. This may indicate that a more directive stance may be necessary in the psychotherapy process with adolescents, in order to provide some structure for patients in this age group, that are characteristically in a developmental stage of transition between childhood and adulthood (Cregeen et al., 2017). Furthermore, this finding also suggests that patient emotional fluctuation and unwillingness to explore is an expected feature of STPP for depressed adolescents, regardless of the case's outcomes.

The third and final factor, named 'young person expressing anger and irritation and challenging the therapist', was statistically significantly more prominent in the poor outcome group. Anger has an important role in the psychoanalytic formulations for depression (Busch et al., 2016; Trowell & Miles, 2011). From these perspectives, depression as a condition may be a defence against anger, and a key therapeutic goal would be to help the patient become able to express their aggressive thoughts and feelings (Cregeen et al., 2017). However, our findings indicate that the expression of this anger does not seem to be therapeutic by itself, being perhaps even harmful.

A study addressing the relationship between the expression of anger and depressive symptoms among adult patients evidenced nuanced process-outcome dynamics (Town et al., 2022). According to the model examined by these authors, the curative role of expressing anger in therapy differs between patients with higher or lower levels of an integrated sense of self and others. Following the expression of these affects, more integrated patients seem to benefit from achieving insight from them, allowing for the exploration of these

feelings in more depth. Conversely, less integrated patients might benefit from higher alliance levels, which would allow for a 'correctional emotional experience' (Town et al., 2022). Therefore, these findings indicate that some contextual factors may make the expression of those feelings more of less effective or fruitful. For instance, in this sample the adolescents might have demonstrated anger in moments when they felt misunderstood or invalidated by their therapists.

Relating the present findings to Town et al.'s (2022), one possible explanation for Factor 3 high scores being associated with poorer outcomes is that they reflect low alliance or alliance ruptures in the process. One limitation of this elucidation is the lack of convergent validity between Factor 3 and the WAI-S. However, it is worth mentioning that this alliance measure has some important limitations, especially in terms of assessing the specifics of the alliance in psychoanalytic processes (Cirasola & Midgley, 2023). Therefore, the non-significant association might have been due to measurement effects. In addition to that, the present study did not include any specific assessment of the patients' insight. Future research including insight and other contextual factors might be required to provide the 'full picture' of the role of anger in youth psychotherapy.

The direct relationship between the expression of anger and outcomes has not been previously investigated specifically with adolescents, but there are initial findings that provide important insights and clues for future investigations. One study performed by Chourdaki et al. (2023), for instance, has shown that STPP practitioners tended to react to angry expressions of their adolescent patients by distancing themselves from them. That distance was characterised by either changing the topic of conversation or relating the patient's feelings to 'other times' in which they had felt angry. In that way, these therapist reactions may not have provided space for giving meaning to those affects, seeing them as empowering, or promote insight (Chourdaki et al.,

2023). Further research addressing the association between therapists' reactions to anger and outcomes could shed light on this topic.

The current study also provides tentative evidence that therapist's directedness when facing an emotionally fluctuating young person may be protective of these angry expressions. As illustrated by the regression analysis where lagged Factor 2 scores significantly predicted lower Factor 3 scores, a directive therapist stance might provide the patient with some boundaries for them to work their feelings effectively in the transference.

Regarding the last aim, no clear correlational patterns between the factors and time were found, considering the different outcome groups. From the current findings, it is argued that the likely outcomes of short-term treatments can be predicted at early sessions depending on the levels of patient manifest aggressiveness or dyadic collaboration. Previous studies focusing on outcomes have suggested that late outcomes could be predicted within the first months of treatment (see Davies et al., 2019; Maalouf et al., 2012, and Chapter 3), while early process features such as poor attendance and failure of rupture-resolution strongly predicted treatment dropout (O'Keeffe et al., 2020). It is highlighted, however, that these findings should be interpreted with caution. The number of sessions assessed for each case and the number of cases included may have not been enough to reveal clear patterns of changes over time. Further studies including more sessions per case and larger samples could contribute to unfolding possible clinically meaningful patterns through multilevel modelling, and latent growth analyses.

4.5 Limitations

The findings of this study were drawn from psychotherapies that took place in NHS Child and Adolescent Mental Health Services (CAMHS) in the London metropolitan area and may not be generalisable for differing settings

or client groups. Furthermore, no causal relations between the factors and outcomes were examined. This was partly due to the uneven session distribution between cases, as well as the number of time points available for the outcome measures. In addition to that, the IMPACT dataset does not have any data available regarding the therapists, so it was not possible to analyse any variables concerning the practitioners beyond the session observation.

Furthermore, we also highlight that due to the sample size examined in this study, the current findings should be taken with caution. Therefore, the findings drawn from the EFA and the t-test could be prone to types I (false positive) and II (false negative) errors (Akobeng, 2016).

It is also pointed out that the main instrument used in this study was based on the perspective of external examiners, focusing on manifest behaviour. Other perspectives assessing the psychotherapy process, such as self-report questionnaires or qualitative interviews could shed light on other aspects of psychotherapy that might have not been captured through the APQ.

4.6 Conclusions

This chapter aimed to analyse and compare the psychotherapy process of good and poor outcome cases of STPP for depressed adolescents. In sum, its findings indicate that clear patterns of the in-session therapeutic process could be identified using the APQ and that higher levels of dyadic collaboration were associated with better outcomes, whilst levels of therapist's directedness alongside patient's emotional fluctuation were similar between groups. Higher levels of patients' expressed anger and challenging the therapist were statistically significantly more prominent in poor outcome cases. No change in factors was detected across time, indicating that early signs of dyadic collaboration or patient in-session anger may well become ongoing features of a therapeutic process and could be key in predicting treatments' outcomes.

Future studies focusing on patient in-session aggression, especially addressing confrontation ruptures could shed light on possible strategies on how to provide better help for this group of patients.

Chapter 5 Treatment 'non-responders': The experience of short-term psychoanalytic psychotherapy among depressed adolescents, their parents and therapists

5.1 Introduction

Up to a third of clinically depressed adolescents who go through psychoanalytic psychotherapy end up not showing any indications of improvement in depressive symptoms (Midgley et al., 2021; NICE, 2019). In this context, while previous literature has mostly focused on understanding what are the characteristics of *successful* treatments, fewer studies have paid attention to examining the interventions that *do not* work (Barlow, 2010). Understanding what is associated with unsuccessful therapies might be key to informing clinicians and researchers about what features may hinder patient response, leading to improved treatments, or at least drawing more parsimonious goals and adaptations in current practices.

Prior investigations have evidenced some predictors that are associated with poor outcomes in adolescent psychotherapy. For example, young people with higher levels of psychological impairments seem to be less likely to improve after receiving a range of mental health treatments when compared with less impaired youth (see Cervin et al., 2021; Edbrooke-Childs et al., 2022 and Chapter 3). Likewise, patients with lower motivation to change or engage in therapy tend to achieve poorer outcomes (Black & Chung, 2014; Fitzpatrick & Irannejad, 2008). Nevertheless, these baseline indicators only throw light on the response likelihood for a given patient in comparison to broader populations and do not capture some relevant variables involved in therapy (Midgley, Hayes, et al., 2017).

Besides the patients' presentation at baseline, some studies have indicated that features that take place during the therapy process could also influence patient response. The literature on the therapeutic alliance, for instance, has demonstrated that adolescent-therapist alliance is associated with outcomes (Karver et al., 2018; B. D. McLeod, 2011; Shirk et al., 2011), even though this seems to work differently depending on the therapy modality being used (Cirasola et al., 2021).

Specifically concerning psychoanalytic psychotherapy with adolescents, the findings shown in Chapter 4 indicate that young people who express higher levels of in-session anger seem to achieve worse outcomes. The anger-outcomes association has been studied in more detail with adult patients. In a key investigation published by Town et al. (2022), it has been identified that the curative potential of expressing anger depends on the patient's personality integration and how it is dealt with within the therapy setting. As described in the previous chapter, more integrated patients seem to benefit from achieving insight from their angry feelings and making sense of them in more depth. In contrast, less integrated patients might benefit from contexts with higher alliance levels, which could allow for a 'correctional emotional experience' (Town et al., 2022). However, it is worth noting that we still do not know how this specific relationship translates to adolescent populations.

Despite the relevance of these investigations for our understanding of 'successful' and 'unsuccessful' psychotherapy, they often rely on self-report questionnaires and the perspectives of external examiners. This framework leads to a limited understanding of the multiple and complex phenomena involved in psychotherapy. In that sense, qualitative investigations, including stakeholders' own perspectives on a lived experience could shed light on treatment aspects that may be overlooked by other methods.

Concerning young people's perspective on psychoanalytic psychotherapy, a meta-synthesis reported by Fiorini et al. (2024) has gathered some initial insights. Firstly, adolescents seem to appreciate different facets of the therapy relationship. That included perceiving the therapist as someone who is warm, caring, and who would be available to 'hear' them. This study also evidenced that many patients perceive psychoanalytic psychotherapy as a painful process, in which they have to access troublesome feelings and expose themselves. Lastly, this review has also indicated that some young people feel like they need to 'navigate' their role as patients in these treatments, including making sense of how psychotherapy should unfold and how they should behave in the setting. Although this review points to relevant aspects of adolescents' experience of therapy, a few aspects should be highlighted: (1) overall, most of the studies included did not address the treatments' outcomes, so little is known about how these perceptions on the relationship, the experience of therapy being painful, and the process of 'navigating' one's role in psychotherapy relate to outcomes; (2) only one of the studies included (i.e., Housby et al., 2021) explicitly focused on good outcome cases, but it is unclear how the experiences of 'successful' cases would relate to the experience of 'unsuccessful' ones; (3) no studies focused on poor outcome cases.

In one of the few studies employing qualitative methods to understand poor outcome psychotherapy cases in the treatment of adolescents, Mehta et al. (2023) analysed interviews with five young people who participated in the IMPACT trial. Their main findings indicated that these young people considered their depression too overwhelming for them to be 'cured' by what therapy can offer. They also reported that therapy could make them feel worse, including feeling like a burden or having a negative experience regarding the therapy relationship. Finally, the authors also found that despite being classified as 'non-responders' by standardised measures, some adolescents would refer to some small improvements such as having better self-awareness or feeling allowed to share their thoughts and feelings (Mehta et al., 2023).

These findings provide valuable insights for the understanding of treatment 'failure'. Nonetheless, they include the perspectives of young people attending different treatments (i.e., STPP, CBT, and BPI), with only one going through STPP. Therefore, we do not know if these experiences are modality-specific or more generalised among 'poor outcome' cases.

Alongside the relevance of giving voice to young people's perspectives on their treatments, it is also important to consider that psychotherapy is a process that implicates different stakeholders in its nature. In a study performed by Werbart et al. (2019), it was in fact evidenced that addressing the intersection of different perspectives can also be crucial to foster a better understanding of therapy 'success' and 'failure'. In this investigation, the authors analysed interviews with 3 psychoanalytically oriented therapists, alongside two patients for each one of them (one being a 'good outcome' case and the other a 'poor outcome' one, making up to six patients in total). The authors' analysis suggested that therapists and patients in 'successful' cases would share a more congruent understanding of the presenting problems and the treatment goals. Also, in the 'good' outcome cases, the dyad would experience their relationship and the psychotherapy process as supportive and challenging, and the therapist would adapt their technique according to the patient's needs. Conversely, 'poor' outcome cases were characterised by a dissonance between the dyad's understanding of the process and outcomes. Therapists were more prone to attribute the difficulties in the process to the patient, and less prone to adapt their technique, and to consider their own role in the therapy 'failure' (Werbart et al., 2019). Despite these important contributions, it is unclear how these perspectives would be found in the context of adolescent psychotherapy.

Besides the relevance of young people and therapists and their perspectives concerning psychotherapy, it is worth noting that parents are also key actors in these treatments. Firstly, parents usually have substantial involvement in the therapy process and can play a role in treatment

continuation: besides being a usual source of referral, they may be the ones paying for the treatments, and providing transportation (Hawley & Weisz, 2005). Secondly, according to a meta-analysis performed by Karver et al. (2018), the alliance established between parents and therapists is as important as the alliance between children and therapists in terms of their relationship with outcomes. In that sense, parents are crucial actors that should be included in research addressing youth psychotherapy.

Considering the factors concerning young people, therapists, and parents and their association with outcomes, one can infer that treatment effectiveness can be affected by multiple factors. Furthermore, the literature points out that any one perspective is likely to provide only a partial understanding if looked at in isolation. Therefore, studying the viewpoint of different stakeholders involved in a given treatment could be key in providing a more rounded understanding of the interventions provided (De Los Reyes et al., 2015). In addition, many studies exploring psychotherapy failure have relied on standardised measures, including patient self-report questionnaires or observer-rated assessment tools. Although standardised measures are useful in mapping general aspects of psychotherapy, they do not provide the full picture of the patients' sufferings (Krause et al., 2019, 2020), with qualitative methods being potentially useful in achieving a more meaningful understanding of what kind of outcomes matter most to patients (J. McLeod, 2013). Considering this background, the present study aimed to investigate the experience of short-term STPP for depressed adolescents who remained clinically depressed after therapy ended, including the perspectives of patients, parents, and therapists.

5.2 Methods

5.2.1 Design

This study was drawn from a larger investigation, namely the IMPACT-My Experience (IMPACT-ME; Midgley et al., 2014) study. The IMPACT-ME study was a qualitative investigation embedded in a larger trial, the Improving Mood with Psychoanalytic and Cognitive Therapies (IMPACT) study (Goodyer et al., 2017b), assessing the treatment and relapse prevention of depression in young people. Within the IMPACT-ME study, young people, their therapists, and their parents were interviewed at three different time points, following semi-structured protocols (see more details in the 'Data Collection' section). In this particular investigation, we focused on examining the experience of STPP of young people who remained clinically depressed after therapy ended, their parents, and therapists. For more information about the IMPACT-ME study see Midgley et al. (2014) and Chapter 2.

5.2.2 Participants

The participants for this study were a sub-sample of adolescents from the IMPACT/IMPACT-ME studies who presented clinical levels of depression before and one year after attending STPP, and their respective parents and therapists. Out of the 156 young people in the STPP arm of the IMPACT trial across England, 38 young people, all from the London region, participated in the IMPACT-ME study. Out of these young people, 21 could be considered responders (measured by an MFQ score equal to or below 27 in their last assessment or reliable change (Jacobson & Truax, 1991)). Since the present examination was part of a larger study that also examined the young people's therapy process through session audio recordings (see Chapter 4), 11 of these patients were also excluded for not having at least eight session recordings available. These criteria led to the selection of four STPP cases, whose

demographic characteristics and depressive symptom ratings are presented in Table 5-1 (all names are pseudonyms).

Table 5-1: Demographic characteristics of young people

Name	Daniel	Riley	Marcus	Anna
Baseline age	16	16	14	17
Ethnicity	White British	White British	Mixed	White (other)
MFQ Baseline	29	61	51	56
MFQ Week 6	20	n/a	45	n/a
MFQ Week 12	43	41	37	39
MFQ Week 36	41	48	38	40
MFQ Week 52	46	45	49	25
MFQ Week 86	29	n/a	36	43

Note: MFQ = Mood and Feelings Questionnaire (scores above 27 are considered within the clinical range). All names are pseudonyms.

All young people selected presented clinical depression levels before therapy and in their respective last assessment, as measured by the Mood and Feelings Questionnaire (MFQ; Wood et al., 1995). Although three of them did show some reduction in their MFQ scores by the one-year follow-up, compared to baseline, and none showed deterioration in their depressive symptoms from baseline to 86-week follow-up, they all met criteria for belonging to the 'unsuccessful ('NO') category of change in general psychopathology presented in Chapter 3, by showing a higher likelihood of membership to the 'NO' trajectory in comparison to the 'SLOW' or 'GO' trajectories. Furthermore, the symptom trajectory presented in Table 5-1 illustrates that these young people did not have a consistent decrease in symptoms over time, presenting some points where their scores increased.

5.2.3 Data collection

The interviews examined in this study took place between the years 2011 and 2014. For each case, they were held at two different time points: either right after the end of therapy (T2) and at a one-year follow-up (T3). The

interviewers were all post-graduate psychologists working on the IMPACT-ME study. They followed a series of semi-structured interview schedules, having received a half-day training session for conducting them.

For T2, the interview schedules were named *Experience of Therapy Interview*, and they were carried out separately with young people, parents, and (where the young person gave permission) therapists. They addressed the participants' perspectives on (a) what were the difficulties of the young person that led them to seek a Child and Adolescent Mental Health Services (CAMHS); (b) how they understood these difficulties; (c) any perceived changes within the last calendar year; (d) the 'story' of therapy, including the participants' impressions on the therapy relationship, and any subjectively meaningful moments; their evaluation of psychotherapy including their understanding if therapy was helpful or unhelpful, and it what aspects; (f) their experience of involvement in taking part in a clinical trial.

The *Thinking back about therapy interview* (T3) schedule was used with YP and parents, and most of its items were a review of the ones addressed in T2. It encompassed the participants' perception of (a) how was life since the last interview; (b) their current understandings on what were the difficulties that led the young person to seek help from CAMHS; (c) 'thinking back about therapy', focusing on the participants' recollection about the experience of therapy; (d) any links between therapy and change/no-change; and their experience of taking part in a clinical trial.

The interviews took place at a CAMHS of choice of the participants or their residence, and took, on average, one hour each (range: 30 to 103 min, M = 69.15min). They were audio-recorded and transcribed verbatim, hiding any identifying information such as names, or places. Young people were invited to choose a pseudonym for themselves to be used in any publications.

The full interview schedules for young people in T2 and T3, Therapists in T2, and Parents in T2 and T3 are presented in Appendices 1 to 5, respectively. The interviews available for each case are presented in Table 5-2.

Table 5-2: Interviews availability per case

Case name	Young Person		Therapist	Parent	
	T2	T3	T2	T2	T3
Daniel	X	X	X	X	
Riley	X				
Marcus	X	X	X	X	X
Anna	X	X	X		

Note: T2 = Time 2 (End of therapy); T3 = Time 3 (1-year follow-up). All names are pseudonyms.

5.2.4 Data analysis

The data analysis followed a generic descriptive-interpretative approach (Elliott & Timulak, 2005; Timulak & Elliott, 2019). This was chosen given the considerable overlap between different qualitative analysis 'brand names' (e.g., grounded theory, interpretative phenomenological analysis, thematic analysis, among others), which involve describing and interpreting a phenomenon of interest (Timulak & Elliott, 2019).

This analysis has a focus on understanding individuals' lived experience, and in the psychotherapy field that is usually applied to patients and therapist. However, while in clinical settings it is widely recognised the parents' and carers' role to the psychotherapy process, their perspectives are often overlooked qualitative studies. With that in mind, this study employed a multiple perspectives design.

In this investigation, the analysis followed several steps. Firstly, two evaluators (A UCL/Anna Freud honorary student and I) independently read and listened to the interviews of one young person. While listening and reading to the interviews, we made independent annotations (Appendix 16) and drew main themes from them. After setting the themes for a single young person, the evaluators discussed the themes between each other and then repeated the same process for the interviews regarding the same case's therapists and parents. Once all interviews for a single case were analysed, the main themes for each 'cluster' (i.e., the young person, therapist, and parent from a single case, combined) were delineated. This process was repeated for all subsequent cases.

After delineating the cluster-level themes, they were examined jointly. In this step, the clusters' overarching themes were organised in terms of their similarities and differences in a general matrix (Appendix 17). The themes comprising the general matrix were examined in terms of how they represented each case, and each 'grouped' perspective (e.g., how each theme was understood by different participants, such as young people, therapists, and parents), and then described in the results section. In different stages of the analysis, Nick Midgley (an expert in qualitative methods) audited the themes, in order to ensure their precision, clarity and their alignment with this chapter's research aim.

5.2.5 Ethical procedures

The IMPACT-ME study protocol was approved by the Cambridgeshire 2 Research Ethics Committee, Addenbrookes Hospital Cambridge, UK (REC Ref: 09/H0308/137). All participants have provided written consent to participate in the study. Aiming to ensure confidentiality, identifiable details were excluded or concealed in this report.

5.3 Results

The data analysis unfolded 3 main themes across cases, each describing one facet of the experience of STPP for the participants. The themes are:

1. Therapy as a safe space.
2. Can short-term psychotherapy ever be enough?
3. Therapists making links and connections that did not make sense to the young people.

The themes encompassed some experiences that are consistent throughout the perspectives of young people, therapists, and parents, while others described perspectives that are contrasting between participants or specific to a determined group, as detailed below.

5.3.1 Theme 1: Therapy as a safe space

Theme 1, named 'Therapy as a safe space' was the most commonly and consistently described among participants, being found in all interviews. In this theme, participants depicted and appreciated therapy as a place where the young person would express themselves or talk about subjects that would not be possible in other contexts. Furthermore, as explained by Daniel, therapy was a place where they did not feel judged, perhaps even allowing for the reflection on their own behaviours:

> **Daniel:** *It's nice to tell someone who's not gonna be like 'oh you shouldn't have done that' or 'that was really stupid of you' … cos there are a lot of things I've done that was really dumb,*

shouldn't have done that, that was really stupid. Whereas when I tell her, she goes 'and what do you think about that?' and I go 'it was really fucking stupid' but it's better than her like going to me 'that was stupid' cos if I say it, it makes me feel better instead of someone telling me I was stupid.

In addition, this sense of a safe space was also understood as including a therapist stance of respecting the young person's time and readiness to discuss certain topics:

Riley: *She'll know … if I don't wanna talk, she won't push me, she's happy just to sit there but I think she can tell when I'm more open to discussing things and when I just wanna be left alone, so it depends.*

Besides agreeing with young people and describing therapy as a safe space, parents also pointed out the differences between their parenting roles and the therapists' roles:

Marcus's Mother: *He said, 'it's good to have someone to talk to from time to time…', that's what he said… and… I don't take it personally, 'cause I know what he means, there are some things you don't wanna talk to your parents about… and I think he obviously feels that it's a safe space for him to talk…*

Whilst Marcus' mother raised her son's possible internal motivations for not wanting to talk about some subjects with her, Daniel's mother also highlighted some external boundaries that limit what and how the young person can express outside therapy:

Daniel's Mother: *I know [therapy] is a forum where he feels he can… go into the therapist's room and express… if he's angry, she [the therapist] allows him to swear and shout and*

all those kinds of things. Whereas in the family home… it's not so free for him to be… shouting and swearing.

Furthermore, in some cases the therapy setting was seen as a place for emotional discharge, where one could let out feelings that could be overwhelming:

Daniel: *I usually [left the sessions] in a good mood. I don't feel very good during it but feel in a much better mood afterwards… cos I say all the things that make me feel upset there, and then I come out and then I've said everything so I kind of feel better.*

In this example, Daniel described session dynamics where he would use therapy as a space to unleash his upsetting feelings, promoting some sort of emotional relief by the end of the sessions. Similarly, Anna's therapist also described comparable interactions, while also highlighting some changes in this over time:

Anna's therapist: *I think that she did come to see me as… a sort of touchstone in the week… She could just come and…collapse, really. Cos she did drive herself very hard, y'know in terms of, work and energy, and often she looked absolutely exhausted. And she would… just come and collapse, and for the first part of the treatment it was, usually... great distress and tears. And towards the end, it was much more, kind of… relief.*

Lastly, the experience of therapy as a safe space was also fostered by providing some clear boundaries in the therapy setting, according to some participants' comments:

> **Riley:** *She knew to ask me like straightforward questions rather than ones that could have any answer. She knew that I liked to have like simple, like to the point questions rather than… people like mixing their words and making it ambiguous.*

This young person reported valuing her therapist's attitude of attuning to her necessities, asking clear and delineated questions, in opposition to open or ambiguous ones. For her, perhaps a therapy setting that presented itself as too open could be felt as too menacing or threatening. Similar remarks could also be found in the perspective of therapists: Daniel's therapist reports becoming more active in the therapy setting, depending on the patient's presentation:

> **Daniel's therapist:** *There were times when he was too depressed to really talk, and he would often then sort of sit with his head down on his knees and I would have to do quite a lot of the sort of talking for him. But he was quite responsive and… he could describe quite a bit what he was experiencing.*

In sum, all these examples illustrate how the different stakeholders understood therapy as a safe space, considering a range of qualities that made them experience it as such. According to the participants, this setting was experienced as a place where the young people could express the thoughts and feelings they considered important or necessary in their own time. Psychotherapy was also felt like a place some young people could 'let out' their feelings, especially negative ones. Lastly, some therapists would shift from a more traditionally 'open' psychoanalytic stance to a more direct one, aiming to provide clearer direction in the setting, whenever they felt it would be helpful for their patients.

5.3.2 Theme 2: Can short-term psychotherapy ever be enough?

In the second theme, named 'Can short-term psychotherapy ever be enough?', the participants provided their own understanding of the treatment's potential to help the young person overcome depression. This theme was broadly characterised by a dissonance between the young people's interviews, who described a degree of fatalism or understanding of certain limitations regarding their treatments, and the therapists' and parents' interviews, who showed a more positive and optimistic stance.

Some young people reported that they did not seem to believe therapy could help them overcome their problems. For example:

> **Marcus:** *Well, I just… I felt like by doing this I was - it didn't feel like it would benefit me in any way cos I guess I couldn't see the benefit so… I couldn't tell if anything was changing. It just felt like something extra I had to do rather than something I knew would be helping.*

From Marcus' perspective, going to therapy seemed like a part of his routine that did not help solve his difficulties. According to him, any potential changes were not personally perceived. Along similar lines, Riley stated:

> **Riley:** *I dunno, I just don't… feel – I don't see how an hour a week with someone is meant to change things, especially if you've been feeling it for such a long time and you see these people for such a short amount of time…I don't think it has the potential to do anything at all.*

According to this young person, therapy was seen as an intervention with limited capacity to make a difference, especially when put into perspective with their overall problems. In this case, Riley's depressive symptoms were

present for a significant time before therapy started and were part of their daily life for much longer than the weekly therapy hour offered.

Both Marcus and Riley seemed to have experienced STPP with a sense of hopelessness from the onset of their treatments. In their remarks, the magnitude of their issues was not felt to be possible to be tackled with therapy, and this was reported with a sense of impotence – maybe regarding the patients themselves or the treatments'. Even though the same young people appreciated therapy as a safe space, as presented in Theme 1, their treatment process was also seen by them as 'pointless', incapable of producing any type of noticeable improvement.

Conversely, Daniel and Anna experienced therapy as a helpful tool. However, this helpful quality had its limitations and was not seen as sustainable over time without some sort of on-going support:

> **Daniel:** *When I miss therapy I feel shit, I'm not entirely sure why, but I do. So, I want to keep having it until I can deal with things without it. Which I can't really at the moment.*

According to Daniel, on the days he would miss his therapy appointment he would feel worse. This scenario made him feel he was not ready to manage his feelings without therapy when the programme offered ended. Anna also reported her own understanding of the limitations this short-term approach had in helping her:

> **Anna:** *I would say… [therapy] did impact my life, and it's always gonna be there somewhere, but also… that it's kind of had… short-term effects on me, and… it's hard to say because…it could be my fault that I got depressed again like… it's… always gonna be there and it helped me a lot… but I think it's my fault that I couldn't make it last longer … I don't*

know use I couldn't deal with, I kind of lost control maybe again about dealing with my problems.

In Anna's case, it is worth noting that by the end of therapy she showed sub-clinical levels of depression, with an MFQ score of 25 (one of the only two sub-clinical scores in this whole group, considering all time points). However, consistently with her own reports, at a one-year follow-up, she showed an increase in her symptom levels, having her highest scores since baseline. Both Anna's interviews and her depressive scores indicate that she benefited from psychotherapy, but those benefits did not last.

Daniel's and Anna's reports depict how these young people managed to experience therapy as beneficial, but only while it lasted or at least not sustained after one year. These young people did not seem to be ready to end psychotherapy after the short-term programme offered, still in need of a space to let out their negative feelings or reflect on life decisions with someone else in a supportive setting. Furthermore, the young people's remarks also suggest some degree of guilt concerning their own outcomes: according to their perspectives, it was not therapy that 'failed them', but rather 'they failed' to sustain their treatments' aid.

Contrasting with the young people's reports, therapists and parents seemed to have a more positive understanding of therapy as a beneficial experience, not focusing on the potential limitations of the treatment approach. Marcus' therapist, for instance, reported:

> **Marcus' therapist***: I mean in terms of <u>presentation</u> he changed quite a lot…. in terms of what he was managing to do… like… going to school … writing, taking part in outside things, the things he'd not done at all before… I think… he'd developed a little bit more understanding of what some of this*

was about… but also a bit more therefore flexibility… in a way that it didn't have to be… everything or nothing.

In this extract, Marcus' therapist highlighted positive changes that were observable both from a behavioural level but also from the young person's internal functioning. According to her, Marcus resumed the activities he used to do before the onset of his depression and seemed to engage in more mature and less fragmented thought processes. Within the same domain, Daniel's therapist added:

Daniel's therapist: *He did manage to… be able to look back at his depression by the time we ended and see how depressed we had been and… he did much better in his educational… achievements than I think he'd thought he could… The story I think was a very good outcome for this particular [young person] because he had insight and he also appreciated he cottoned on to transference in… understanding about what was going on in the relationship with me and who he saw me figuring as in a way which worked very well for him.*

In this case, Daniel's therapist pointed to academic achievement as one indication of improvement. Furthermore, according to her perspective, Daniel managed to develop his insight capacity and use the transference work as a learning tool.

Overall, all therapists' reports included broad criteria for assessing the young people's improvement: academic success, engagement and re-engagement in activities, flexibility when dealing with personal issues, self-understanding, and reflection on relationships. Along the same lines, parents also described noticing a positive change:

> **Marcus' mother:** *Well, he's certainly… not in that dark place… and what I think is most important… is that he can now say 'this is upsetting me, that is making me angry'… he's actually now able to analyse some of his feelings… for example… he says 'before I explode or before I get angry I go and take a walk' and so to me he's made a lot of progress… from being depressed but also… analysing what he's feeling at the moment.*

Marcus' mother noticed improvements in her son's capacity to express his own feelings, but also considered that his depressive symptoms had decreased. Her descriptions of her son's capacity to 'analyse' his emotions seemed to describe Marcus' increased skills for self-reflection and self-regulation. However, even though she directly attributed the positive change and these skills' development to psychotherapy, this was not true for all cases:

> **Daniel's mother:** *There was a huge amount of positive change. [Interviewer: what would you say were the most important reasons for that change?] I think he thought-it was his perceptions-he thought that... his depression had been caused by his GCSEs… were over.*

In this excerpt, Daniel's mother reported that her son attributed his problems to the stress caused by the preparation for his GCSEs, and the passing of the GCSEs as the reason why the problems diminished. Even though she explicitly considered therapy as necessary in her son's life during her interview, she did not associate his life changes directly with the treatment process.

5.3.3 Theme 3: Therapists making links and connections that did not make sense to the young people

The third and last theme, named 'Therapists making links and connections that did not make sense to the young people', was comprised of the young people's perspectives only, and did not appear as a theme in the parent or therapist interviews. This theme describes the adolescents' experience of not understanding the reason for some interventions, or appreciating some of them as unhelpful or inappropriate during their therapy process:

> **Anna:** *I kind of still don't understand is how she always... tried to see my relationship with other people through my relationship with her...*

From this excerpt, it is noticed that Anna stated not understanding the reason why her therapist would frequently try and establish connections between their relationship and the patients' relationships outside psychotherapy. According to these young people, not understanding these connections was not the only issue concerning the discussion of the therapy relationship, as the links made by the therapist were also sometimes perceived as inaccurate:

> **Marcus:** *She linked a lot of things to go into therapy… and… sometimes it just didn't feel like that at all, a lot of the time.*

The young people's reports seem to describe the therapists' attempts to make transference interpretations, using the therapy relationship as a tool to discuss unconscious thoughts. These interventions, however, seemed to not resonate with these young people at given moments in the therapy process.

The struggles related to therapy interventions were not limited to the ones focusing on the dyads' relationships. Daniel, for example, stated:

> **Daniel:** *One time she asked me what I was doing, like what I had done that day and I said I was on the computer for about half an hour, and then she asked me what I was doing on the computer, and I said I was playing a game. And then she asked me to describe the game and I described it and she started making analogies for other things I said about the game, and I said 'no, I just played it for half an hour, it's not my entire life'.*

From this data extract, this young person illustrates how his therapist would attribute symbolic meanings to some experiences he did not see as having such. In different interviews, those types of intervention were employed concerning diverse types of content, such as dreams, games, and films the young people would bring up in the therapy hour.

In addition, the young people also described some emotional reactions when facing comments from their therapists that were deemed inaccurate or not meaningful:

> **Daniel:** *Sometimes I get frustrated because she will (…) come up with a theory for why I'm thinking this or saying this and that will just not be right. And then I'll try and say that, but it sometimes doesn't sink in. And sometimes things are looked into too in-depth like I find it frustrating that I mentioned something in passing and then that is explored, y'know, as if it's affecting me. Like I mention that I saw something… in the news and then that'll be picked apart when I don't really see there's any point in that.*

According to Daniel, his therapist's interventions at times would make him feel frustrated, as they would deviate the therapy's focus from the topics he considered more important to be discussed in the hour. Another type of reaction is presented by Anna:

> **Anna:** *She [was] always saying... I remember how even at the end how if I'm gonna think... if she still thinks about me or when I went [home] for Christmas so I didn't see her for two weeks she… asked me if I'm gonna be… over these 2 weeks thinking if she thinks about me or if she remembers me… and I always thinking... I never thought about that, so it was kind of... weird for me for her to ask things like that.*

This young person's comments seem to describe a degree of confusion or awkwardness following some of her therapist's inferences about her own thoughts.

In general, from the young people's perspectives, some comments from their therapists would not make sense to them, such as establishing connections between the therapy relationship and relationships outside therapy and attributing symbolic meaning to everyday activities or dreams. Furthermore, they also reported that these interventions would come across as imprecise at times or moving the focus away from issues that felt more important to the young people, and such situations at times lead to feelings of frustration or confusion.

5.4 Discussion

The present study aimed to investigate how young people with major depressive disorder who remained clinically depressed after short-term psychoanalytic psychotherapy, their therapists and parents made sense of the

experience of psychotherapy. By analysing semi-structured interviews using a descriptive-interpretative approach, three main themes emerged. The different themes evidenced positive aspects of the therapy process according to the different participants, as well as their own understanding of how helpful therapy potentially was and some setbacks and struggles with aspects of the therapeutic interventions.

The first theme, 'Therapy as a safe space', evidenced that young people, their therapists, and parents appreciated therapy as a space where the patients could express their thoughts and feelings that they would not be able to in other contexts. This theme was surprisingly present in this sample, considering that this study addressed cases where young people remained clinically depressed after follow-up. In general, this theme suggests that 'unsuccessful' therapy does not reflect a negative experience in psychotherapy, just like 'successful' therapies do not necessarily reflect positive experiences (De Smet et al., 2021).

This chapter's findings are to some extent similar to the ones found by McElvaney and Timulak (2013). By studying the perspectives of 11 adult patients who attended a treatment combining Cognitive-behavioural Therapy and Person-centred approaches, these authors found that even in poor outcome cases the patients were found to have positive experiences of therapy. According to their analysis, poor outcome cases specifically appreciated therapy as a tool to raise awareness of problematic functioning and mastering of problematic experience. Furthermore, these patients also valued the guidance provided by their therapists'. While we also found positive experiences among our cases, with participants referring to therapy as a 'safe space', this was more related to issues of self-expression (including how young people could and should behave in different environments) and trust (e.g., non-judgemental stance and confidentiality). Taken altogether, these results indicate that positive experiences of psychotherapy can also be seen in the

treatment of young people and that experiencing therapy as a ‘safe space’ by itself may not reflect a reduction in the patients’ symptoms.

In Theme 2, ‘Can short-term psychotherapy ever be enough?’, the participants presented their perspectives on the curative potential of STPP. While parents and therapists tended to be more positive concerning the outcomes achieved after STPP, the young people’s perspective was more reserved. Adolescents’ interviews evidenced either a degree of fatalism or an understanding of the limitations of the approach offered. According to some adolescents, their depression and overall problems were too overwhelming in their lives in comparison to the weekly hour offered in the treatment programme. In addition, some young people reported believing that therapy was only helpful while it lasted, only allowing for temporary improvement.

The discrepancies in the participants’ reports could be understood considering outcome studies including different stakeholders. When rating young people’s internalising symptoms, young people seem to provide higher scores about their own difficulties when compared to their parents (e.g., Makol & Polo, 2018; Orchard et al., 2017, 2019; Serafimova et al., 2021). However, it is worth noting that parents and therapists accounted their perception of change based on other potentially meaningful outcomes, such as academic and social functioning and coping skills (Krause et al., 2020). Hence, these cases also indicate that the understanding of ‘poor outcome’ in psychotherapy is more nuanced than a simple ‘failure’.

The third and last theme, named ‘Therapists making links and connections that did not make sense to the young people’, was only raised by young people and described moments in the process where the patients would not understand the reasons for some given interventions, or even consider them as inaccurate or confusing.

On one hand, these reports seem to describe therapists who were employing saturated (i.e., explicitly transferential, or more 'direct') interpretations when treating these young people (Ferro, 2006). Considering that adolescence is a developmental stage in which individuals are trying to develop their own identity away from primary figures – which are often the focus of transference interpretations – (Laufer, 1997), these types of interventions can be triggering. For example, Della Rosa and Midgley (2017) examined transference interpretations concerning the end of therapy among depressed adolescents in the IMPACT study STPP arm. These authors found two types of responses elicited when therapists directly linked the adolescents' life events or relationships with therapy: adolescents showed either a degree of dramatization – describing over-pessimistic or catastrophic expectations for their lives after therapy ended - or down-playing – stating that they feel fine about the treatments' ending and that their problems have already been solved. In that context, direct transference interpretations could induce anxiety and self-consciousness in adolescents, hindering their capacity for in-depth self-reflection and effective understanding (Briggs, 2019).

Along similar lines, another possible interpretation concerning this theme is that those therapists were – at least at moments – not adopting a mentalizing (or 'not-knowing') stance (Bateman & Fonagy, 2006). In that regard, the young people's reports seemed to describe interactions where their therapists jumped to conclusions, putting themselves in a position where they knew more about the patients' minds than the patients themselves. In that sense, although the interventions employed seemed to be aligned with the STPP manual (Cregeen et al., 2017), they were not always received by the young people as intended. Regarding this issue, a meta-analysis on the relationship between treatment adherence and outcomes in child and adolescent psychotherapy found that adherence only accounted for a small effect size, suggesting that applying prescribed therapy practices plays a minor role in therapy success (Collyer et al., 2020). Overall, this indicates that

therapists' flexibility to their patients' specific needs might be key to effective treatments, instead of rigid loyalty to a given treatment protocol.

It is worth observing that both Themes 2 and 3 encompassed characteristics described by O'Keefe et al. (2019) as part of a 'dissatisfied' drop-out. In that study, the authors examined the perspectives of depressed young people who dropped out from the short-term psychotherapies within the IMPACT trial. Some patients in the 'dissatisfied' group reported that they dropped out because they felt they were not benefitting from therapy (like Marcus and Riley in Theme 2), and some within the STPP arm stated that some of the therapists' interpretations did not make sense to them (Like Marcus, Anna, and Daniel in Theme 3). In the present sample, these characteristics did not make the patients interrupt their treatments, since all were treatment completers. One potential hypothesis on why these patients stayed in treatment is that even though some of them did not think they were benefitting from therapy *per se*, they appreciated the sense of safe space it fostered, as present in Theme 1. Furthermore, even though some young people reported finding some interventions pointless or inaccurate, it could mean that they were not overwhelming characteristics of their treatments, but rather facets of a broader experience.

5.4.1 Strengths and limitations

The present study has a series of strengths and limitations. Firstly, by drawing its data from a randomised trial, counting with standardised research protocols, the participants had a fairly homogeneous experience: all treatments took place in London CAMHS, following the same treatment manual, and the qualitative interviews followed a similar structure across participants.

Nevertheless, it is highlighted that there are also some limitations in terms of the conclusions that can be drawn from this theme considering the present dataset. While patients and parents were interviewed by the end of therapy (week 36) and one year after the treatment ended (week 86), the therapists' interviews took place only on week 36. Hence, therapists did not have contact with patients and therefore did not have evidence to know how the young people were presenting themselves one year after therapy ended. Perhaps having longer-term contact with the patients could have led therapists to have a different understanding of how they changed – or not – following the intervention.

It is worth noting that this study was part of a larger investigation, which also analysed the same cases' psychotherapy process. For this purpose, cases were selected according to data availability, considering the availability of session recordings and qualitative interviews. By selecting patients who had more recordings and who had participated in more interviews, this study might have indirectly selected young people and families who were more compliant and who had more positive views regarding the research protocol and their own treatment. Examining the same research questions with adolescents who dropped out or with participants who had a more dissatisfied or conflicted relationship with their therapists and the research programme could also be valuable in understanding other facets of therapy 'failure'. Furthermore, this study broadly addressed participants who remained clinically depressed after STPP, with some patients even showing some limited degree of improvement in their clinical symptoms. Investigations addressing young people who had their symptoms worsened after psychological treatments could also shed light on other experiences of 'unsuccessful' psychotherapy.

Lastly, this investigation only counted on the perspectives of the parents of two young people. Further studies addressing parental perspectives on youth psychotherapy can be valuable in widening our understanding of how they experience the therapy process.

5.4.2 Clinical implications

One can draw some clinical implications from the present findings. Firstly, therapists should be mindful that patients' positive experiences of therapy do not necessarily reflect effective therapy. In that sense, when keeping track of a given treatment, clinicians should pay attention to multiple indicators that go beyond the therapy relationship and the patient's symptoms.

Secondly, young people's perspectives on their outcomes may differ from their therapists' and parents'. Giving voice to the patients' perspectives on their progress (or lack of it) can be useful in determining potential areas that need attention (e.g., symptoms that were not perceived by parents or therapists, and not brought up spontaneously during therapy).

Lastly, it is highlighted that the use of some direct transference interpretations may elicit negative reactions in depressed adolescents, including feelings of confusion and inadequacy. Employing 'unsaturated' – or tentative – interpretations would be favoured in key moments, since they open the way to new understandings that are mutually built between the dyad, rather than being narrow, limiting, and perhaps even intimidating. In this approach, talking about the patient's issues in a more open and general way could be more effective than directly connecting them to the therapy relationship.

5.5 Conclusions

This investigation indicates that young people who remain clinically depressed after STPP present some convergences and divergences with their parents and therapists concerning their experiences of therapy. While all participants regarded therapy as a 'safe space', the adolescents had more negative views about their treatments' outcomes when compared to their

parents and therapists. In terms of the therapists' interventions, the young people reported not understanding some connections the therapists would make between the therapy relationship and relationships outside therapy, or even deeming these interventions inaccurate. Future research addressing the experience of psychotherapy under other treatment modalities and in cases with different outcomes could provide useful insights into this field.

Chapter 6 General discussion and conclusions

The current thesis aimed at understanding therapeutic 'success' and 'failure' in psychotherapies for depressed adolescents. Given the array of variables related to this topic, this research drew on data from the IMPACT (Goodyer et al., 2017a, 2017b) and IMPACT-ME (Midgley et al., 2014) studies, allowing for examinations encompassing a range of methods and perspectives. With chapters building upon each other, this volume includes a quantitative investigation of how depressed adolescents change over time in terms of their general psychopathology (Chapter 3), followed by an examination of in-session interactions between psychoanalytic psychotherapists and adolescents (Chapter 4). Lastly, it presents a qualitative analysis of the subjective experience of different stakeholders on 'poor outcome' psychoanalytic psychotherapy (Chapter 5).

This general discussion will bring together the individual chapters' contributions by reviewing the thesis 'journey', relating the main findings with my initial research questions and the relevant literature on the topic. It will then point to key clinical implications of those findings, divided into what we learned about the young people's baseline presentations and behaviours in the psychotherapy process and the therapists' behaviours and reactions to those young people. In its final sections, this chapter will highlight the studies' limitations and gaps that could be addressed in future research.

6.1 The thesis 'journey'

After starting by mapping out the main findings from previous studies about treatment 'success' and 'failure' with depressed adolescents (Chapter 1), the next task taken was to decide how to address this topic within the IMPACT sample. One of the most intriguing aspects of this trial is that all treatments achieved similar outcomes (Goodyer et al., 2017b), even though the modalities were in fact significantly different in their delivery (Calderon et

al., 2017; Midgley et al., 2018). With this in mind, one hypothesis was that this was due to measurement effects, with the instruments used – more specifically the narrow-band assessment of depression - not capturing the patients' change (or lack thereof) in its complexity. Psychoanalysis has historically taken a more holistic or generalist approach in its understanding of psychopathology (Luyten et al., 2015; Luyten & Fonagy, 2022) in comparison to cognitive approaches (A. T. Beck, 1979), for instance, which are more focused on symptomatic improvement related to psychiatric diagnosis. In that sense, adopting more generalist or holistic measurements could have evidenced specific treatment differences. This rationale, alongside the novel contributions on the general psychopathology factor (p-factor; Caspi et al., 2014; Luyten & Fonagy, 2022; G. T. Smith et al., 2020) made me interested in re-examining the IMPACT sample through this perspective (Chapter 3).

To do so, I partially replicated Aitken et al.'s (2020) confirmatory factor analysis and extracted the p-factor scores concerning the IMPACT study patients. After extracting the factor loadings, I investigated how patients changed over time through a series of LGCAs and LCGAs. The analyses showed that participants' change was best explained by a three-class model, with one category showing quick and significant change in p-factor over time (GO), one category showing slow but consistent change over time (SLOW), and one category showing little change in the first 12 weeks, which was halted in the subsequent assessments (NO).

Intriguingly, in these analyses, it was demonstrated that there were no statistically significant differences between treatments in terms of having patients belonging to the different categories. In other words, contrary to my initial hypothesis, adopting an approach specifically targeted to depression (i.e., CBT and BPI) or a more generalist one (i.e., STPP) did not make a difference in relation to how young people changed over time, even when outcomes were explored at a more holistic level.

While treatment modality did not seem to have impacted outcomes, it was identified that patients' baseline p-factor predicted trajectory membership. Patients who had higher p levels at baseline were more at risk of belonging to the 'NO' category than the ones with lower p levels. Age, gender, and narrow-band symptom scores did not predict trajectory membership. Chapter 3's results seem to be partially in line with Norcross and Lambert's (2019) findings concerning adult patients. They estimated that therapy techniques account for only 10% of the change in therapy, while patient factors account for 30%. In that regard, high-p young people seem to benefit less from the psychotherapies examined in this thesis, and the type of therapy offered does not seem to play a role in differential response in adolescent psychotherapy.

While Chapter 3 provided evidence that, on average, patients who have worse symptoms at baseline tend to have worse outcomes, it did not explain why some patients with the same level of initial impairment may still achieve different outcomes. Therefore, I became interested in understanding what 'successful' and 'unsuccessful' psychotherapies with depressed adolescents looked like beyond the patients' symptom severity, and whether there were within-session patterns of interaction that might be associated with differential outcomes, irrespective of baseline impairment. However, in order to have a deeper understanding of this topic, some methodological and contextual factors lead me to have a narrower focus than on Chapter 3. Firstly, performing analyses including all three treatment arms in the IMPACT Trial could 'wash out' potential nuances between treatments. Although studies that run joint analyses provide meaningful contributions to our understanding of psychotherapy processes (e.g., Calderon et al., 2018; Lilliengren et al., 2019), their insights tend to be more general than the ones from studies that examine one approach only (e.g., Gazzillo et al., 2014; Goodman et al., 2014; Halfon, 2021; Jones, 2000a). This methodological argument was coupled with the current literature context, as presented in Chapter 1 most recent evidence on psychotherapy 'success' and 'failure' mostly focuses on CBT processes and cognitive mediators, meaning that the therapeutic process in other types of

therapy is less well understood, from an empirical perspective. With this rationale in mind, the following chapters addressed STPP exclusively.

The deliberate decision of focusing on STPP was then followed by considerations regarding the evidence base on the psychotherapy process with depressed adolescents. Current findings in fact suggest that the therapy alliance has some association with outcomes (Karver et al., 2018; B. D. McLeod, 2011; Shirk et al., 2011), as well as the employment of specific techniques (Halfon, 2021; Kennard et al., 2009; Ulberg et al., 2021). However, there are also some indications that psychotherapy variables are dynamic and contextual (Calderon et al., 2018; Cirasola et al., 2022; Halfon, 2021), hence examining them in isolation could be misleading. Therefore, to address this identified gap, Chapter 4 focused on examining STPP sessions of good and poor outcome cases of depressed young people who started therapy with equivalent symptom levels. This examination was done through the Adolescent Psychotherapy Q-Set (APQ; Calderon, 2014; Calderon et al., 2017), a holistic measure that examines psychotherapy sessions with young people considering the young person's and therapist's behaviours and their interaction.

Following its respective data analysis, Chapter 4's main findings shed light on relevant relational patterns between depressed young people and their STPP therapists, as well as the association between these different relational patterns and treatment outcomes. Firstly, results indicated that young people who were on average more collaborative and open to discussing their thoughts and feelings, coupled with a therapist that helped them explore their inner world were more likely to achieve better outcomes in their treatments (Factor 1). This chapter also identified that both good and poor outcome cases included interactions in which the young people would be reluctant in exploring their thoughts and feelings and fluctuating in their emotional state, alongside a therapist that would behave in a more directive manner (Factor 2). Finally, the findings also suggested that young people who on average presented

higher levels of anger in their sessions (Factor 3) tended to have worse outcomes.

To some degree these findings fit with the theoretical model of STPP. Factor 1 seemed to integrate different components that, if present in STPP for depressed adolescents, might be associated with therapeutic 'success'. One of these components is keeping a 'psychoanalytic stance', which includes a therapist working alongside the young person to make sense of their experience, using clear language (Cregeen et al., 2017). Added to that there is the presence of a positive therapy alliance, verified both by the therapist and young person items included in this factor, illustrating a degree of mutuality. Lastly, this factor highlighted the patient's active role in the outcomes achieved, with their motivation and openness to engaging into a psychoanalytic process as important features for therapy 'success'. Therefore, considering patients with the same symptomatic impairment level at baseline, this study established that the young people who can establish a positive therapy alliance, and engage in the therapy process and work alongside a therapist who helps them explore their thoughts and feelings, are more likely to achieve better outcomes.

The items described in Factor 2 provide interesting findings concerning the treatment of adolescents with depression. Overall, this factor described interactions in which the therapist seemed to be moving away from a psychoanalytic stance (see Chapter 2), or even acting in a 'CBT-ish' manner, being more directive and trying to structure the setting. This took place alongside a young person who was fluctuating in emotional state and unwilling to explore their thoughts and feelings. Since this factor did not differentiate 'successful' and 'unsuccessful' cases, one could argue that this type of interaction can be found across STPP treatments for depressed adolescents regardless of outcome. Adolescence is a developmental phase between childhood and adulthood that usually involves many challenges (Cregeen et al., 2017; Laufer & Laufer, 1995). Bearing in mind that all cases selected were

treatment completers, perhaps therapists establishing a more structured setting contributed to keeping the young people attending the sessions.

The identification of adolescents' in-session anger (Factor 3) and their association with poorer outcome cases offer interesting discussion points for psychoanalytic psychotherapies for this population. Anger has a central role in the psychoanalytic understanding of adolescent depression (Busch et al., 2016; Trowell & Miles, 2011) and it was indeed found as a common symptom among these patients (Gresham et al., 2016). In addition to that, it has also been theorised as a key component of the psychoanalytic therapy process, with the expression of negative feelings discussed by classical authors as an essential element of the therapeutic process (e.g., Bion, 1959; Klein, 1932).

It seems, however, that the expression of anger by the young person in sessions was not therapeutic in itself. A hypothesis raised is that practitioners in those cases failed to use the therapy space to explore those feelings and give meaning to them. Interestingly, in a previous investigation also focusing on STPP sessions in the IMPACT trial, it has been identified that therapists tended to distance themselves from the young people's anger (Chourdaki et al., 2023). This was done by clinicians either changing the topic being discussed in the session or by referring to other instances in which the patient felt angry. Chourdaki et al. (2023) noted that these angry manifestations seemed to elicit a strong emotional reaction in the therapists, and anger was often interpreted as attacks or expressions of the patient's destructiveness, with not much room for other understandings. While the APQ did not indicate any aspects of the therapists' reactions facing the patients' anger and aggressive feelings, these findings indicate a fruitful field for future research.

Despite the contributions drawn by Chapter 3 and Chapter 4 to our understanding of therapy 'failure' and 'success', their data and insights left some important questions unanswered. For instance, Chapter 3 only included the perspectives of young people, and through self-report questionnaires

formulated by researchers. Although Chapter 4 also included therapists features in the sessions' observations, these were drawn from external observers' viewpoint. As such, neither of these studies was grounded fully in the adolescents' own subjective experiences of treatment, its processes and impact. Therefore, the next step taken in the thesis was to examine different stakeholders' own reports on their experience of therapy, giving voice to them. In addition to that, besides including young people and therapists' accounts, parents were also integrated, considering their relevance to the therapy process (Karver et al., 2018; B. D. McLeod, 2011). With this in mind, Chapter 5 analysed data from the IMPACT-ME study (Midgley et al., 2014) through a generic descriptive-interpretative approach (Elliott & Timulak, 2005; Timulak & Elliott, 2019), which aimed to understand how people make sense of a particular experience.

When adopting this approach, I expected to see (at least to some extent) 'negative' remarks about the process, with stakeholders describing different facets of why they had a 'poor' experience of psychotherapy, what the therapist 'did wrong' and/or what problems they identified in the adolescent-therapist relationship. The three themes identified through this descriptive-interpretative approach, however, evidenced a more nuanced picture of those treatments. The themes were: 'Therapy as a safe space'; 'Can short-term psychotherapy ever be enough?'; and 'Therapists making links and connections that did not make sense to the young people'.

The first theme, 'Therapy as a safe space', seemed to converge the points of view of all stakeholders (i.e., adolescents, therapists and parents), with this theme being present in all interviews. Different participants felt that therapy was a space where the young people could express themselves in a way that would not be possible in other environments, and 'let out' feelings that could be felt as a burden or overwhelming. The young people also valued when therapists respected their own pace and readiness to address certain topics, and different participants discussed the therapists' role in providing

some degree of structure to the setting. Additionally, parents recognised that the therapists had a different role in their children's lives, with young people able to behave during the sessions in ways that would not be accepted or tolerated at home.

In a recent systematic review of qualitative studies addressing children and adolescents' experiences of psychoanalytic psychotherapy (Fiorini et al., 2024), it has been identified that adolescents indeed value when therapists keep a non-judgemental stance and are attuned to their individual needs. Chapter 5's findings add to this literature by pointing out that the presence of these features in the setting might not necessarily lead to positive outcomes. In that way, it seems that having a 'good' experience of therapy does not equate to achieving positive outcomes from it, just like some 'successful' therapies might involve 'poor' or unpleasant experiences (De Smet et al., 2021).

Unlike Theme 1, which was seen as a 'consensus' among participants, the second theme 'Can short-term psychotherapy ever be enough?' evidenced some differences between the views of young people in comparison with their parents and therapists. Young people seemed to be pessimistic about STPP's curative potential, stating that the hourly session would not 'make up' for their broader suffering and experience of depression in their everyday lives, or that the possible changes would not be sustained over time. Parents and therapists, on the other hand, reported noticing improvement in the adolescents, using criteria such as academic achievement, social functioning, and coping skills (which were not addressed in the trial's outcome assessments).

Theme 2's findings are an addition to the extensive literature addressing multiple informants' perspectives concerning child and adolescent psychotherapy outcomes. As highlighted by previous studies(Makol & Polo, 2018; Orchard et al., 2017, 2019; Serafimova et al., 2021), young people who suffer from internalising conditions such as depression seem to rate their

problems as more severe than their parents. In addition to that, different stakeholders consider different outcome domains to assess change, as described in other studies (Krause et al., 2020, 2023).

Finally, the third theme, named 'Therapists making links and connections that did not make sense to the young people' focused solely on the young people's experiences and described their reactions to specific interventions and comments made by their therapists. According to those young people, the purpose of some of their therapists' remarks would not make sense to them or would be deemed inaccurate or confusing. The data excerpts included in this theme indicate that at least some of the therapists' interventions were direct transference interpretations. Concerning the use of this type of intervention while working with depressed adolescents, the literature has some intriguing findings. On one hand, it seems that depressed adolescents whose therapists employ transference interpretations in their treatment achieve a greater reduction in depressive symptoms when compared with adolescents whose therapists do not (Ulberg et al., 2021). However, it is also noted that some authors postulate that transference interpretations should be used with caution with adolescents (Briggs, 2019), as they can be especially destabilising for individuals in this age group (see Della Rosa & Midgley, 2017). Additionally, Chapter 5's findings also seem to indicate that some of those interventions were delivered in a way that was imposed by the therapists, not allowing space for the young people to contribute to the 'making sense' process.

Overall, this thesis 'journey' was characterised by an iterative process where my research questions and hypotheses were challenged in each of the empirical chapters. The combination of research methods and the inclusion of different perspectives evidenced how complex psychotherapy and its processes are, and that there are several factors associated with therapeutic 'success' and 'failure'. These factors range from the client's features at baseline, in-session interactions that provide some hints on how psychoanalytic psychotherapy for depressed adolescents looks like when it is

'on track' or 'off track', and indicators that can only be observed when hearing service users' perspectives.

6.2 Clinical implications

The empirical chapters presented in this thesis have a series of clinical implications. Considering the range of variables and perspectives related to the topic of therapy 'success' and 'failure' and the variety of methods employed in this thesis, the clinical implications described below encompass an aggregation of this thesis' findings. They are presented under the following topics: (1) the young person's baseline presentation and behaviours in the psychotherapy process, and (2) the therapists' behaviours and reactions to young people.

6.2.1 The young person: baseline presentation and behaviours in the psychotherapy process

First, this thesis' findings provide insights for the planning phase of treatments for young people. Bearing in mind that patients with more severe baseline symptoms were at risk of benefitting less (or not benefitting) from the treatments, it is important to re-think our approach when supporting them. All modalities offered in the IMPACT trial were provided on a weekly basis and covered up to 28 sessions. Concerning this context, the quantitative and qualitative data indicate that this might not be 'enough' for some young people. In that sense, clinicians should be mindful that adolescents who are perceived as more impaired at baseline might require other type of support, perhaps including more frequent sessions, longer treatment programmes, or multidisciplinary care.

In terms of when psychotherapy is already taking place, this thesis provides tentative evidence that treatments with young people who are open

to exploring their thoughts and feelings and able to engage with the therapy process are more likely to be 'successful'. In that sense, if an adolescent is presenting this stance in therapy, one could take it as an indication that the treatment is on the 'right track'. If the young person is *not* acting this way during therapy, practitioners might consider exploring what are the barriers hindering openness and engagement and working on them. It is worth noting, however, that the methods employed in this thesis could not clarify if patients 'came' to therapy ready to be open and to discuss their thoughts and feelings, if there were any aspects of how therapy was conducted that allowed to be behave like that, or a combination of those factors.

Despite not knowing if the lack of engagement was due to young people's characteristics or treatment features, it is also worth thinking about what patients STPP is suited for. In a study performed by Nakajima et al. (2022), it was identified that STPP therapists considered the patients' capacity to reflect, think, and engage in the therapy process as some of the main criteria when assessing suitability. Therefore, it might be the case that patients with difficulties in these areas could benefit more from other types of interventions.

On the other hand, adolescents who consistently present anger and irritation in the therapy process throughout different sessions could signal potential risks for the treatment. This thesis' findings indicate that the mere expression of those feelings might not be beneficial in itself, and clinicians should attempt to make these emotions be worked through during the psychotherapy process and not only 'discharged' in it. To do so, therapists could foster a space where the young people could feel that they are allowed to think about those feelings and explore their meaning without being judged. In such contexts, it would then be possible to discuss the aggression either in its 'negative' valence (e.g., a manifestation of anger and destructiveness), as well as in its 'positive' potential (e.g., a sign of capacity to communicate one's needs or overall improvement). Additionally, therapy could also be presented as a place where the young person could express these affects in the presence

of someone who can tolerate them, creating a 'corrective emotional experience' (Alexander & French, 1980).

Clinicians should also be aware that, when treating depressed adolescents, some degree of emotional fluctuation and unwillingness to explore is expected in the patients. These behaviours might be explained by these individuals' developmental stage and should not be seen as a breaking point for the therapy relationship. In that sense, those behaviours have been identified both in 'successful' and 'unsuccessful' cases.

Finally, it is also noted that patients appreciating psychotherapy as a safe and validating space does not equate to good outcomes in therapy, as assessed by a range of outcome measures using in the IMPACT study. In that sense, clinicians and researchers should keep a critical *mindset* in relation to the treatment, and bear in mind that young people's positive views on psychotherapy might not necessarily be indications of treatment effectiveness, at least considering the outcome indicators that are most commonly employed in current research.

6.2.2 The therapist: behaviours and reactions to young people

This thesis' findings also provide contributions concerning the psychoanalytic therapist's behaviour in session and how their techniques resonate with young people. First, it seems that it is expected that clinicians that work with depressed adolescents at times behave in a more directive manner, providing some boundaries in the setting. This approach does not seem to be related to differential outcomes with this population and might just reflect a technical adjustment to these patients' developmental needs. Hence, therapists perhaps should not feel compelled to adopt a strictly traditional 'psychoanalytic stance' of open exploration, but rather be flexible in their technique when working with adolescents with depression. This may be especially useful in moments when young people present themselves with

more fluctuating or reactive mood. However, it is worth noting that this was observed only in time-limited work with this population and might differ for longer-term and open-ended treatments.

Other implications relate to this thesis' findings on patient in-session anger and the broader literature on this topic. This thesis indicated that patient in-session anger might be associated with poorer outcomes, and previous literature pointed out that therapists tended to distance themselves from young people's angry feelings. Therefore, it is noted that anger is a topic that should be given closer attention in training and also for moments when it occurs in-session. Since these angry feelings might be difficult to address when manifested in the sessions, therapists should be aware of their countertransferential reactions. This awareness could allow for more deliberate practice, avoiding just acting out on the transference with avoidance or other behaviours that hinder discussions.

Lastly, the qualitative findings on how adolescents perceived some of their therapists' interventions, aligned with contemporary psychoanalysis propositions (Ferro, 1999, 2006), may inform clinicians about how to deliver certain interpretations. In that sense, interpretations could be delivered more tentatively, allowing for meanings to be co-constructed with the young person. As illustrated by the cases included in this thesis, using interpretations that do not leave space for the young person to 'build upon' them collaboratively, or adopting the role of an 'expert' who does not consider the patient's perspective, could both contribute to poorer outcomes.

6.3 Limitations and directions for future research

Despite its methodological and clinical contributions, this thesis has several limitations. First, although it addressed change over time in terms of general psychopathology levels, it is worth noting that these scores were skewed towards internalising problems. The current general psychopathology

model included only one discrete externalising domain (i.e., antisocial behaviour), favouring internalising facets of mental health difficulties (i.e., depression, anxiety), including one tentative 'thought' or mixed problem (i.e., obsessions and compulsions, Ramires et al., 2023). In addition to this bias, it is also noticeable that this model was focused on symptoms only and has not addressed other aspects of mental health such as overall functioning and identity integration. Since this thesis was based on secondary analyses of data that was already collected, this reflected in it not addressing some of the gaps raised in Chapter 1 about how 'success' and 'failure' is measured *per se*. Future studies examining psychotherapy, especially psychoanalytic ones, could include psychoanalytically-oriented diagnostic tools such as the Psychodynamic Functioning Scales (PFS; Høglend et al., 2000) and the Operationalised Psychodynamic Diagnosis (OPD; OPD-CA-2 Task Force, 2017), in order to provide a more thorough and theoretically-informed assessment of change.

In terms of the analysis of psychotherapy sessions through the APQ, it is worth noting that because of the Q-sort nature of the instrument used and the analysis employed, it was not possible to separate young people and therapists' items. In that sense, we could not analyse any causal interactions between the items within the same factor (e.g., did the young people who were more 'open' and engaged compel the therapists to help them explore their thoughts and feelings or therapists who were actively helping young people explore their thoughts and feelings making the young people more engaged?). Additionally, through our analysis we could not identify any contextual feature that was associated with Factor 3, addressing young people's anger in-session. Therefore, we do not know if there were any internal or external factors that would provoke those reactions, nor anything about the therapists' reaction to those feelings. Finally, while Factor 1 items seem to describe a psychoanalytic process taking place 'on model', the current thesis has not specifically analysed how the sessions compare with the prototypes developed for adolescents (Goodman et al., 2021). Future investigations addressing the

relationship between sessions' similarity to prototypes and outcomes could be a fruitful field for further examinations.

As pointed out in different sections throughout this thesis, most studies focusing on youth psychotherapy focus on WEIRD samples (i.e., drawn from Western, Educated, Industrialized, Rich, and Democratic backgrounds; Henrich et al., 2010), and the current thesis is not an exception. A recent meta-analysis has indicated that the effect of psychotherapy for young people differs between low- and-middle-income countries (LMIC) and high-income countries (Venturo-Conerly et al., 2023). This suggests that findings addressing WEIRD samples are not necessarily transferrable to other populations. Future investigations should focus on the different phenomena involved in psychotherapy in terms of how they take place in different cultural and socioeconomic settings. This would allow for better optimisation of current resources, which is particularly relevant when we consider the lack of access to psychotherapy in LMIC in comparison with high-income countries (Cuijpers, 2023).

6.4 Conclusions

The psychotherapeutic work with depressed young people is multifaceted, and this reflects on this thesis' findings on 'successful' and 'unsuccessful' treatments. The evidence presented in this volume indicate that several features can be related to differential outcomes, such as young people's baseline impairment and their in-session behaviour including openness and engagement, and anger. Alongside the young people's factors, there is some evidence concerning the importance of the therapist helping the young person exploring their inner thoughts and feelings, as well as the manner some interventions are delivered. Taken altogether, these findings reiterate that no discrete feature or point of view can provide the full picture about psychotherapy 'success' and 'failure' in isolation, reinforcing how

methodological integration is essential. Future research should address other outcome domains besides symptoms, in order to assess treatments more meaningfully. Furthermore, further studies should investigate what are the features that might play a role in promoting or hindering patient engagement (in-session or beyond the therapy hour). Finally, the intricacies related to anger could be scrutinised: what might provoke anger in-session, how anger is dealt with, and what are the association of those with outcomes.

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Appendices

Appendix 1: IMPACT-ME Interview Schedule – Young Person – End of Therapy (T2)

IMPACT
Improving Mood with Psychoanalytic And Cognitive Therapies

Caring for young minds
Anna Freud Centre

Overcoming depression in adolescence: the experience of young people and their families

Experience of Therapy Interview – Young Person

Confidentiality
Interviewing therapist?

1. The difficulties that have brought the young person into contact with Child and Adolescent Mental Health

- Can you tell me how you came to be referred to the CAMHS service [use name of clinic, if known]? What was going on for you at the time?

(Try to unpack what is said, e.g. 'When you say "depressed", what do you mean by that?').

- In what way did these things affect your life *at the time*?

(concrete examples - daily life, relation to others, education, feelings)

2. The young person's understanding of those difficulties

- How do you make sense of what was going on for you *at the time?* (Or 'Can you tell me the story of how things came to be the way you described?')

(Possible prompts: What do you think has made things get like they were? how did the whole thing begin? Was going on at that time? How's that connected to how things became?)

3. Change

- Compared to about a year ago, how have you been feeling/how have you been experiencing things?

[Prompt with referral to CAMHS if they don't understand about a year ago]

[E.g. of prompts: What has improved? What has got worse? (Concrete examples)]

- In thinking about the changes you have mentioned, what are the things that contributed to those changes (concrete examples)? What has been helpful/ unhelpful?

4. The story of Therapy

- What ideas did you have about therapy before you first met your therapist?

- What were your first impressions of your therapist?
(How did you feel about starting therapy with them? How did you feel after the first meeting?)

- Can you tell me the 'story' of your therapy as you see it?
  (What happened next?)

Possible prompts:

- How would you describe your relationship with your therapist? How did it change during the therapy?

- Can you think of a word to describe your therapist? Can you think of a particular moment when your therapist was [word]?

- Are there any specific moments or events that you remember about the therapy?

[E.g. of prompts: Things that happened that seemed important? Things that you or the therapist did or said that you particularly remember?]

- Were your parents/carers involved in the therapy? If so, how did this affected things?

- Can you tell me about the ending of the therapy?

[Prompts: How did therapy end? How do you feel about the way therapy ended?]

- What was it like for you knowing that your therapy was a time-limited intervention?

- Looking back, how did it feel to be in therapy? What has it been like for you overall?

5. Evaluating therapy

- What were the most helpful things about the therapy? (Concrete examples).

- What kinds of things about therapy were unhelpful, negative or disappointing (concrete examples)?

- Was medication ever discussed with you?

- If you were starting therapy again, what would you like to be different?

- If a friend of yours was in difficulty or feeling depressed, do you think you would recommend that they went for therapy?

[Why/why not?]

- If you were describing therapy to a friend who had never been, how would you describe it?

6. Involvement in research

- I'd like to ask you a few questions about what it has been like being involved in the research side of the IMPACT study...

- Can you tell me about your experience of being involved in the research side of things? How did you feel about your therapy sessions being recorded?

- When you initially joined the IMPACT study, you were allocated to one of three treatments on a random basis. Looking back, how do you feel about that process? Did you have a view on which of the three you hoped to get / not get?

- Can you tell me a bit about the regular meetings with the research assistants?

(Prompts: What has it been like having those meetings? Have you met different research assistants? How did that feel like? Did you ever talk about those meetings in your therapy? What was it like to attend research meetings at different points in time while you were still receiving therapy? And how do you feel now about attending research meeting after the therapy has ended?)

- Overall, what difference do you think it has made that your therapy has been part of a research study?

- Do you have any suggestion for us regarding the research side of the study?

6. Therapist

- Check whether the young person is okay with their therapist being interviewed.

7. Pseudonym

- Would you like to choose your own pseudonym?

8. Interviewer's reflections

(For interviewer, after interview, to dictate into recorder) How did the interview feel? Was it difficult or easy to conduct? Was it difficult to hold the 'frame' of the interview?

Version 3, March 12

Appendix 2: IMPACT-ME Interview Schedule – Young Person – 1 Year Follow-up (T3)

IMPACT
Improving Mood with Psychoanalytic And Cognitive Therapies

Caring for young minds
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Thinking back about therapy interview – Young Person

Confidentiality

"So it's been 12 months since we last saw you and this is the final research meeting. We aren't trying to test your memory and see if you tell us the same things as you told us before – we're interested in how you see things now.

1. Your life since the last IMPACT-ME interview

(the idea is to get a sense of things since their last IMPACT-ME interview, so we should try to introduce things in a way that will convey this e.g. 'since I last saw you', 'since Sally last saw you' etc)

- How are things now?
- What has been going on in your life over the last 12 months [since we last saw you]? (E.g. life events, school, family, friends)
- How have things been for you over the last 12 months?'
- If you compare today with how things were 12 months ago, have things changed? How are things similar or different? (Concrete examples)
- *Explore how change/non-change has come about*
- What has made things get better/worse/stay the same?
- *Explore how change has been sustained*

2. Thinking back about your referral to CAMHS

- Thinking about it now, how do you make sense of what was going on for you when you were first referred to CAMHS? How did the whole thing begin?
- Is that different to how you understood it a year ago?

3. Thinking back about your therapy
[Establish whether YP is still in therapy and whether they have received any further treatment/help]

- What has stayed with you from the therapy you received? Why?
- What do you remember from your IMPACT therapy?'

- Do you ever find that moments from your therapy pop into your head? When? Like what?

- What kind of things about your therapist/ therapy do you think about? What kind of situations make you think of your therapy/ therapist? What does it feel like when you think about your therapy/ therapist?)

- What things about therapy/ your therapist do you remember the most?

- Has how you see your therapy changed compared to when you finished therapy?

- Thinking about it now – can you tell me about your experience of therapy?

- Was medication ever discussed with you? [Explore – what happened / feelings about this].

- Can you tell me about the ending of the therapy? Thinking about it now, how do you feel about the way therapy ended?

- What was it like for you knowing that your therapy was a time-limited intervention?

If still in therapy with same therapist:
- How did the decision to continue with therapy come about?
- How has your therapy been going over the last year?
- Do you ever discuss the ending of your therapy in your sessions?

If started therapy again:
- How did the decision to start therapy again come about?
- What has your experience of therapy been like this time? [Go through story of therapy in relation to new therapy]
- (If therapy is with different therapist) How is it similar/ different to the therapy you were receiving before? (Concrete examples)
- How do you feel about being in therapy now compared to the last time?
- What do you hope will come out of your therapy this time? How do you hope things will be different?

[Story of therapy prompts: relationship with therapist, specific moments, parents involvement, ending]

[If yp has had more than one therapist, ask about IMPACT therapy and then therapy they have had since]

4. Your therapy and its effect on your life today

Explore the role of therapy in any changes/non-changes in their lives and how they've coped/haven't coped with any new difficulties that have come up

- Now that we've talked about therapy, do you feel that your therapy is linked to the changes? [**NB.** Summarise changes/non-changes] *(IF YES – how/why?)*

- If no change, ask why do you think therapy didn't make any difference

- Do you feel that your experiences of therapy have affected your views now about how things began/what was going on at the time when you were first referred to the [name of clinic]? *(IF YES – how/why?)*

5. Your experience of IMPACT research

"As this is your final IMPACT research meeting, I'd like to ask you a few questions about what it has been like being involved in the research side of the IMPACT study."

- Can you tell me about your experience of being involved in the research side of things?

- Can you tell me a bit about the regular meetings with the research assistants? [N.B. If the meetings with RA are compared with meetings with the therapist, explore this comparison.]

- Can you tell me how you feel about the ending of your research meetings?

6. Interviewer's reflections

(For interviewer, after interview, to dictate into recorder) How did the interview feel? Was it difficult or easy to conduct? Was it difficult to hold the 'frame' of the interview? Did you feel there were any 'turning point' moments during the interview…what happened? What was the difference, what caused this? And 'were there any moments you found your mind wandering? What happened? What were you thinking about?)

Appendix 3: IMPACT-ME Interview Schedule – Therapist – End of Therapy (T2)

IMPACT
Improving Mood with Psychoanalytic And Cognitive Therapies

Caring for young minds
Anna Freud Centre

Overcoming depression in adolescence: the experience of young people and their families

Experience of Therapy Interview - Therapist

As recommended in guidelines for qualitative research interviewing (e.g. Smith et al., 2009), the interview would be semi-structured, with the interviewer having in mind some key areas to be explored, but flexibly and led by the therapist.

The key areas to be explored would be:

1. The difficulties that brought the young person into contact with Child and Adolescent Mental Health Services (this section will probably be quite brief)

Thinking back to before you met [client's name - YP] what was your understanding of the difficulties that led them to be referred to CAMHS?

Do you remember any thoughts or feelings you had about [YP] before you even met them?

2. The 'story' of therapy

Do you remember what your first impressions were of YP? [Did you think that YP was a suitable person for this type of therapy? Why/why not?]

What were your thoughts about the YP starting this particular type of treatment?

Can you tell me 'the story' of the therapy as you see it?

Possible prompts:

How would you describe your relationship with YP? How do you think YP would describe his/her relationship with you?

Are there any particular moments in the therapy that come to mind?
[Prompts: Things that happened that seemed important? Things that you or YP did or said that you particularly remember?]

Were YP's parents/carers involved in the therapy? If so, what involvement did they have?

Can you tell me about the ending of the therapy?
[Prompts: How did therapy end? How do you feel about the way therapy ended? What questions linger in your mind regarding this case? Since the therapy ended, how have your thoughts about this young person/family changed?]

3. Change

If you compare today with when YP began therapy, what do you think is different and what remains unchanged with regard to his/her problems and difficulties? [What has improved? What has got worse? (Concrete examples)]

4. Evaluating the therapy

What do you think were the most helpful things about the therapy? (General/specific)
What kinds of things about therapy do you think were unhelpful, negative or disappointing? [If young person's treatment ended prematurely: In what way might your actions have contributed to this young person's departure?

Do you think [YP] would see it the same way? How would his/her view be similar or different?

If you were starting therapy again with YP, would you want to do anything different? What/why?

In hindsight, do you think that YP was a suitable person for this type of therapy? Why/why not?

Was medication ever discussed?

Are there other things *besides the therapy* that have been of help regarding YP's difficulties and problems? (Can you give concrete examples?) What do you think has been unhelpful regarding YP's difficulties and problems?

5. Involvement in research

I would like to ask you a few questions about what it has been like being involved in the research side of the IMPACT study so far...

First, ask a broad question to get a sense of what for the therapist has been the most significant element of the research context with this YP. E.g.

What has the research side of IMPACT been like with this young person?

Prompts of areas to explore (including what impact, if any, it had on treatment itself):

- The process of random allocation*
- Working to a manualised treatment
- Audio-taping sessions*
- Delivering therapy in a fixed time frame
- Filling in forms
- The YP's regular meetings with an RA*
- Being part of a large, national-study
- Any other

What do you think [YP] would say about how being part of a research study has affected his/her experience of therapy?

For you, what has it been like overall to take part in the IMPACT study?

Do you have any suggestions for us regarding the research?

6. Interviewer's reflections

(For interviewer, after interview, to dictate into recorder) How did the interview feel? Was it difficult or easy to conduct? Initial thoughts or understanding of what heard.

Appendix 4: IMPACT-ME Interview Schedule – Parent – End of Therapy (T2)

IMPACT
Improving Mood with Psychoanalytic And Cognitive Therapies

Caring for young minds
Anna Freud Centre

Overcoming depression in adolescence: the experience of young people and their families

Experience of Therapy Interview - Parent/Carer

---

2 interviews – 1 year follow-up
Confidentiality

1. The difficulties that have brought the young person into contact with Child and Adolescent Mental Health Services (CAMHS)

- Can you tell me how your son/daughter came to be referred to the CAMHS service? *[Use name of clinic, if known]*

- What was going on for him/her at the time? *[Try to unpack what is said, e.g. 'When you say "depressed", what do you mean by that?']*

- In what ways did these things affect your family's life *at the time*? *[Concrete examples – daily life, relation to others, education, feelings - both in relation to the young person, and impact on parents/family generally. If parent speaks about their partner then ask how these things affected their relationship with their partner at the time]*

2. The parent's understanding of those difficulties

- How do you make sense of what was going on for your son/daughter *at the time?*

- Can you tell me the story of how things came to be the way you described? *[Possible prompts: What do you think made things get like they were? How did the whole thing begin? What was going on at that time? How's that connected to how things became?]*

3. Change

- Compared to about a year ago, how has your son/daughter been feeling/experiencing things? *[Prompt with 'referral to CAMHS' if they don't understand 'a year ago']* What has improved? What has got worse? What has stayed the same? *[Concrete examples]*

- Compared to then, what is similar or different for you as a parent?

- In thinking about these changes you have just mentioned, what are the things that contributed to these changes? *[Concrete examples of changes for both the YP and the parent(s)]* What has been helpful/unhelpful?

- In relation to how things began/what was going on for your son/daughter at the time, do you see things differently now to how they seemed at the time? *[Explore how/why]*

- Do you think your son/daughter sees things differently now? *[Explore how/why]*

4. The story of therapy

[This section should aim to explore what seems most relevant in the parent's experience – this could include significant meetings with the YP's therapist; impressions of the YP's therapy; the parent's own involvement in the IMPACT therapy (or if the parent wasn't involved, what that was like), or all of the above, but led by what seems to be most significant for the individual parent]

Parental involvement:

- What was your involvement with CAMHS? *[E.g. saw a therapist regularly for their own sessions; was only involved in their son's/daughter's therapy at the beginning; had review meetings with their son's/daughter's therapist; spoke to their son's/daughter's therapist on the phone]*
- If no involvement:
  - Can you tell me why not?
  - Looking back, would you like it to have been different? *[Explore how/why]*
- If were involved:
  - Can you tell me about what happened when you went to the clinic?
  - Can you tell me about what your meetings were like? *[Include both joint and separate meetings]*
  - Are there any specific things you remember about your own meetings at CAMHS?
  - What types of things did you and your therapist discuss during your meetings?
  - Can you tell me about the therapist you met with? *[If the participant describes the person as a 'psychiatrist' or 'parent worker' etc rather than therapist, then use that term]*

Young person's therapy:

- What ideas did you have about therapy before your son/daughter's therapy began?
- What were your first impressions of your son's/daughter's therapist? How did you feel about your son/daughter starting therapy with them? How did your son/daughter feel after the first meeting? How would you describe your son's/daughter's relationship with their therapist? How did it change during the therapy?
- Can you tell me the 'story' of your child's therapy as you see it?
- Are there any specific moments or events that you remember about your son's/daughter's therapy? *[Possible prompts: Things that happened that seemed important? Things that the therapist did or said that you particularly remember?]*
- Can you tell me about the ending of your child's therapy? *[Possible prompts: How did the therapy end? How do you feel about the way therapy ended?]*
- What was it like for you knowing that your child's therapy was a time-limited

intervention?

- Overall, how did it feel to have your son/daughter in therapy? What do you think it has been like for him/her overall?

5. Evaluating therapy

Young person's therapy:

- What were the most helpful things about the therapy for your child? *[Concrete examples]*
- What kinds of things about your child's therapy were unhelpful, negative or disappointing? *[Concrete examples]*
- Was medication for your child ever discussed? *[Explore what happened]*
- If your son/daughter was starting therapy again, what would you like to be different?

Parental involvement:

- What do you think were the most helpful things about your own involvement with the therapy?
- What kinds of things about your involvement were unhelpful, negative or disappointing?
- Do you feel that your experiences of your son's/daughter's therapy/your own involvement with CAMHS have affected your views now about how things began/what was going on at the time when your son/daughter was first referred to the CAMHS? *[Explore how/why]*
- Do you think that your son/daughter would see it the same way? *(How/why?)*

6. Involvement in research

- Can you tell me about your experience of being involved in the research side of things? *[Explore any comparisons made between therapy and the research]*
- When you and your son/daughter initially joined the IMPACT study, your son/daughter was allocated to one of three treatments on a random basis. Looking back, how do you feel about that process? Did you have a view on which of the three you hoped to get/not get?
- Can you tell me a bit about the regular meetings with the research assistants? *[Possible prompts: What has it been like having those meetings? Have you met different research assistants? How do you feel now about attending research meetings after the therapy has ended?]*
- Overall, what's it been like for you/your son/daughter to have had therapy as part of a research study?
- Do you have any suggestions for us regarding the research?

7. Parent worker

- If the family have been part of the STPP treatment arm and the parent has had their own sessions, check whether the parent is OK with us interviewing their parent worker.

8. Interviewer's reflections

[This section is for the interviewer, after the interview, to dictate into their recorder]

- How did the interview feel?
- Was it difficult or easy to conduct?
- Was it difficult to hold the 'frame' of the interview?

Appendix 5: IMPACT-ME Interview Schedule – Parent – 1 Year Follow-up (T3)

IMPACT
Improving Mood with Psychoanalytic And Cognitive Therapies

Caring for young minds
Anna Freud Centre

Overcoming depression in adolescence: the experience of young people and their families

One Year Follow-Up 'Thinking Back' Interview – Parent/Carer

- Confidentiality
- It's been 12 months since we last saw you and this is your final interview with us. I don't want to test your memory or check whether you tell us the same things now as before – we're interested in how you see things now.

1. **Thinking back about referral to CAMHS**

- Thinking back to when your son/daughter was referred to CAMHS *[use name of clinic, if known]*, what was going on at that time? *[Explore how their son/daughter was feeling/behaving at that time and how things began]*

- Is that different to how you understood things back then? *[Explore how/why]*

2. **Life since their last IMPACT-ME interview**

- How are things with your son/daughter now?

- Compared to when we last saw you a year ago, how have things changed for your son/daughter? How have things changed for you as a parent?

- What has made things stay the same/get better/get worse? *[Explore how any changes/non-changes have come about and how any changes/non-changes have been sustained]*

3. **Thinking back about therapy**

Parental involvement:

- What was your involvement with CAMHS? *[E.g. saw a therapist regularly for their own sessions; was only involved in their son's/daughter's therapy at the beginning; had review meetings with their son's/daughter's therapist; spoke to their son's/daughter's therapist on the phone]*

- If no involvement:

  - Can you tell me why not?
  - Looking back, would you like it to have been different? *[Explore how/why]*

- If were involved:

- Thinking about it now - can you tell me about your experience of being involved with CAMHS?
- What stands out in your memory about the involvement that you had? *[Explore why]*
- What things about the therapist that you saw *[their therapist or their child's therapist]* do you remember the most?
- Looking back, how do you feel about the involvement that you had?
- Do you feel any differently about it now compared to when your involvement ended?
- How did you feel about your involvement ending?

Young person's therapy:

- Is your son/daughter still in therapy? Have they had any further therapy? *[Ask about their son's/daughter's IMPACT therapy first and then about any therapy that they have had since]*

- IMPACT therapy:

  - Thinking about it now – can you tell me about your son's/daughter's experiences of therapy? *(E.g. helpful/unhelpful aspects of therapy, specific moments or events that they particularly remember about their son's/daughter's therapy?)*
  - Which aspects of therapy do you think have continued to have an impact for your son/daughter?
  - Was medication ever discussed with you? *[Explore what happened/their feelings about this]*

- Ending of IMPACT therapy:

  - Thinking about it now, how do you feel about the way in which your son's/daughter's therapy ended?
  - Since your son/daughter finished therapy, do you ever think about their therapy or therapist? *[Explore what/when]*
  - Looking back, how do you feel about the therapy that your son/daughter had? Do you feel any differently about it now compared to when it ended? *[Explore how/why]*
  - If your son/daughter was starting therapy again, is there anything that you would like to be different? *[Explore what/why]*

- If young person is still in therapy with the same therapist:

  - How has your son's/daughter's therapy been going over the last year?
  - Has the ending of your son's/daughter's therapy been discussed?

- If young person has started therapy again:

  - How did the decision to start therapy again come about?
  - What has your child's experience of therapy has been like this time?

- How is it similar/different to the therapy your son/daughter was receiving before? *[Concrete examples]*
- How do you feel about your son/daughter being in therapy now compared to the last time?
- What do you hope will come out of your child's therapy this time? How do you hope things will be different?

4. Reflecting on possible links between therapy and change/non-change

- Now that we've talked about therapy, do you feel that your son's/daughter's therapy is linked to the changes that we've talked about? *[Explore how/why]*

- *[If there hasn't been any change]* Why do you think therapy hasn't made any difference for your son/daughter?

- Do you feel that your experiences of CAMHS have affected your views now about how things began/what was going on at the time when they were first referred to CAMHS? *[Explore how/why]*

5. Reflecting on involvement in research

- Can you tell me about your experience of being involved in the research side of things? *[Explore any comparisons made between therapy and the research]*

- How do you feel about the ending of your research meetings?

- How has it felt for you to be part of the IMPACT study?

6. Parent worker

- If the family have been part of the STPP treatment arm and the parent has had their own sessions, check whether the parent is ok with us interviewing their parent worker.

7. Interviewer's reflections *[to be dictated by the interviewer into their recorder]*

- How did the interview feel? Was it difficult or easy to conduct?

- Was it difficult to hold the 'frame' of the interview?

- Did you feel there were any 'turning point' moments during the interview? *[Explore what happened and what caused this]*

- Were there any moments when you found your mind wandering? *[Explore what happened and what you were thinking about]*

Appendix 6: Research Ethics Committee Approval

NHS

National Research Ethics Service

Cambridgeshire 2 Research Ethics Committee

Victoria House
Capital Park
Fulbourn
Cambridge
CB21 5XB

Telephone: 01223 597693
Facsimile: 01223 597645

09 October 2009 SECOND LETTER

Prof Ian Goodyer
Professor of Child and Adolescent Psychiatry
Section of Developmental Psychiatry
University of Cambridge
Douglas House
18b Trumpington Road
Cambridge
CB2 8AH

COPY FOR YOUR INFORMATION

Dear Prof Goodyer

Study Title: **Randomised Controlled Trial of Short term Psychodynamic Psychotherapy (STPP), Cognitive Behaviour Therapy (CBT) and Specialist Clinical Care (SCC) in adolescents with moderate to severe depression attending routine child and adolescent mental health clinics**

REC reference number: **09/H0308/137**
Protocol number: **3**

Thank you for your letter of 09 October 2009, enclosing the amended IRAS form listed below, as referred to in the Committee's first letter of today's date.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to

the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk. *Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.*

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Check list		19 June 2009
Investigator CV	Prof Goodyer	19 June 2009
Summary/Synopsis	2 Flow chart attachment to PIS	05 May 2009
Questionnaire: RTSHIA		
Questionnaire: DEQ (A and S)		
Questionnaire: DES-IV		
Questionnaire: NEO-FFI		
Questionnaire: YPQ (incorporating MFQ, RCMAS, LOI, RSES and Behaviour checklist)		
GP/Consultant Information Sheets	3	27 April 2009
Questionnaire: K-SADS-PL(Depressive disorders, Depression supplement, pyschosis supplement, panic disorder supplement, attention deficit hyperactivity disorder supplement, alcohol abuse supplement)		
Questionnaire: DSC		
Questionnaire: SCL-90		
Questionnaire: WAI-S (Therapist,Client)		
Questionnaire: APQ (Child, parent, APQ-P-S, APQ-C-S)		
Questionnaire: HCAM		
Questionnaire: CDRS		
Questionnaire: CGI		
Questionnaire: HoNOSCA		
Questionnaire: ZAN-BPD		
Questionnaire: Early experiences (non-validated)	2	01 March 2006
Questionnaire: Life events (non-validated)	8	10 August 2005
Questionnaire: Friendships (non-validated)	6	01 February 2008
Questionnaire: C-SSRS		
Questionnaire: CA-SUS		
Measures Glossary	3	18 May 2009

Questionnaire: FAD		
Questionnaire: RRS		
letter from funder (NIHR)		13 May 2008
Protocol	3	19 May 2009
REC application 26218/67654/1/699		19 June 2009
Response to Request for Further Information		09 October 2009
study Timeline	4	15 July 2009
E-mail from CI re study timeline		15 July 2009
Participant Information Sheet: Child 16-17	10	11 September 2009
Participant Information Sheet: Child 11-15	10	11 September 2009
Participant Information Sheet: Parent	5	11 September 2009
Participant Consent Form	4	04 August 2009
Participant Consent Form: assent	4	04 August 2009
Lone Working Policy	1	24 August 2009
Participant Consent Form: saliva	1	04 August 2009
Participant Consent Form: assent saliva	1	04 August 2009
Letter from UOC insurance team		28 July 2009
E-mail with response from Prof Goodyer		06 October 2009
Response to Request for Further Information		06 October 2009

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

Appendix 7: Young People Consent Form

IMPACT

Improving Mood with
Psychoanalytic And Cognitive Therapies

IMPACT ID:……..

[redacted]

PARTICIPANT CONSENT FORM
Young person

1. I confirm that I have read and I understand the information sheet dated 11th May 2011 for the above study. I have had the opportunity to consider the information, and ask questions, and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I'm free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐
3. I understand that relevant sections of medical notes and data collected during the study from myself may be looked at by individuals from the IMPACT research team, from regulatory authorities or from the NHS Trust, where it is relevant to me taking part in this research. I give permission for these individuals to have access to my records. ☐
4. I agree to my therapy and research sessions being recorded for quality control, and that other researchers working in mental health research can have access to recordings made as part of the study. ☐
5. I agree to my GP being informed of my participation in the study. ☐
6. I agree to take part in the above study. ☐
7. I agree to a researcher contacting me after the end of the IMPACT study about possible future research and follow up. ☐

If any answers to the above are 'no' or if you don't want to take part, don't sign your name!

→ If you do want to take part, please sign your name below:

Sign your name……..Date……

→ The researcher who explained this project to you needs to sign too

Print name ……

Signed……Date……..

Thank you for your help.

11th May 2011 /Version 5

Appendix 8: Parent Consent Form

IMPACT

Improving Mood with
Psychoanalytic And Cognitive Therapies

IMPACT ID:……

[redacted]

Parent/Guardian Consent Form

Please initial box

1. I confirm that I have read and I understand the information sheet dated 11th May 2011 for the above study. I have had the opportunity to consider the information, and ask questions, and have had these answered satisfactorily. ☐
2. I understand that our participation is voluntary and that we are free to withdraw at any time without giving any reason, without our medical care or legal rights being affected. ☐
3. I understand that relevant sections of medical notes and data collected during the study from both me and my child may be looked at by individuals from the IMPACT research team, from regulatory authorities or from the NHS Trust, where it is relevant to our taking part in this research. I give permission for these individuals to have access to my records. ☐
4. I agree to my child's therapy and research sessions being recorded for quality control and that other researchers working in mental health research can have access to the recordings made as part of the study. ☐
5. I agree to my child's GP being informed of their participation in the study. ☐
6. I agree to both me and my child taking part in the above study. ☐
7. I agree to a researcher contacting me after the end of the IMPACT study about possible future research and follow up about my child. ☐

…….. ……..
Name of Patient's parent or carer Date Signature

…… …… ……
Name of Person taking consent Date Signature

11th May 2011 /Version 6

Appendix 9: Standardized Factor Loadings for Multilevel Orthogonal Bifactor Model

Item description	Item #	*P* factor	Melancholic Features	Depressive Cognitions	Anxiety	Obsessions-Compulsions	Conduct Problems
Melancholic Features							
I didn't enjoy anything	MFQ 2	.813	.091				
I felt so tired I just sat around and did nothing	MFQ 5	.638	.364				
I was moving and walking more slowly than usual	MFQ 6	.673	.499				
It was hard for me to make up my mind	MFQ 10	.695	.111				
I felt like talking a lot less than usual	MFQ 12	.716	.336				
I was talking more slowly than usual	MFQ 13	.682	.477				
I found it hard to think properly or concentrate	MFQ 21	.785	.261				
I didn't have any fun at school/college/work	MFQ 29	.705	.174				
Depressive Cognitions							
I thought that life was not worth living	MFQ 16	.801		.499			
I thought about dying	MFQ 17	.750		.632			
I thought my family would be better off without me	MFQ 18	.769		.383			
I thought about killing myself	MFQ 19	.718		.645			
I thought nobody really loved me	MFQ 28	.811		.234			
Anxiety							
I did everything wrong	MFQ 31	.883			.027		
I worried when things did not right for me	RCMAS 2	.539			.516		
Others seemed to do things more easily	RCMAS 3	.555			.385		
I was afraid of a lot of things	RCMAS 6	.640			.356		
I felt that others did not like the way I did things	RCMAS 9	.589			.447		

I worried about what was going to happen	RCMAS 17	.572	.535		
I felt someone would tell me I did things … wrong	RCMAS 21	.582	.475		
I wake up scared some of the time	RCMAS 22	.590	.113		
I worried	RCMAS 26	.467	.400		
I often worried…something bad happening to me	RCMAS 28	.608	.473		
Obsessions-Compulsions					
I felt had to do things certain way…stop something bad	LOI 1	.514		.675	
I hated dirt and dirty things	LOI 3	.402		.660	
I had a special number that I counted up to …	LOI 4	.451		.682	
I worried about being clean enough	LOI 6	.486		.557	
I moved or talked in a special way to avoid bad luck	LOI 7	.407		.647	
I was fussy about keeping my hands clean	LOI 9	.376		.644	
I had special numbers or words … kept bad things away	LOI 10	.434		.808	
Conduct Problems					
I deliberately broke the rules or disobeyed ….	BC 1	.520			.664
I stole things …	BC 2	.365			.665
I deliberately damaged property …	BC 3	.354			.764
I deliberately hurt or threatened someone …	BC 4	.378			.710
I skipped lessons or work, or played truant	BC 5	.464			.410
I ran away from home	BC 7	.412			.578
I have carried or used a weapon …	BC 10	.340			.683

Note. Item description abbreviated. Measures are: MFQ = Mood and Feelings Questionnaire; RCMAS = Revised Children's Manifest Anxiety Scale; LOI = Leyton Obsessions Inventory; BC = Behaviour Checklist

Appendix 10: Baseline characteristics for depressive cognitions trajectories

	Class 1 (*n* = 187) Lower and stable		Class 2 (*n* = 245) Med-level and stable symptoms		Class 3 (*n* = 33) Higher and stable symptoms		Comparison	
	Mean (*n*)	SD (%)	Mean (*n*)	SD (%)	Mean (*n*)	SD (%)	c^2/F	*p*
Demographics								
Female	144	77%	180	73.5%	24	72.7%	.778	.674
Age	15.63	1.40	15.56	1.45	15.89	1.30	.821	.440
Region	-	-	-	-	-	-	11.801	.019
East Anglia	59	31.5%	107	43.7%	19	57.6%	-	-
North London	57	30.5%	62	25.3%	8	24.2%	-	-
North West	71	38%	76	31%	6	18.2%	-	-
England								
Ethnicity (white)	150	80.2%	185	75.5%	28	84.8%	2.325	.313
Treatment arm	-	-	-	-	-	-	4.410	.353
BPI	63	33.7%	80	32.7%	12	36.4%	-	-
CBT	70	37.4%	76	31%	8	24.2%	-	-
STPP	54	28.9%	89	36.3%	13	39.4%	-	-
Baseline symptoms								
MFQ	44.01	10.5	47.14	10.59	48.15	9.33	5.516	.004
RCMAS	41.42	7.13	40.64	7.38	40.27	7.08	.755	.471
LOI	10.76	5.00	9.66	5.37	8.30	5.39	4.207	.015
BC	3.74	3.49	3.12	2.94	2.38	2.62	3.547	.030
Comorbidity	-	-	-	-	-	-	20.312	.061
0	79	42.2%	126	51.4%	18	54.5%	-	-
1	69	36.9%	52	21.2%	9	27.3%	-	-
2	18	0.1%	41	16.7%	2	0.1%	-	-
3	12	0.1%	19	0.1%	3	0.1%	-	-
Baseline SSRI presc.	31	16.6%	47	19.2%	11	6.1%	9.437	.051

Note. BPI = Brief Psychosocial Intervention; CBT = Cognitive-Behavioural Therapy; STPP = Short-term Psychoanalytic Psychotherapy; MFQ = Mood and Feelings Questionnaire; RCMAS = Revised Children's Manifest Anxiety Scale; LOI = Leyton Obsessions Inventory; BC = Behaviour Checklist.

Appendix 11: Baseline characteristics for obsessions-compulsions trajectories

	Class 1 (*n* = 328) Lower and stable symptoms		Class 2 (*n* = 137) Higher and stable symptoms		Comparison	
	Mean (*n*)	SD (%)	Mean (*n*)	SD (%)	c^2/F	*p*
Demographics						
Female	240	73.2%	108	78.8%	1.645	.200
Age	15.57	1.41	15.69	1.46	.670	.414
Region	-	-	-	-	7.039	.030
East Anglia	142	43.3%	43	31.4%	-	-
North London	80	24.4%	47	34.3%	-	-
North West England	106	32.3%	47	34.3%	-	-
Ethnicity (white)	256	78%	107	78.1%	.000	.990
Treatment arm	-	-	-	-	2.949	.229
BPI	105	32%	50	36.5%	-	-
CBT	105	32%	49	35.8%	-	-
STPP	118	36%	38	27.7%	-	-
Baseline symptoms						
MFQ	45.48	10.77	47.08	10.03	2.215	.137
RCMAS	40.39	7.38	42.21	6.82	6.117	.014
LOI	8.22	4.46	14.26	4.57	173.400	.000
BC	2.99	2.83	4.09	3.74	11.834	.001
Comorbidity	-	-	-	-	1.463	.962
0	161	49.1%	62	45.3%	-	-
1	88	26.8%	42	30.7%	-	-
2	44	13.4%	17	12.4%	-	-
3	23	0.1%	11	0.1%	-	-
Baseline SSRI prescription	65	19.8%	24	17.5%	.378	.828

Note. BPI = Brief Psychosocial Intervention; CBT = Cognitive-Behavioural Therapy; STPP = Short-term Psychoanalytic Psychotherapy; MFQ = Mood and Feelings Questionnaire; RCMAS = Revised Children's Manifest Anxiety Scale; LOI = Leyton Obsessions Inventory; BC = Behaviour Checklist.

Appendix 12: Baseline characteristics for conduct problems trajectories

	Class 1 (*n* = 214) Lower and stable symptoms		Class 2 (*n* = 213) Med-level and stable symptoms		Class 3 (*n* = 38) Higher and decreasing symptoms		Comparison	
	Mean (*n*)	SD (%)	Mean (*n*)	SD (%)	Mean (*n*)	SD (%)	c^2/F	*p*
Demographics								
Female	183	85.5%	149	70%	16	42.1%	37.274	.000
Age	15.87	1.37	15.37	1.41	15.49	1.56	6.706	.001
Region	-	-	-	-	-	-	4.258	.372
East Anglia	85	39.7%	90	42.3%	10	26.3%	-	-
North London	55	25.7%	58	27.2%	14	36.8%	-	-
North West England	74	34.6%	65	30.5%	14Û	36.8%	-	-
Ethnicity (white)	169	79%	168	78.9%	26	68.4%	2.248	.325
Treatment arm	-	-	-	-	-	-	7.352	.118
BPI	69	32.2%	69	32.4%	17	44.7%	-	-
CBT	69	32.2%	79	37.1%	6	15.8%	-	-
STPP	76	35.5%	65	30.5%	15	39.5%	-	-
Baseline symptoms								
MFQ	46.80	10.13	45.50	10.98	43.71	10.50	1.739	.177
RCMAS	40.93	7.26	41.02	7.76	39.29	7.82	1.072	.343
LOI	9.81	5.07	10.35	5.44	9.11	5.23	1.145	.319
BC	1.54	1.72	4.22	2.97	8.03	3.46	130.753	.000
Comorbidity	-	-	-	-	-	-	9.539	.656
0	100	46.7%	105	49.3%	18	47.4%	-	-
1	62	29%	56	26.3%	12	31.6%	-	-
2	26	12.1%	33	15.5%	2	0.1%	-	-
3	19	0.1%	11	0.1%	4	0.1%	-	-
Baseline SSRI presc.	42	19.6%	42	19.7%	5	13.2%	2.034	.729

Note. BPI = Brief Psychosocial Intervention; CBT = Cognitive-Behavioural Therapy; STPP = Short-term Psychoanalytic Psychotherapy; MFQ = Mood and Feelings Questionnaire; RCMAS = Revised Children's Manifest Anxiety Scale; LOI = Leyton Obsessions Inventory; BC = Behaviour Checklist.

Appendix 13: Baseline predictors for lower-level factors

	Depressive Cognitions		Obsessions-compulsions		Conduct Problems	
	OR	95% CI	OR	95% CI	OR	95% CI
Gender	0.64	0.41—1.01	1.84	0.99—3.45	**2.70****	**0.22—0.61**
Age	0.95	0.83—1.09	1.16	0.96—1.39	**1.24****	**0.69—0.94**
SSRI	**1.02***	**1.00—1.03**	0.99	0.98—1.01	1.00	0.98—1.01
Arm	1.13	0.90—1.42	0.95	0.69—1.30	1.09	0.71—1.19
P-factor	1.20	0.58—2.45	**0.37***	**0.14—0.99**	**2.85****	**0.15—0.81**
MFQ	**1.07****	**1.03—1.12**	0.98	0.92—1.04	0.98	0.97—1.07
RCMAS	**0.95***	**0.92—0.99**	0.96	0.92—1.01	0.99	0.97—1.05
LOI	**0.92****	**0.88—0.96**	**1.52****	**1.40—1.65**	1.03	0.92—1.02
BC	**0.91****	**0.85—0.97**	1.08	0.98—1.18	**0.53****	**1.68—2.08**
Comorbidity	0.92	0.78—1.09	0.87	0.68—1.09	1.12	0.73—1.08

*p<0.05, **p<0.01.

Note. OR = Odds Ratio, CI = Confidence Interval, SSRI = baseline intake of selective serotonin reuptake inhibitors, MFQ = Mood and Feelings Questionnaire, RCMAS = Revised Children's Manifest Anxiety Scale; LOI = Leyton Obsessions Inventory; BC = Behaviour Checklist.

Appendix 14: APQ Coding Manual

ADOLESCENT

PSYCHOTHERAPY Q-SET

CODING MANUAL

Ana Calderon, PhD

Nick Midgley, PhD

Celeste Schneider, PhD

Professor Mary Target

University College London

Anna Freud Centre

November 2014

The 100 items of the Adolescent Psychotherapy Q-set (APQ) provide a basic language for the description and classification of psychotherapy process in the treatments of young people (ages 12-18). Its general purpose is to provide a meaningful index of the psychotherapeutic process, which may be used in comparative analyses or studied in relation to pre- and post-psychotherapy assessments. The APQ is intended to be neutral with respect to any particular theory of psychotherapy, and should permit the portrayal of a wide range of events, interventions, and processes in the psychotherapy process. It is hoped that the use of a standard language and rating procedure will provide the means for systematically characterizing young person-therapist interactions. Raters Q-sort the entire psychotherapy session, rather than small segments of young person or psychotherapist communications.

The procedure is the following: after studying a psychotherapeutic session and arriving at some formulation of the material, raters revise the 100 items and sort the cards into a row of nine categories. At one end raters place those cards believed to be the *most characteristic* with reference of the understanding of the material, while at the other end raters place those cards believed to be *most uncharacteristic* with respect to their formulation.

A conventional method of sorting is to first form three stacks of cards – those items deemed uncharacteristic, those items deemed characteristic, and those items that are relatively unimportant to the session. At this time, no attention needs to be paid to the number of items falling into each of these three stacks. When the three piles of cards have been put together, they can be further divided into the proportions indicated for each category. The number of cards to be placed in each category is:

Category	Number of cards	Label of Category
9	5	Extremely characteristic or salient
8	8	Quite characteristic or salient
7	12	Fairly characteristic or salient
6	16	Somewhat characteristic or salient
5	18	Relatively neutral or unimportant
4	16	Somewhat uncharacteristic or negatively salient
3	12	Fairly uncharacteristic or negatively salient
2	8	Quite uncharacteristic or negatively salient
1	5	Extremely uncharacteristic or negatively salient

Raters may feel some discomfort at the constraints imposed by the sorting procedure or the Q-set items, but the assignment of a fixed number of cards to each category has been shown empirically to be a more valuable procedure than the situation in which a clinician can assign any number of items to a category. It should also be noted that the Q-items themselves represent a good deal of reflection and advice; however, as is true of other systems of content analysis, the Q-set is designed to reduce complex interaction to manageable proportions, and to achieve research economy. Although no instrument of this kind perfectly fits or captures all the possible events in a psychotherapy session, the Q-set intends to allow the description of events of a psychotherapy process by means of a suitable placement of cards and the ultimate configuration of multiple cards.

The APQ is composed of three types of items: (1) items describing young person's emotional states, attitude, behaviour or experience; (2) items reflecting the therapist's actions and attitudes; and (3) items attempting to capture the nature of the interaction of the dyad, or the climate or atmosphere of the encounter.

This manual should be carefully studied, as the definitions, descriptions, and examples provided are intended to minimize potentially varying interpretations of the items. It is important that the full rating description of each item should be used when rating, rather than just the item name. Raters are asked to take the position of a "generalized other" i.e. an observer who stands mid-way between young person and therapist and who views the interaction from the outside. In placing each item, raters should ask themselves: Is this attitude, behaviour, or experience clearly present (or absent)? If the evidence is not compelling, raters should ask themselves: To what extent is it present or absent? Raters should try to be as open-minded and objective as possible, focusing on the behavioural and linguistic cues presented in the clinical material, and searching for *specific* evidence. Raters should also try not to be influenced by their personal reactions to either therapist or patient and avoid the judgments of whether a particular therapist activity is effective or ineffective, or desirable or undesirable from a particular theoretical point of view.

Raters are sometimes uncertain as to whether a particular item should be placed in the relatively neutral or unimportant category. An item should be placed in the neutral category when it is truly irrelevant or inconsequential in relation to the interaction. For example, item number 4 (The young person's treatment goals are discussed) should be rated as neutral when the discussion

of the young person's treatment goals is irrelevant to the psychotherapy session. An uncharacteristic rating would be appropriate when its absence is a notable descriptor of the hour (i.e., there is no reference or allusion by therapist or young person to the possible goals of the therapy even when the therapist and the young person appear to be establishing the frame of therapy in other ways). **In other words, a more extreme placement of the card in the uncharacteristic direction signals that the absence of a particular behaviour or experience is remarkable.**

It should be noted as well that the APQ includes items referring to similar events but in relation to different people; hence, raters should be careful to rate the events with the appropriate item. For example, item 63, 64, and 98 refer to the discussion of the young person's interpersonal relationships, but item 63 alludes to the young person's social or family relationships or personal emotional involvements, item 64 to the romantic relationships, and item 98 to the therapy relationship.

Raters may occasionally feel that there is insufficient evidence to make a judgment of item placements with good confidence. However, extensive research employing Q-methodology has demonstrated that with patience and care, Q-ratings capture meaningful descriptions of experience in the consulting room and achieve high inter-rater reliability.

ADOLESCENT PSYCHOTHERAPY Q-SET: ITEMS AND DEFINITIONS

Item 1: Young person expresses, verbally or non-verbally, negative feelings towards therapist

Place toward *characteristic* direction if young person expresses, verbally or non-verbally, negative feelings (such as criticism, dislike, envy, scorn, or anger), or antagonism toward therapist. For example, young person rebukes therapist for failing to provide enough direction in the therapy.

Place toward *uncharacteristic* direction if young person expresses, verbally or non-verbally, positive or friendly feelings about therapist. For example, makes what appear to be complimentary remarks to therapist.

Item 2: Therapist draws attention to young person's non-verbal behaviour

Place toward *characteristic* direction if therapist draws attention to young person's non-verbal behaviour such as facial expressions, blushes, or body movements. For example, the therapist points out that, although young person says she is angry, she is smiling.

Place toward *uncharacteristic* direction if there is little or no focus by the therapist on non- verbal behaviour. For example, young person repeatedly clears her throat or taps her fingers, but the therapist does not acknowledge this.

Item 3: Therapist's remarks are aimed at facilitating young person's speech

Place toward *characteristic* direction if therapist's responses or behaviour indicate that he is listening to the young person and encouraging him to continue. For example, therapist frequently utters 'mm hmm', 'yeah', 'sure', 'right' and the like. N.B. Item does not refer to questions or exploratory comments.

Place toward *uncharacteristic* direction if therapist does not attempt to facilitate young person's talk, but leaves the young person to decide how much to speak.

Item 4: Young person's treatment goals are discussed

Place toward *characteristic* direction if there is talk about what young person wishes to achieve as a result of therapy. These wishes or goals may refer to personal or 'inner' changes or change in life circumstances. For example, therapist says 'When you started this therapy you said you wanted to be able to stay out of trouble at school, how do you feel about that now?' or

young person says ‘I wonder if therapy will result in my getting on better with my parents?’.

Place toward *uncharacteristic* direction if there is no discussion by therapist or young person of the possible goals of the therapy. For example, young person says ‘why am I coming here anyway?’ and the question is not further explored.

Item 5: Young person has difficulty understanding therapist’s comments

Place toward *characteristic* direction if young person seems confused by therapist’s comments. For example, young person repeatedly says ‘what?’ or otherwise indicates that she does not know what the therapist means.

Place towards *uncharacteristic* direction if young person readily comprehends therapist’s comments.

Item 6: Young person describes emotional qualities of the interactions with significant others

Place toward *characteristic* direction if young person discusses feelings associated with his interactions with those he is close with (including the therapist). For example, young person describes feeling shocked when his friend apologized, or upset when therapist had not wished him good luck for his exams the previous week.

Place toward *uncharacteristic* direction if, when talking about interactions with significant others, young person does not describe feelings or emotions connected to the interactions with them. For example, young person talks about his mother complaining about his untidiness without alluding to the feelings of irritation, anger, etc., that this provokes him.

Item 7: Young person is anxious or tense

Place toward *characteristic* direction if young person manifests tension, anxiety, or worry during the course of the session. This may be demonstrated by direct statements as well as non-verbal behaviour.

Place toward *uncharacteristic* direction if young person appears calm, relaxed or conveys a sense of ease.

Item 8: Young person expresses feelings of vulnerability

Place toward *characteristic* direction if young person shows the capacity to share the experience of feeling vulnerable (e.g. around issues of dependency, sadness, loss, etc.). For example, young person describes feeling lost and profoundly mournful since one of her parents left the family home and speaks about how disoriented she feels.

Place toward *uncharacteristic* direction if young person does not express vulnerable feelings. For example, when talking about a painful topic, young person quickly distances from feeling and says, 'never mind, it's all fine'.

Item 9: Therapist works with young person to try to make sense of experience

Place toward *characteristic* direction if the therapist actively works to help the young person to make sense of her experience, encouraging further exploration of a particular incident with a focus on how the young person experienced it. For example, young person describes never feeling like she wants to come home recently, and the therapist actively works with the young person to understand what this is about.

Place toward *uncharacteristic* direction if the therapist does not work with young person to try to make sense of her experience. For example, when young person struggles to make sense of an experience of a friend behaving very cruelly to her without apparent reason, therapist responds by suggesting that the young person should focus more on other friendships, rather than working with the young person to try to make sense of this experience.

Item 10: Young person displays feelings of irritability

Place toward *characteristic* direction if young person displays irritability (verbally and non-verbally). For example, young person becomes annoyed as therapist attempts to explore the anxiety-provoking subject of his parents.

Place toward *uncharacteristic* direction if young person remains calm or composed, even when the therapist may be exploring an anxiety-provoking subject or in other way behaving in a way that may be challenging for the young person.

Item 11: Young person explores sexual feelings and experiences

Place toward *characteristic* direction if young person discusses her sexuality. This can take the form of discussion of attraction, sexual experiences, problems, erotic feelings or fantasies (including toward the therapist).

Place toward *uncharacteristic* direction if young person does not discuss sexual or erotic material. For more extreme ratings, young person actively evades the topic of sexuality or appears unaware of issues of sexual attraction. For example, the therapist tries to explore sexual feelings and experiences but young person is unwilling to do this.

Item 12: Silences occur during the session

Place toward *characteristic* direction if there are many periods of silence during the session. N.B. rate this item irrespective of the 'quality' of the silence (i.e. the silence has a sad, angry, or thoughtful feel to it).

Place toward *uncharacteristic* direction if there are few silences.

Item 13: Young person is animated or excited

Place toward *characteristic* direction if young person directly expresses, or behaviourally displays, a feeling of excitation or appears animated. For example, when talking about plans for the future, young person talks excitedly about all of the possible paths he can pursue.

Place toward *uncharacteristic* direction if young person appears bored, dull, or lifeless when describing events that might usually be reason for being animated or excited. For example, young person appears flat when talking about having passed exams with great success.

Item 14: Young person does not feel understood by therapist

Place toward *characteristic* direction if young person expresses concern about feeling misunderstood by therapist, or assumes that therapist cannot understand her experience or feelings. For example, young person says she doubts that therapist can understand her position because 'you're an adult – you wouldn't get it'.

Place toward *uncharacteristic* direction if young person conveys the sense that therapist understands her experience or feelings. For example, in response to therapist's remark, young person responds 'Yes, that's exactly what I mean'.

Item 15: Young person does not initiate or elaborate topics

Place toward *characteristic* direction if young person does not initiate or elaborate topics for discussion, does not bring up problems, or otherwise fails to assume some responsibility for the session. For example, young person states that he does not know what to talk about.

Place toward *uncharacteristic* direction if young person is willing to break silences, or supplies topics either spontaneously or in response to therapist's probes, and actively pursues or elaborates them.

Item 16: Young person fears being punished or threatened

Place toward *characteristic* direction if young person expresses fears that she will be punished, or that someone or something is a potential source of pain, injury, danger, harm, or evil to her.

Place toward *uncharacteristic* direction if young person expresses expectation of being praised or protected.

Item 17: Therapist actively structures the session

Place toward *characteristic* direction if therapist actively plans the session or intervenes to focus the discussion. For example, when young person seems unfocused the therapist actively intervenes to suggest a particular focus for the session rather than waiting and see where it would lead; or therapist suggests activities that the young person and therapist can try in the session.

Place toward *uncharacteristic* direction if therapist makes little effort to structure the interaction, and allows the young person to determine what is or is not spoken about.

Item 18: Therapist conveys a sense of nonjudgmental acceptance

Place toward *characteristic* direction if therapist explores 'unacceptable' or problematic behaviour of the young person while conveying the sense that young person is worthy and that the therapist is not judging such behaviour.

Place toward *uncharacteristic* direction if therapist's comments or tone of voice convey criticism, a lack of acceptance, or objection to young person's behaviour. A more extreme placement indicates therapist communicates that young person's character or actions are somehow displeasing, objectionable, or unacceptable.

Item 19: Young person explores loss

Place toward *characteristic* direction if young person explores feelings of loss during the session. For example, young person describes how his close friendships are changing and he is struggling with the feeling that things will never be the same.

Place toward *uncharacteristic* direction if young person does not explore feelings and themes of loss. For example, young person angrily describes how his past girlfriend was never right for him, and there was nothing good to hold on to from that relationship, and does not recognize that he has lost anything by the relationship ending.

Item 20: Young person is provocative, tests limits of therapy relationship

Place toward *characteristic* direction if young person behaves in a manner aimed at provoking an emotional response in therapist. Young person may invite rejection from therapist by behaving in a way that might anger her, or by violating an aspect of the therapy setting. For example, when upset, young person refuses to get up and leave at the end of the session, telling therapist 'You're going to have to make me leave'.

Place toward *uncharacteristic* direction if young person is particularly compliant, deferential, or seems to be playing the role of the 'good' patient.

Item 21: Therapist self-discloses

Place toward *characteristic* direction if therapist reveals personal information, or personal reactions to the young person. For example, therapist tells young person where he grew up, or says 'I have a son about your age'.

Place toward *uncharacteristic* direction if therapist refrains from such self-disclosure. For example, therapist does not answer question about whether he has children even when young person asks.

Item 22: Young person expresses feelings of remorse

Place toward *characteristic* direction if young person expresses remorseful feelings. For example, young person tells therapist that she had been reflecting on how she had spoken to her father and could see how that could have hurt her father's feelings and experiences regret.

Place toward *uncharacteristic* direction if young person does not express feelings of remorse. For example, when talking about having hurt a friend, young person shows no remorse or quickly shifts to talking about how many times the friend has done her wrong.

Item 23: Young person is curious about the thoughts, feelings, or behaviour of others

Place toward *characteristic* direction if young person exhibits curiosity or interest in the thoughts, feelings, or behaviour of others (including the therapist). For example, young person asks questions about whether therapist likes him more than his other patients, or appears very curious about the motivations of a friend for deciding on a particular course of study.

Place toward *uncharacteristic* direction if young person does not seem curious about the thoughts, feelings and behaviour of others. For example, young person describes the way his friend behaved differently than usual to him at school the previous day, but does not express any curiosity about why the friend might have behaved in that way.

Item 24: Young person demonstrates capacity to link mental states with action or behaviour

Place toward *characteristic* direction if young person is able to describe mental states (of self or other), and link those with action or behaviour. For example, young person guesses that the reason her mother stopped talking while they were arguing was probably because she was overwhelmed by her own anger or feelings of helplessness.

Place toward *uncharacteristic* direction if young person does not evidence the capacity to link mental states of self or others with action or behaviour. For example, young person explains that her best friend did not call back after an argument they had the previous day, but is not able (or willing) to think about why she might have behaved in this way.

Item 25: Young person speaks with compassion and concern

Place toward *characteristic* direction if young person speaks about self and others with compassion and concern. For example, young person can see that her friend is struggling to keep up in school, and worries about how this is affecting her friend and hopes that she can talk to her family about this.

Place toward *uncharacteristic* direction if young person does not speak with compassion or concern about herself or others. For example, young person describes a friend who got mugged on the way home, but simply insists that 'she was stupid to be walking on her own at night', without any expression of compassion or concern.

Item 26: Young person experiences or expresses troublesome (painful) affect

Place toward *characteristic* direction if young person experiences troublesome affects during the session (placement towards the extreme direction indicates the intensity of the affect). For example, while talking about a difficult experience the young person expresses shame, guilt, fear, or sadness.

Place toward *uncharacteristic* direction if young person does not experience troublesome feelings during the session.

Item 27: Therapist offers explicit advice and guidance

Place toward *characteristic* direction if therapist gives explicit advice or makes particular suggestions. For example, therapist says, 'you should find a quiet place to do your homework, so you're not so distracted'.

Place toward *uncharacteristic* direction if therapist refrains from giving advice. Extreme placement in this direction indicates that therapist does not supply such guidance despite pressure from young person to do so. For example, young person asks therapist whether to contact the police about a crime that he has witnessed and therapist actively refrains from giving any explicit advice or guidance on this matter.

Item 28: Young person communicates a sense of agency

Place toward *characteristic* direction if young person expresses or displays a sense of agency or confidence that her efforts will come to fruition.

For example, young person describes confidently how a club that she recently formed is on its way to being able to achieve all that she had hoped.

Place toward *uncharacteristic* direction if young person communicates with a lack of agency, as if she does not have any expectation of her own actions having any impact or effect.

Item 29: Young person talks about wanting to be separate or autonomous from others

Place toward *characteristic* direction if young person talks about wanting greater distance or a sense of autonomy from someone (excludes the therapist). For example, young person expresses wish to finally be free of his parent's influence; or tells the therapist that he can handle a difficult situation without the therapist's help.

Place toward *uncharacteristic* direction if young person does not communicate a sense of wanting autonomy. For example, when speaking about spending most evenings at home with his parents, young person says that he is quite comfortable with this.

Item 30: Young person has difficulty beginning the session

Place toward *characteristic* direction if young person manifests discomfort or awkwardness in the initial moments or minutes of the session. For example, young person says 'Well, I don't know what to talk about today'.

Place toward *uncharacteristic* direction if young person jumps right into what is concerning him. For example, young person starts the session saying 'I was thinking about what we were talking about last time, and I think that my depression is very related to my low self-esteem'.

N.B. This item should be rated independently of how the therapist starts the session.

Item 31: Therapist asks for more information or elaboration

Place toward *characteristic* direction if therapist asks questions designed to elicit information, or presses young person to revise in more detail some occurrence. For example, therapist asks young person to go back to something she has spoken about and invites exploration of it from different perspectives; or therapist might go back and examine an experience moment by moment in more detail.

Place toward *uncharacteristic* direction if therapist does not ask for more information or elaboration from young person. For example, young person may start to wonder about why she keeps getting into the same conflicts with her mother, and therapist either allows young person to move on or quickly starts to explore solutions, without getting any further elaboration about what kind of conflicts the young person is having.

Item 32: Young person achieves a new understanding

Place toward *characteristic* direction if a new perspective, connection, or understanding emerges during the course of the session for the young person. For example, following a therapist's remark, the young person appears thoughtful and speaks in a way that shows that he sees things in a new light.

Place toward *uncharacteristic* direction if no evidently new understanding or awareness emerges during the session, and the session seems to be going over familiar ground, without any new developments.

Item 33: Therapist adopts a psychoeducational stance

Place toward *characteristic* if therapist adopts a psychoeducational stance i.e., sharing knowledge of the field and expertise explicitly. For example, when young person claims to not know why she feels down after staying up until early in the morning, the therapist speaks about the link between poor sleep patterns and depression, and the need for good sleep patterns.

Place toward *uncharacteristic* if therapist does not offer an "expert" or knowledge-based explanation. For example, young person brings up concerns about her anxiety attacks and wonders how much longer she might expect to have them, and the therapist invites exploration of the nature of the concern rather than offering psychoeducation about panic attack symptom.

Item 34: Young person blames others or external forces for difficulties

Place toward *characteristic* direction if young person tends to externalize, blame others or chance events for difficulties. For example, young person claims her problems with school stem from bad luck with teachers.

Place toward *uncharacteristic* direction if young person tends to assume responsibility for her problems. For example, young person notes that unhappiness in her romantic relationships may be the result of choosing unsuitable partners.

Item 35: Self-image is a focus of the session

Place toward *characteristic* direction if young person and/or therapist discuss young person's feelings, attitudes, and perceptions of self (whether positive or negative). For example, young person contemplates, 'who am I really?', or expresses, 'I don't really see myself fitting into a mainstream job situation when I am older'.

Place toward *uncharacteristic* direction if young person's self-image has little or no part in dialogue. For example, when therapist encourages the young person to think about some aspect of her self-image or identity, young person

says ‘that’s just who I am’, or ‘what is there to talk about that – that is what I am like’.

Item 36: Therapist openly reflects on ‘mistakes’, misunderstandings, or misattunements that have taken place in the relationship with the young person

Place toward *characteristic* direction if therapist speaks openly about interaction with young person where therapist feels he has made a mistake or done something that has upset/angered the young person (including ‘ruptures’ in the therapy relationship). For example, therapist actively acknowledges that something he said may have been wrong and that young person may have felt angry about it and encourages some reflection on what may have happened between them.

Place toward *uncharacteristic* direction if therapist does not address his own mistakes or misunderstandings. For example, young person is angry because therapist said something that offended him, but therapist attributes this to young person’s sensitivity without exploring the possibility that he could have contributed to young person’s experience.

Item 37: Therapist remains thoughtful when faced with young person’s strong affect or impulses

Place toward *characteristic* direction if therapist remains thoughtful when faced with young person’s expression of strong affect either verbally or through action. For example, when young person says life is not worth living, the therapist is thoughtful about the meaning of the young person’s anger and explores the wish to completely give up on life.

Place toward *uncharacteristic* if therapist does not seem capable of a thoughtful approach when faced with young person’s strong affects. For example, therapist becomes anxious, disapproving, or attempts to inhibit the young person’s strong impulses.

Item 38: Therapist and young person demonstrate a shared understanding when referring to events or feelings

Place toward *characteristic* direction if young person and therapist share a perspective on events or feelings. For example, they share a familiar vocabulary to describe the patient’s experience or the experiences between them, using short hand or a phrase that they appear to have used before, like ‘that hot potato feeling’.

Place toward *uncharacteristic* direction if young person and therapist struggle to understand one another’s experience. For example, young person

describes feelings of being in a tunnel when scared, and therapist speaks in terms of anxieties and negative thoughts, leaving out young person's words in such a way that it appears to impede mutual understanding.

Item 39: Therapist encourages young person to reflect on symptoms

Place toward *characteristic* if therapist invites young person to share his own impressions on how he is doing. For example, therapist says 'how have you managed your angry feelings since the last time we met?'.

Place toward *uncharacteristic* if therapist does not encourage young person to focus on symptoms. For example, when young person says he has had trouble sleeping this past week, therapist does not encourage further reflection or elaboration on this experience.

Item 40: Young person communicates with affect

Place toward *characteristic* direction if young person's communications are affect-laden. Young person expresses a range of affects or highly-charged affects through various intonations, postures, or vivid language.

Place toward un*characteristic* direction if young person speaks or presents information in a monotone or affectless manner. For example, young person describes the death of a friend in an affectless or dissociated style.

Item 41: Young person feels rejected or abandoned

Place toward *characteristic* direction if young person discusses or displays feelings of rejection or abandonment by others (including the therapist). For example, young person becomes upset when therapist announces a cancellation and tells therapist that this just shows that the therapist does not care about him.

Place toward *uncharacteristic* direction if young person denies or is seemingly unaware of an experience of rejection or abandonment. For example, young person says he was not bothered at all when his mother left home when he was very young.

Item 42: Young person rejects therapist's comments and observations

Place toward *characteristic* direction if young person typically disagrees with, or rejects therapist's suggestions, observations, or interpretations. For example, after the therapist makes an intervention, young person immediately remarks that she does not think that therapist knows what she is talking about.

Place toward *uncharacteristic* direction if young person tends to take on board therapist's remarks and give them due consideration.

Item 43: Therapist suggests the meaning of others' behaviour

Place toward *characteristic* direction if therapist attempts to interpret the meaning of the behaviour of people in young person's life. For example, therapist suggests reasons for a parent's behaviour or suggests that his girlfriend has problems with intimacy.

Place toward *uncharacteristic* direction if therapist does not make comments about the meaning of the behaviour of others. For example, young person asks therapist why he thinks someone behaved in a certain way, but therapist responds by encouraging young person to come up with his own ideas.

Item 44: Young person feels wary or suspicious of the therapist

Place toward *characteristic* direction of young person appears wary, distrustful, or suspicious of the therapist. For example, young person wonders if therapist really likes him or if there is another hidden meaning in the therapist's remarks.

Place toward *uncharacteristic* direction if young person seems to be trusting and unsuspicious of the therapist.

Item 45: Young person is concerned about his or her dependence on the therapist

Place toward *characteristic* direction if young person appears concerned about dependency. For example, young person shows a need to withdraw from the therapist, or in some manner reveals a concern about becoming dependent on the therapy.

Place toward *uncharacteristic* direction if young person does not convey concern about dependency. This may take the form of the young person expressing how much she relies on the therapist; or young person may appear either comfortable or gratified by a dependent relationship with the therapist.

Item 46: Therapist communicates with young person in a clear, coherent style

Place toward *characteristic* direction if therapist's language is unambiguous, direct and readily comprehensible.

Place toward *uncharacteristic* direction if therapist's language is diffuse and overly abstract.

Item 47: When the interaction with young person is difficult, therapist accommodates in an effort to improve relations

Place toward *characteristic* direction if therapist appears willing and open to compromise and accommodate when disagreement occurs or conflicts arise in the dyad. For example, when young person becomes annoyed with therapist, therapist makes some effort to accommodate saying;

'I can see that this is really upsetting for you to talk about, so we can come back to it when you are ready'.

Place toward *uncharacteristic* direction if therapist does not take steps to improve relations when the interaction with the young person becomes difficult. For example, therapist remains silent even when young person becomes increasingly distressed about therapist's refusal to answer direct questions.

Item 48: Therapist encourages independence in the young person

Place toward *characteristic* direction if therapist urges young person to think for himself and/or to take action based on what he thinks best. For example, therapist notes that she has now heard from the young person what his mother and peers think he should do, but it is not clear what he wants or thinks.

Place toward *uncharacteristic* direction if therapist does not introduce the issue of independence or initiative as a topic of discussion. For example, young person seems passive and compliant and the therapist does not intervene.

Item 49: There is discussion of specific activities or tasks for the young person to attempt outside of session

Place toward *characteristic* direction if there is discussion of a particular activity the young person might attempt outside of therapy, such as carrying out a particular task, or behaving in a different way than she might typically do and seeing what happens. For example, the therapist and young person plan for the young person to try facing a feared situation or object that she usually avoids.

Place toward *uncharacteristic* direction if there is no talk about the young person attempting particular actions of this sort outside of therapy. For example, young person talks about a situation outside the therapy with which she struggles and there is no discussion of specific activities the young person could attempt to face it.

Item 50: Therapist draws attention to feelings regarded by young person as unacceptable

Place toward *characteristic* direction if therapist comments upon or emphasizes feelings that are considered by young person as inappropriate, wrong, or dangerous (such as anger, envy, or sexual attraction). For example, therapist remarks that young person might not wish to consider how sometimes she feels jealousy toward her more successful brother.

Place toward *uncharacteristic* direction if therapist tends not to emphasize feelings that young person finds difficult to recognize or accept. For

example, young person indicates that there are thoughts in her mind which she knows are 'bad', but therapist does not attempt to explore more about these feelings but asks instead what young person could do to get rid of them.

Item 51: Young person attributes own characteristics or feelings to therapist

Place toward *characteristic* direction if young person attributes desirable or undesirable characteristics or feelings to therapist that appear to be reflective of his own experience or sense of self. For example, in the context of feeling dejected about the loss of a girlfriend, young person calls therapist a loser and wonders how he has any patients.

Place toward *uncharacteristic* direction if young person acknowledges his own characteristics or feelings and does not appear to attribute them to the therapist.

Item 52: Young person has difficulty with ending of sessions

Place toward *characteristic* direction if young person communicates or displays difficulty with the ending of sessions. For example, when therapist announces the end of the session young person brings up a new topic and discusses it elaborately and runs over time to finish the idea.

Place toward *uncharacteristic* direction if young person appears to be able to manage the end of sessions without difficulty.

Item 53: Young person discusses experiences as if distant from his feelings

Place toward *characteristic* direction if patient displays little concern or feeling in the way he speaks, and is generally flat, impersonal, or indifferent.

Place toward *uncharacteristic* direction if affect is apparent and young person is emotionally involved with the material. Place toward *very uncharacteristic* direction if young person expresses sharp affect, or outbursts of emotion, or demonstrates powerful emotional involvement with issues during the session.

N.B. This item refers to the young person's attitude towards the material spoken, how much he appears to care about it, as well as how much overt affective expression there is.

Item 54: Young person is clear and organized in self-expression

Place toward *characteristic* direction if young person expresses himself in a manner that is easily understandable, and relatively clear and fluent.

Place toward *uncharacteristic* direction if young person's speech is characterized by rambling, frequent digression, or vagueness. This can

sometimes be judged by the rater's inability to readily follow the connections between the topics the young person discusses.

Item 55: Young person feels unfairly treated

Place toward *characteristic* direction if young person describes or reacts to being treated unfairly by others. For example, young person is indignant that his teacher did not accept the homework as good enough and gave him a remedial assignment.

Place toward *uncharacteristic* direction if young person does not express feelings of being treated unfairly. For example, young person describes a teacher betraying his trust, but young person accepts this as just 'the way that adults behave' or assumes the teacher must have had a good reason.

Item 56: Material from a prior session is discussed

Place toward *characteristic* direction if young person or therapist refers to material or experience of prior session(s). For example, young person says 'this reminds me of what I was saying about my mother last week' or tells therapist that he has tried doing one of the things that he was discussing with therapist in the last meeting.

Place toward *uncharacteristic* direction if either therapist or young person does not take up the other person's attempts to link present material to prior session material. For example, when therapist attempts to make links, young person dismisses the comment and says, 'I don't remember' or 'this hasn't got anything to do with what we were talking about before'.

Item 57: Therapist explains rationale behind technique or approach to treatment

Place toward *characteristic* direction if therapist explains some aspect of the therapy to the young person, or answers questions about the therapy process. For example, the therapist might say, when suggesting something to the young person, 'The reason I'm asking you about this is because I've found that it can be helpful when....'.

Place toward *uncharacteristic* direction if little or no explanation is offered by therapist regarding the rationale behind some aspects of the treatment, even if there is pressure from young person to do so. For example, even when the young person asks 'what's the point of you always doing that?', the therapist does not give any explanation for the way they work.

Item 58: Young person resists therapist's attempts to explore thoughts, reactions, or motivations related to problems

Place toward *characteristic* direction if young person resists therapist's attempts to examine her experience in relationship to problems. For example, young person is reluctant to examine her own role in perpetuating problems, or balks, avoids, blocks, or repeatedly changes the subject whenever the topic of her violent temper is introduced by the therapist.

Place toward *uncharacteristic* direction if young person goes along with the therapist's attempts to explore thoughts, reactions, or motivations connected to her difficulties.

Item 59: Young person feels inadequate and inferior

Place toward *characteristic* direction if young person expresses feelings of inadequacy, inferiority, or ineffectiveness. For example, young person states that nothing she attempts really turns out the way she had hoped.

Place toward *uncharacteristic* direction if young person expresses a sense of effectiveness or superiority. For example, young person recounts personal achievements, or claims attention for a personal attribute or skill.

Item 60: Therapist draws attention to young person's characteristic ways of dealing with emotion

Place toward *characteristic* direction if therapist draws attention to characteristic ways young person deals with emotions. For example, 'have you noticed how, when you got angry with your friend, you kept it all inside you and were left feeling bad about yourself'.

Place toward *uncharacteristic* direction if therapist does not draw attention to young person's characteristic ways of dealing with emotion. For example, therapist does not comment when it is clear that every time the young person begins to cry, he quickly says, 'but I can't let myself go here'.

Item 61: Young person feels shy or self-conscious

Place toward *characteristic* direction if young person appears shy or self-conscious. This may be expressed by direct comments (for example: 'I find this really difficult to talk about'), or by the young person's behaviour. An extreme rating might denote that young person feels mortified or humiliated.

Place toward *uncharacteristic* direction if young person appears un-self-conscious, assured or certain of herself. For example, young person describes a situation where a mistake she had made was publicly exposed in front of her peers, but she appears not to be bothered by this at all.

Item 62: Therapist identifies a recurrent pattern in young person's behaviour or conduct

Place toward *characteristic* direction if therapist points out a recurrent pattern in young person's behaviour either in the session or outside it. For

example, therapist notes that young person repeatedly seeks out unavailable sexual partners or therapist suggests that young person's continuously late arrival to the session may have a meaning.

Place toward *uncharacteristic* direction if therapist does not identify an existing or evident theme or recurrent pattern.

Item 63: Young person discusses and explores current interpersonal relationships

Place toward *characteristic* direction if a major focus of discussion is the young person's current social or family relationships or personal emotional involvements. For example, the young person is very concerned with peer group relationships and speaks at length about who is best friends with whom.

Place toward *uncharacteristic* direction if the discussion of interpersonal relationships is absent during a good portion of the session. For example, therapist brings up the subject of interpersonal relationships but young person shifts focus to the on-line games he likes to play.

Item 64: Feelings about romantic love relationships are a topic

Place toward *characteristic* direction if romantic or love relationships are talked about during the session. For example, young person talks about feelings toward a boyfriend.

Place toward *uncharacteristic* direction if love relationships do not emerge as a topic. For example, young person may say 'its private' or may talk about someone who she appears to have romantic of sexual feelings about, but denies that this is the case.

Item 65: Therapist restates or rephrases young person's communication in order to clarify its meaning

Place toward *characteristic* direction if one aspect of therapist's activity is restating or rephrasing young person's affective tone, statements, or ideas in a somewhat more recognizable form in order to render their meaning more evident. For example, therapist remarks, 'What you seem to be saying is that you're worried about what therapy will be like'.

Place toward *uncharacteristic* direction if therapist seldom employs this kind of clarifying activity during the session.

Item 66: Therapist is directly reassuring

Place toward *characteristic* direction if therapist attempts to directly allay young person's anxieties and instils the hope that matters will improve. For example, therapist tells young person there is no reason for worry; he is sure the problem that the young person is describing can be solved.

Place toward *uncharacteristic* direction if therapist tends to refrain from providing direct reassurance of this kind. For example, young person describes feeling worried about the day ahead, and the therapist refrains from telling young person, 'It will be fine', even if young person explicitly asks therapist if he thinks things will go OK.

Item 67: Young person finds it difficult to concentrate or maintain attention during the session

Place toward *characteristic* direction if young person has difficulty concentrating or maintaining focus or attention during the session. For example, young person often has to ask the therapist to repeat what she was saying or does not appear to be concentrating on what is happening in the room.

Place toward *uncharacteristic* direction if young person shows capacity to concentrate.

Item 68: Therapist encourages young person to discuss assumptions and ideas underlying experience

Place toward *characteristic* direction if therapist encourages young person to discuss the assumptions and ideas that underlie her experience. For example, therapist encourages young person to talk about where her idea of having caused her parents' divorce comes from, or to think where she got the idea that the world is dangerous. N.B. Distortions and erroneous assumptions should also be included.

Place toward *uncharacteristic* direction if therapist does not focus attention on young person discussing the assumptions and ideas that underlie her experience. For example, young person repeatedly says that people always want to take advantage of other people and therapist does not encourage young person to discuss that assumption.

Item 69: Therapist encourages the exploration of the potential impact of young person's behaviour on others

Place toward *characteristic* direction if therapist actively encourages young person to think about the potential impact of their behaviour on others. For example, therapist asks young person how he imagines his parents feel when young person refuses to speak to them.

Place toward *uncharacteristic* direction if therapist does not encourage such exploration. For example, when young person is describing situations where his behaviour was likely to have had a strong impact on others, the therapist does not encourage exploration.

Item 70: Young person attempts to manage feelings or impulses

Place toward *characteristic* direction if young person attempts to manage or control strong emotions or impulses. For example, young person fights to hold back tears while obviously distressed.

Place toward *uncharacteristic* direction if young person does not appear to make an effort to manage or control feelings or impulses he is experiencing. For example, he may quickly start shouting as soon as he experiences any frustration.

Item 71: Therapist challenges over-generalized or absolute beliefs

Place towards *characteristic* direction if therapist confronts young person when she is making overgeneralized or absolute comments about self or other. For example, young person states that she knows she is stupid so there is no point even trying in her exams, and therapist identifies this as a belief and tries to explore the assumptions behind this belief, as part of challenging the statement itself.

Place towards *uncharacteristic* direction if therapist does not challenge young person's statements that demonstrate strong beliefs about self and others. For example, young person says that all teachers are against her, and therapist ignores or goes along with this view.

Item 72: Young person demonstrates lively engagement with thoughts and ideas

Place toward *characteristic* direction if young person's discourse is imaginative, lively, and generates new ideas. For example, when talking about aspirations, young person playfully considers options with therapist and invites collaboration.

Place toward *uncharacteristic* direction if young person presents himself as rigid, stilted, repetitive, or if discourse appears rote.

Item 73: Young person is committed to the work of therapy

Place toward *characteristic* direction if young person expresses or displays an emotional or practical commitment to the work of therapy. This may include willingness to make sacrifices to continue therapy in terms of time, travel, or inconvenience; it may also include genuine desire to understand more about himself in spite of the psychological discomfort this may entail.

Place toward *uncharacteristic* direction if young person seems unwilling to tolerate the emotional or practical hardships that therapy might entail. This might be expressed in terms of complaints about the effort to come, uncertainty about wanting change, or arriving very late for sessions with no good reason.

Item 74: Humour is used

Place toward *characteristic* direction if therapist or young person display humour during the course of the session. For example, therapist uses wit or irony to make a point or young person demonstrates an ability to laugh at herself or her predicament.

Place toward *uncharacteristic* direction if the interaction appears grave, austere, or sombre.

Item 75: Therapist pays attention to young person's feelings about breaks, interruptions, or endings in therapy

Place toward *characteristic* direction if either young person or therapist talk of interruptions or breaks in the treatment. Includes all references to treatment interruptions or termination (i.e. whether it is wished for, feared, or threatened). For example, young person's feelings about interruptions for holidays or illness, or of ending therapy are discussed.

Place toward *uncharacteristic* direction if interruptions in the treatment, or endings seem to be avoided. For example, an upcoming lengthy break in the treatment due to the summer vacation is mentioned in passing, but neither young person nor therapist pursues the topic.

Item 76: Therapist explicitly reflects on own behaviour, words, or feelings

Place toward *characteristic* direction if therapist explicitly discusses his own behaviour, words, or feelings with the young person, using 'self-reflection' as an explicit aspect of the therapeutic work. For example, therapist notices aloud that she had not said anything when the young person told her that she was going to miss therapy when it ended, and perhaps that was because it was hard for both of them to think about the ending.

Place toward *uncharacteristic* direction if therapist does not reflect on her own behaviour, words or feelings. For example, young person notices that the therapist has appeared to be more irritable with him than the therapist usually is, and asks therapist what is going on, but therapist explores this in terms of young person's own thoughts and fantasies, rather than reflecting explicitly on his own behaviour.

Item 77: Therapist encourages young person to attend to somatic feelings or sensations

Place toward *characteristic* direction if therapist draws attention to young person's bodily sensations, or experiences in different parts of the body. For example, when young person talks about how angry she is with her father, therapist invites young person to think about where in her body the anger is located.

Place toward *uncharacteristic* direction if therapist does not encourage young person to attend to somatic feelings or sensations. For example, young person may say that she have got a funny feeling in her stomach and go on to describe a flirtatious encounter with a boy, but therapist does not make any link to the somatic sensations.

Item 78: Young person seeks therapist's approval, affection, or sympathy

Place toward *characteristic* direction if young person behaves in a manner that appears designed to make therapist like him or to gain approval or reassurance. For example, young person tells the therapist that he avoided a fight with his mum this week by remembering what the therapist had suggested last time they met, and then checks whether the therapist thinks he handled it well or not.

Place toward *uncharacteristic* direction if young person does not seek therapist's approval or sympathy. For example, young person is quite upset about a recent break up, but when therapist responds sympathetically, he pushes the therapist away.

Item 79: Young person's experience of his/her body is discussed

Place towards *characteristic* direction if young person or therapist focus on young person's experience of her body. For example, young person discussed how she feels with the changes her body is going through due to puberty.

Place towards uncharacteristic direction if there is no discussion of the young person's experience of her body. For example, therapist invites the young person to discuss how she feels her body has changed in the last year and young person changes the subject.

Item 80: Therapist presents an experience or event from a different perspective

Place toward *characteristic* direction if therapist restates what young person has described in such a way that young person is invited to look at the situation differently. For example, after young person berates herself for having started an ugly quarrel with a peer, the therapist says 'perhaps this is your way of expressing what you need in that relationship'.

Place toward *uncharacteristic* direction if this does not constitute an important aspect of the therapist's activity during the session.

Item 81: Therapist reveals emotional responses

Place toward *characteristic* direction if demonstrates or speaks of his own emotional responses to the young person. For example, when young

person describes burying a beloved pet without feeling, therapist says: 'as you were describing that, I found myself feeling very sad'.

Place toward *uncharacteristic* direction if therapist personal emotions are not evident in the session. For example, young persons asks to the therapist 'How do you feel about that?' and therapist does not share own emotional response.

Item 82: Therapist adopts a problem-solving approach with young person

Place toward *characteristic* direction if therapist actively works with young person in looking at her experiences as problems that they can solve together. For example, when thinking about a teacher with whom the young person is often in conflict, therapist invites the young person to think of a number of possible ways to respond if a conflict situation arises again in the future, and to look at the pros and cons of each.

Place toward *uncharacteristic* direction if therapist does not adopt a problem-solving approach with young person. For example, therapist focuses exclusively on how young person was feeling, even when young person explicitly asks therapist for help in deciding what to do about a difficult situation at home.

Item 83: Young person is demanding

Place toward *characteristic* direction if young person makes demands or requests of therapist or pressures therapist to meet a request. For example, young person says that therapist should be able to cancel appointments with other people to make time to meet her more often.

Place toward *uncharacteristic* direction if young person is reluctant or hesitant to make usual or appropriate requests of therapist. For example, young person fails to ask for a different appointment time the following week despite the regular time clashing with an important exam at school; or is highly deferential or apologetic toward therapist when asking for help.

Item 84: Young person expresses angry or aggressive feelings

Place toward *characteristic* direction if young person expresses resentment, anger, bitterness, hatred or aggression towards others verbally and non-verbally. N.B. If directed towards therapist, see item number 1.

Place toward *uncharacteristic* direction if young person does not express verbally or non-verbally anger or aggression. For example, young person describes a situation where a friend betrayed her trust, but young person does not express any anger about this.

Item 85: Therapist encourages young person to try new ways of behaving with others

Place toward *characteristic* direction if therapist suggests alternative ways of relating to people. For example, therapist asks young person what she thinks might happen if she were to be more direct in telling her mother how it affects her when she nags. More extreme placement implies that the therapist actively coaches young person on how to interact with others, or rehearses new ways of behaving with others, for example, through role-play.

Place toward *uncharacteristic* direction if therapist tends not to make suggestions about how to relate to others.

Item 86: Therapist encourages reflection on the thoughts, feelings and behaviour of significant others

Place toward *characteristic* direction if the therapist actively encourages young person to reflect on the thoughts, feelings, and behaviour of significant others. For example, if young person talks about the way that a friend or family member has behaved, therapist invites young person to reflect on why that person may have behaved in that way or how they may have been feeling.

Place toward *uncharacteristic* direction if therapist does not encourage such reflection.

Item 87: Young person is controlling of the interaction with therapist

Place toward *characteristic* direction if young person exercises a restraining or directing influence in the session. For example, young person dominates the interaction with compulsive talking or interrupts the therapist frequently.

Place toward *uncharacteristic* direction if young person does not exert control over the interaction with therapist, working with the therapist in a more collaborative fashion, or hands over all direction to therapist.

Item 88: Young person fluctuates between strong emotional states during the session

Place toward *characteristic* direction if the emotions expressed by young person during the session change quickly or abruptly. For example, young person moves between criticizing the therapist and expressing positive feelings towards her; or appears to be very excited at one point and dramatically shifts to becoming tearful and sad.

Place toward *uncharacteristic* direction if the young person does not experience fluctuations between strong emotions during the session. For example, young person maintains a steady emotional state even when describing a wide range of situations.

Item 89: Therapist makes definite statements about what is going on in the young person's mind

Place toward *characteristic* direction if therapist makes statements about young person's thoughts and feelings that indicate that the therapist feels he knows what young person is really feeling. For example, the therapist says 'you look as if you are angry, but I think you are really feeling very frightened'.

Place toward *uncharacteristic* direction if therapist offers statements about the content of young person's mind tentatively and provisionally. For example, therapists says 'I'm wondering whether, when you say that you are angry, there might be other feelings going on as well – perhaps you feel frightened too?'.

Item 90: Young person's dreams or fantasies are discussed

Place toward *characteristic* direction if there is a discussion about dreams and fantasies (including daydreams or night-dreams). For example, young person describes a dream of being spotted by a talent scout and being offered a part in a movie, and the young person and therapist explore the meaning of this day-dream together.

Place toward *uncharacteristic* direction if there is no discussion of young person's dreams or fantasies.

Item 91: Young person discusses behaviours or preoccupations that cause distress or risk

Place toward *characteristic* direction if young person describes contemplating or engaging in reckless, dangerous, or distressingly risky behaviour towards self or other. For example, young person describes missing school due to reckless alcohol use, or discusses risky traumatic/intrusive thoughts, problematic sexual behaviour, drug-taking, violent impulses, or the like.

Place toward *uncharacteristic* direction if young person describes avoiding of risky action, or acknowledges a reduction in preoccupation with risky behaviour towards self or other. For example, young person describes how she no longer thinks about hurting herself when angry, or tells therapist about avoiding her usual pattern of getting into a fight at a party.

Item 92: Young person's feelings or perceptions are linked to situations or behaviour of the past

Place toward *characteristic* direction if links or salient connections are made between young person's current emotional experience or perception of events with those of the past. For example, therapist points out that current fears of abandonment are related to the loss of a parent during childhood or

says that such fears are the 'toddler part' of his personality expressing themselves.

Place toward *uncharacteristic* direction if current and past experiences are discussed but not linked. For example, young person has spoken about being frightened of his older brother when he was younger and later talks about his fear of a peer in college, but therapist does not link these two.

Item 93: Therapist refrains from taking position in relation to young person's thoughts or behaviour

Place toward *characteristic* direction if therapist tends to refrain from taking a particular stand in relation to young person's opinion, declarations, ideas, or experience. For example, when young person asks therapist if she approves of a particular behaviour, therapist responds by asking the young person what position she imagines her or others taking, rather than directly responding to the question.

Place toward *uncharacteristic* direction if therapist expresses opinions, or takes positions either explicitly or by implication. For example, therapist tells young person that her friends have a bad influence on her, or that it is very important that she learn how to express her anger.

Item 94: Young person feels sad or depressed

Place toward *characteristic* direction if young person's mood in the session seems melancholy, sad, or depressed.

Place toward *uncharacteristic* direction if young person appears delighted or joyful or conveys a mood of well-being or happiness.

Item 95: Young person feels helped by the therapy

Place toward *characteristic* direction if young person indicates a sense of feeling helped, relieved, or encouraged by the way therapy is progressing.

Place toward *uncharacteristic* direction if young person indicates discouragement or frustration with the way therapy is progressing. For example, young person claims to feel that no deepening of self-understanding is taking place.

Item 96: Therapist attends to the young person's current emotional states

Place toward *characteristic* direction if therapist focuses on how young person is feeling about what has just happened or just been said in the room. For example, therapist notes that young person seems distracted and raises the question of his current emotional state and wonders what might be going on.

Place toward *uncharacteristic* direction if therapist does not attend to young person's current emotional states in the therapy room. For example, young person speaks to the therapist in a rather irritable way, but therapist makes no comment on this and continues to speak to young person about an event at school that day.

Item 97: Therapist encourages reflection on internal states and affects

Place toward *characteristic* direction if therapist encourages young person to explore and verbalize thoughts and feelings of self or others. For example, therapist states, 'what do you think was going on for your brother when he said that to you?'.

Place toward *uncharacteristic* direction if therapist does not encourage young person to reflect on or be curious about his thoughts and feelings.

Item 98: The therapy relationship is a focus of discussion

Place toward *characteristic* direction if the therapy relationship is discussed. For example, therapist calls attention to features of the interaction or interpersonal process between the young person and herself.

Place toward *uncharacteristic* direction if therapist or young person do not focus on the relationship or interaction between the two of them.

Item 99: Therapist raises questions about young person's view

Place toward *characteristic* direction if therapist somehow raises a question about young person's view of an experience or an event. For example, therapist might say 'how is that so?' or 'I wonder about that'. For example, when young person states that it does not matter to him if he does not get good grades, the therapist says that she wonders if that is really true.

Place toward *uncharacteristic* direction if therapist somehow conveys a sense of agreement, concurrence with, or substantiation of young person's perspective. For example, therapist says, 'I think you're quite right about that' or 'You seem to have a good deal of insight into that'.

Item 100: Therapist draws connections between the therapeutic relationship and other relationships

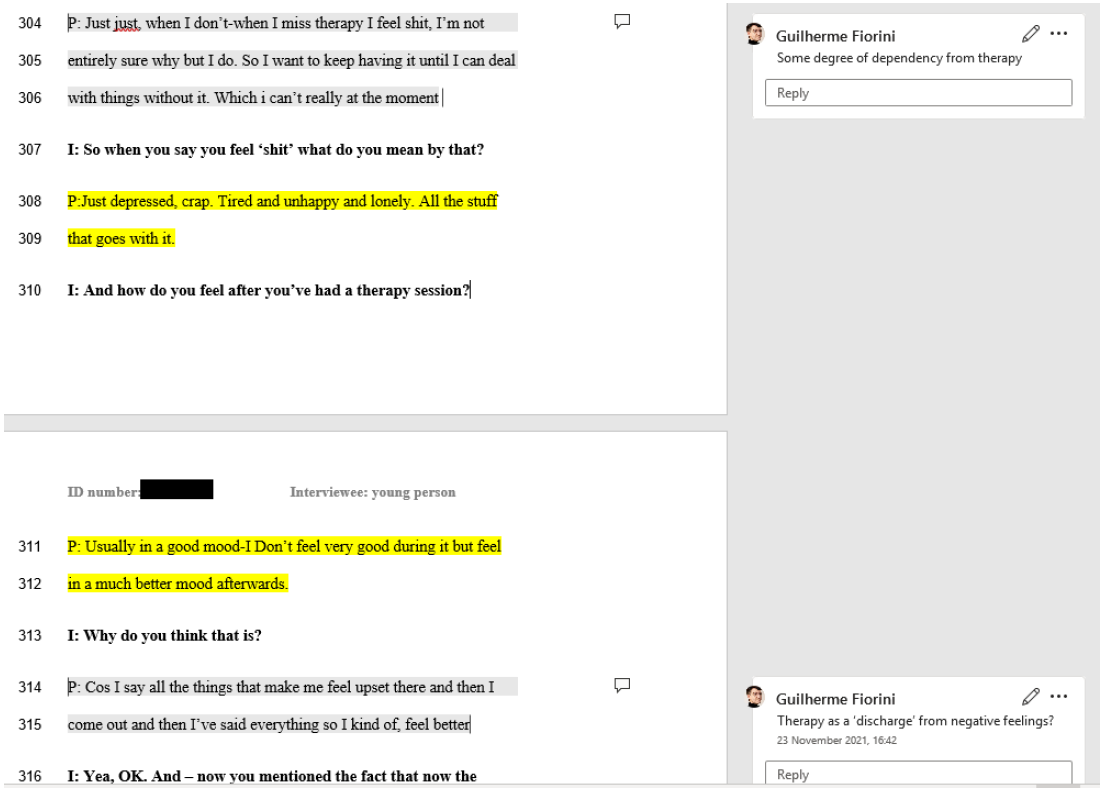
Place toward *characteristic* direction if therapist makes salient comments linking young person's feelings about the therapist and feelings toward other significant individuals in her life, including current relationships with parents. For example, therapist remarks that she thinks young person is sometimes afraid that therapist will criticize her just as her mother does.

Place toward *uncharacteristic* direction if therapist's activity during the session does not attempt to link the interpersonal aspects of therapy with young person's experiences in other relationships.

Appendix 15: Exploratory factor analysis iterations

Iteration	Variance Explained	Items Removed
1	30.57%	2, 4, 5, 11, 16, 18, 21, 23, 26, 27, 29, 33, 36, 39, 41, 43, 45, 46, 47, 52, 56, 57, 59, 60, 62, 64, 69, 75, 76, 77, 79, 80, 81, 86, 90, 91, 92, 93, 96, 97, 98, 100
2	45.72%	31, 50
3	46.47%	37
4	47.01%	n/a

Appendix 16: Annotated interview



304 P: Just just, when I don't-when I miss therapy I feel shit, I'm not
305 entirely sure why but I do. So I want to keep having it until I can deal
306 with things without it. Which i can't really at the moment

307 **I: So when you say you feel 'shit' what do you mean by that?**

308 P:Just depressed, crap. Tired and unhappy and lonely. All the stuff
309 that goes with it.

310 **I: And how do you feel after you've had a therapy session?**

Guilherme Fiorini
Some degree of dependency from therapy
Reply

ID number: [redacted] **Interviewee: young person**

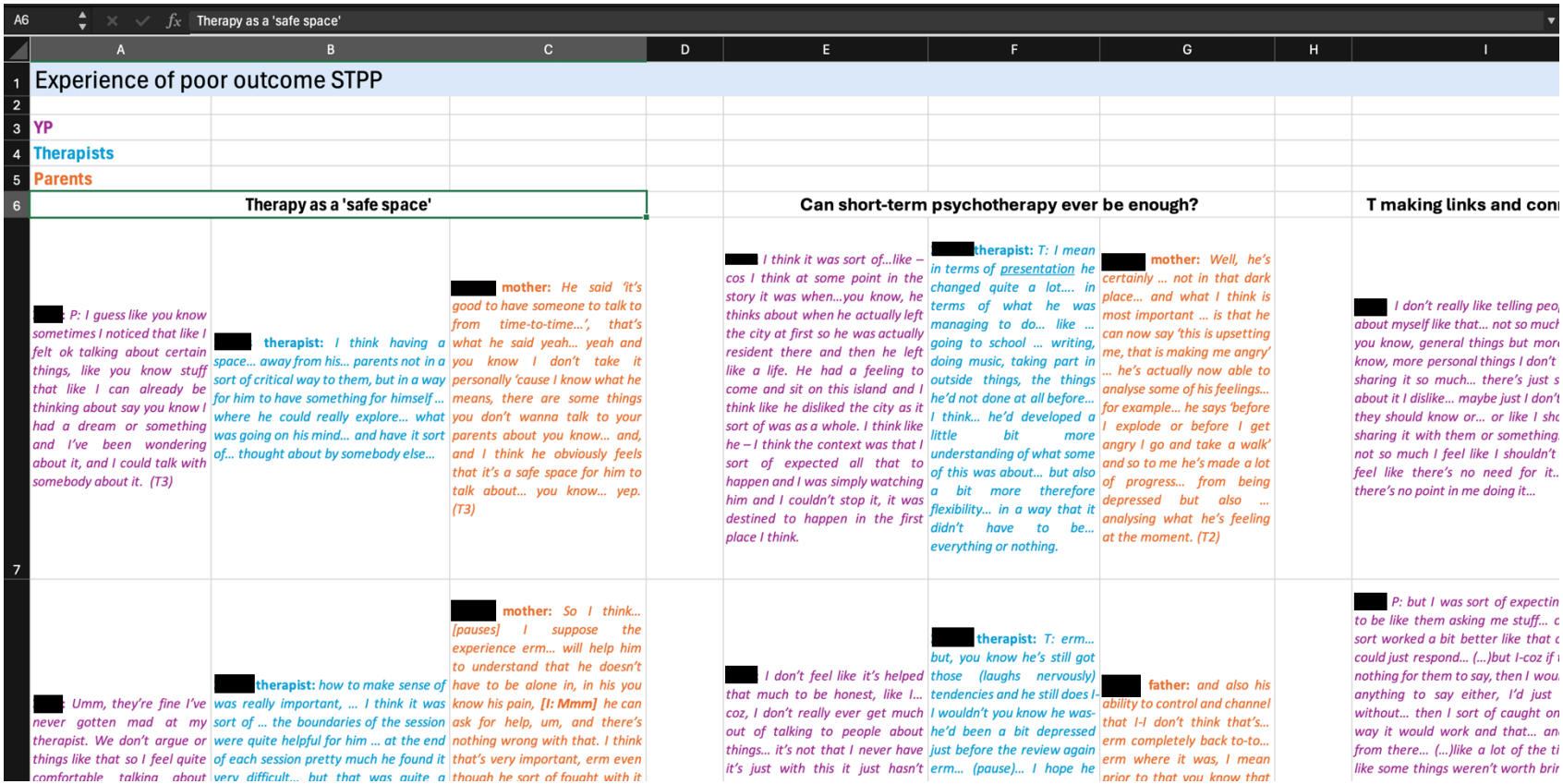
311 P: Usually in a good mood-I Don't feel very good during it but feel
312 in a much better mood afterwards.

313 **I: Why do you think that is?**

314 P: Cos I say all the things that make me feel upset there and then I
315 come out and then I've said everything so I kind of, feel better

316 **I: Yea, OK. And – now you mentioned the fact that now the**

Guilherme Fiorini
Therapy as a 'discharge' from negative feelings?
23 November 2021, 16:42
Reply



A6 | Therapy as a 'safe space'

	A	B	C	D	E	F	G	H	I
1	Experience of poor outcome STPP								
2									
3	YP								
4	Therapists								
5	Parents								
6	Therapy as a 'safe space'				Can short-term psychotherapy ever be enough?				T making links and con
7	[redacted]: *P: I guess like you know sometimes I noticed that like I felt ok talking about certain things, like you know stuff that like I can already be thinking about say you know I had a dream or something and I've been wondering about it, and I could talk with somebody about it. (T3)*	[redacted] **therapist:** *I think having a space... away from his... parents not in a sort of critical way to them, but in a way for him to have something for himself ... where he could really explore... what was going on his mind... and have it sort of... thought about by somebody else...*	[redacted] **mother:** *He said 'it's good to have someone to talk to from time-to-time...', that's what he said yeah... yeah and you know I don't take it personally 'cause I know what he means, there are some things you don't wanna talk to your parents about you know... and, and I think he obviously feels that it's a safe space for him to talk about... you know... yep. (T3)*		[redacted] *I think it was sort of...like – cos I think at some point in the story it was when...you know, he thinks about when he actually left the city at first so he was actually resident there and then he left like a life. He had a feeling to come and sit on this island and I think like he disliked the city as it sort of was as a whole. I think like he – I think the context was that I sort of expected all that to happen and I was simply watching him and I couldn't stop it, it was destined to happen in the first place I think.*	[redacted]**therapist:** *T: I mean in terms of presentation he changed quite a lot.... in terms of what he was managing to do... like ... going to school ... writing, doing music, taking part in outside things, the things he'd not done at all before... I think... he'd developed a little bit more understanding of what some of this was about... but also a bit more therefore flexibility... in a way that it didn't have to be... everything or nothing.*	[redacted] **mother:** *Well, he's certainly ... not in that dark place... and what I think is most important ... is that he can now say 'this is upsetting me, that is making me angry' ... he's actually now able to analyse some of his feelings... for example... he says 'before I explode or before I get angry I go and take a walk' and so to me he's made a lot of progress... from being depressed but also ... analysing what he's feeling at the moment. (T2)*		[redacted] *I don't really like telling peo about myself like that... not so much you know, general things but mor know, more personal things I don't sharing it so much... there's just s about it I dislike... maybe just I don't they should know or... or like I sh sharing it with them or something not so much I feel like I shouldn't feel like there's no need for it.. there's no point in me doing it...*
8	[redacted]: *Umm, they're fine I've never gotten mad at my therapist. We don't argue or things like that so I feel quite comfortable talking about*	[redacted]**therapist:** *how to make sense of was really important, ... I think it was sort of ... the boundaries of the session were quite helpful for him ... at the end of each session pretty much he found it very difficult... but that was quite a*	[redacted] **mother:** *So I think... [pauses] I suppose the experience erm... will help him to understand that he doesn't have to be alone in, in his you know his pain, **[I: Mmm]** he can ask for help, um, and there's nothing wrong with that. I think that's very important, erm even though he sort of fought with it*		[redacted] *I don't feel like it's helped that much to be honest, like I... coz, I don't really ever get much out of talking to people about things... it's not that I never have it's just with this it just hasn't*	[redacted]**therapist:** *T: erm... but, you know he's still got those (laughs nervously) tendencies and he still does I- I wouldn't you know he was- he'd been a bit depressed just before the review again erm... (pause)... I hope he*	[redacted] **father:** *and also his ability to control and channel that I-I don't think that's... erm completely back to-to... erm where it was, I mean prior to that you know that*		[redacted] *P: but I was sort of expectin to be like them asking me stuff... c sort worked a bit better like that could just respond... (...)but I-coz if nothing for them to say, then I wou anything to say either, I'd just without... then I sort of caught on way it would work and that... an from there... (...)like a lot of the ti like some things weren't worth brir*