

**Adolescent patients' responses to interpretations focused on endings
in short-term psychoanalytic psychotherapy**

Abstract

Discussing endings is a crucial part of the work of short-term psychoanalytic psychotherapy with adolescents, but there are different views on how best this should be done, and whether it is helpful or appropriate to link endings to interpretations of the transference. This study looks at how adolescent patients suffering from moderate to severe depression respond to interpretations around endings in a 28 sessions long, manualized psychoanalytic psychotherapy. Data comes from a randomized clinical trial in which all sessions were audio-recorded. Purposive sampling was used to identify four sessions with four different adolescents in which therapists raised the issue of upcoming endings, explored the patients' emotional responses and linked these to the transference. The four extracts were transcribed and analysed using Conversation Analysis. Findings show that patients either emphasized or diminished the importance of their relationship to the therapists and the consequences of the separation from them in response to transference interpretations. They managed the conversational exchange by either "trouble-telling" or "story-telling". The authors reflect on the implication of patients' responses for treatment technique and consider whether transference work with adolescents should be paced and adapted more flexibly in short term psychoanalytic psychotherapy.

Introduction

By its nature psychotherapy always deals with issues of separation and endings, but in short-term work, this feature comes especially to the fore. Whether such a focus is helpful in therapeutic work with adolescents, and how best to work with such issues, has been debated for many years, especially within the psychoanalytic and psychodynamic tradition. For example, Golombek & Kozenblum (1995) argue that shorter-term therapies are a suitable form of therapy for the adolescents who are dominated by a fear of regression and dependency and a striving for autonomy and clarity: the short nature and focus on a particular issue may limit these anxieties. Christogiorgos et al. (2011) believe that transference interpretations in short-term psychoanalytic psychotherapy (STPP) should be focused on the positive transference and on work in the "here and now", while others (Mak-Pearce, 2001) believe that an exploration of the transference to the institution where the therapy is taking place (e.g. school, or the mental health service) should be at the forefront of a therapist's agenda, rather than an exploration of the transference relationship with the therapist per se. This is because the former would help a reflection on the adolescent's unconscious ways of relating to the external world.

Whatever approach is taken, most therapists agree that feelings about receiving help and issues about ending and fears and hopes for the future are in evidence from the beginning, and often become the predominant themes for most short-term psychoanalytic therapies with adolescents (Coren, 1999). But there are disagreements as to whether such feelings should be explored by means of 'transference work', or in less direct ways. Psychotherapists sometimes find it challenging to talk about the transference to adolescents, and likewise adolescents may find it awkward to become aware or discuss their feelings towards their therapists (Coren, 1999; Golombek & Kozenblum, 1995; Hall, 2012; Gretton, 2012). Although these feelings of discomfort may be present in all transference work, they may have particular significance in work with teenagers. After all, adolescence can be thought about as a developmental stage

characterized by a re-emergence of infantile wishes and the need to separate from parental figures, as well as defining one's own identity, which can push the adolescent to become over-dependent and regressed or conversely, to withdraw into a narcissistic state, where self-preoccupations and defences against engaging with others may predominate (Meltzer, 1978). Nevertheless, Aliprandi et al. (2014) suggest that psychoanalytic therapists should not emphasise transference work with adolescents, as this may encourage them to invest too much in the therapeutic relationship, at a point in their life when they should be trying to find their identity in relation to the world of peers rather than revisiting earlier relationship with parental figures, which is often the focus of transference work.

Given the debates and controversies about transference work in short-term psychoanalytic psychotherapy with adolescents, there is an urgent need for empirical research that focuses on the actual process and outcome of this work. Ulberg et al. (2012) have reported on a quantitative study in progress in which the effectiveness of short-term psychoanalytic psychoanalytic therapy with adolescents will be examined, comparing treatment with or without the explicit use of transference interpretation. However the focus of that study is on quantitative outcomes, rather than on an exploration of the therapeutic process itself. The current study therefore aims to explore in detail the way in which adolescents respond to transference work in the context of short-term psychoanalytic psychotherapy, with a particular focus on transference work focused on the ending of therapy.

Design

Setting for the study

The four sessions used in this study were recorded as part of the Improving Mood with Psychoanalytic and Cognitive Behaviour Therapy (IMPACT) study, a randomised clinical trial (RCT) which compared the effectiveness of short-term psychoanalytic psychotherapy (STPP) with cognitive behaviour therapy (CBT) and a brief psychosocial intervention (Goodyer et al. 2011). The study was based in the UK, and involved 465 young people aged 11-17 with moderate to severe depression, referred to 15 child and adolescent mental health services (CAMHS) in different regions of the UK. The study found that there were no statistically significant differences in either clinical or cost-effectiveness between the three treatments (Goodyer et al., 2017). The study concluded by suggesting that all three treatments should be made available to young people with depression, in order to support patient choice. Further studies which may be able to identify specific moderators or mediators of treatment effectiveness will be reported at a future date.

All three treatments in the IMPACT study were manualised, and sessions were audio-recorded. The current study focuses only on the short-term psychoanalytic therapy (Creegen, S. Hughes, C. Midgley, N. Rhode, M. Rustin, M. 2016). This was a 28-session model, in which the manual defines three stages within the psychotherapeutic treatment, each of which is characterized by different ways of working in the transference. In the early a focus on the therapeutic alliance and exploration of the main unconscious conflict of the patient and setting up treatment; in the last stage, therapists are encouraged to focus on mourning, separation and the progress and gains achieved during treatment. In the middle phase of treatment there should be a deepening of the transference relationship where therapist are encouraged to address the negative transference and to monitor symptoms and risk closely as these are likely to increase at this time, and also keep reiterating the amount of time there is left. In the final phase of the therapy, therapists are thinking more openly about ending and issues of separation.

The current study

As part of the assessment of fidelity to treatment for the main study, all therapy sessions were audio-recorded. Using theoretical sampling (Glaser and Strauss, 1967) STPP sessions with a high level of transference interpretations were identified, based on a rating done on a sub-sample of sessions using the Adolescent Psychotherapy Q-Set (Calderon et al., 2016). Sessions with a high level of transference activity were considered, as they would allow the researchers to focus on clinical work in which transference activity was a core element. Fifteen sessions (out of the 72 STPP sessions that had been coded with the APQ) scored high (a mean of 7 or more) on the items related to the use of transference interpretation. The sample was then further narrowed to include only sessions which took place in the middle phase of therapy (sessions 10-19), as this is the phase of therapy where, according to the STPP manual, the transference should be explored in depth and where issues around endings were expected to be brought into the work. This left us with four sessions, which therefore became the data for this study.

Within each of these four sessions, the sections where transference work related to endings took place were identified. . Transference work focused on endings refers to the therapists' attempt at analyzing how the patient feels about ending treatment and separating from their therapists when the treatment will reach the end of the twenty-eight sessions. In all four of the sessions, the therapists attempted to carry out transference work related to endings at more than one point in the session.

The participants

All therapists delivering the STPP treatment were either final-year trainees or qualified child psychotherapists who trained in the UK, and were members of the Association of Child Psychotherapists. In this study, the four therapists were child and adolescent psychotherapists, three females and one male. They were all experienced in psychoanalytic psychotherapy with young people and

received forth-nightly supervision. All adolescents in the overall IMPACT study were between the age of 11 and 17 and had been diagnosed with moderate or severe depression.

Data analysis

Data was analysed using Conversation Analysis (CA, Sidnell, 2013). CA was developed originally to study naturally occurring conversations in everyday context, but has been adapted as a way to approach the study of psychotherapy sessions as it looks at sequential structures and patterns of activity in conversations between two or more participants (Perakyla, 2010, 2006, 2005 and et al., 2008). In CA words are seen as actions which "come close to the original Freudian observations of 'slips of the tongue' by which he deepened his conviction that the unconscious must show up in a way or another". (Bucholz et. al, 2015, p.879) CA considers the therapeutic exchange as something co-created by therapist and patient: each turn is always connected to the expectation projected by the previous speaker. There is a constant inter-connectedness between an interpretation of the therapist and the elaboration of the patient. CA focuses particularly on sequences and details such as intonations. Both psychoanalysis (Joseph, 1989) and CA are concerned with the question "why that (utterance) now?" (Forrester and Reason, 2002) This aspect shows a similarity in the two disciplines in paying attention to what the participants are doing or mobilizing in the other when they are saying something. The application of CA to psychotherapy aims at clarifying how therapists and patients act and express themselves through their talk in interaction. CA researchers take into account the "professional stocks of interactional knowledge", namely how institutions dictate a certain kind of conversational exchange, in this case the rules of the setting and of psychoanalytic psychotherapy.

Procedure:

The first stage of the CA involved a detailed transcription of the four sessions by the first author, using a transcription methodology created by Jefferson (1989), which constitutes the basis of Conversation Analysis. This method attempts to capture the sounds and the sequences, including pauses and changing tones of how the sentences are uttered by both participants. In order to help readers understand the content of the material and what was taking place, only a few symbols have been applied to these transcriptions. Once this was done, the analysis of the data extracts was done starting with a categorization of the participants' actions, how they took turns, and how the beginning of the extract was initiated and ended. The credibility of the analysis was checked by the second author, and in addition group sessions where CA researchers look at a short sequence within a session and analyse it together were used, to further enrich and to check the credibility of the analytic process.

Ethics

The study protocol was approved by Cambridgeshire 2 Research Ethics Committee, Addenbrookes Hospital Cambridge, UK (REC Ref: 09/H0308/137), and informed written consent was obtained from all participants in the study, including parental consent for those participants under 16 years old. In order to protect confidentiality, identifiable details are excluded or disguised, and participants are described using only gender and age at the start of the study (e.g. 'female, 15'). All therapists and young people in the IMPACT study agreed to their sessions being tape recorded for the primary purpose of assessing treatment fidelity, and additionally for the purpose of examining the process of psychotherapy.

Results:

In all four of the sessions being analysed, therapists talked to the patients about the fact that the end of therapy was in sight and explored how it was affecting them and affecting their relationship to the therapy and to their therapists. They did this by making links between the patients' anxieties about external events (e.g. ending school) and related these to the anxiety the therapist suggested they also had towards ending therapy. The therapists encouraged the young people to consider how they would be managing without the therapy, and they made links between the patient's non-engagement with therapy and interpreted this as a defence against the separation which was in sight.

The analysis of the data identified two main kinds of responses to this transference work which was focused on endings. These were classified as "dramatizing" and "down-playing" responses, and each will be described in more detail here, with extracts from the data to illustrate each of the response types.

Type 1: "Dramatizing" responses to interpretations which focus on the meaning of separation from therapy and therapist

"Dramatization" refers to the patients' tendency to respond with high emotionality and make catastrophic statements about themselves, their futures and their relationship with the therapist, in response to the therapist's focus on the ending of therapy and its significance in the transference. Two of the four young people predominantly made use of this type of response. Three main characteristics define the Dramatic responses.

Firstly, CA of the extracts shows intensity in the verbal tone and choice of words used by the patients in response to the topic of ending and its significance within the transference. The extracts show a wide range of variations in the patient's emotionality: these patients can go from a grave tone, to laughter; or from an angry loud tone to yawning and mumbling which makes it inaudible; there are

several risings and lowering of tone, which show a change and rupture in the previous emotional tone. It can be described as a continuously changing tune, which can be read as an intensified emotionality.

Secondly, both patients respond to the interpretations about their feelings about separating from their therapists/therapy by focusing on their future and describing a hopeless situation where they may feel sad or suicidal and they won't be able to let anyone know, or have anyone to help them.

Thirdly, swear words are used by these patients in their responses to the interpretations and used to describe their worry about the future. They both specifically refer to "fucking themselves up again" once the therapy is over, which intensifies the emotional impact of their statement.

In the following extract from session 15, Therapist A talks to Will about his shock, anger and upset when he was reminded earlier in the session about the approaching ending:

T: I think that you also:: (.) a::re (0.5) were quite- (.) shocked whe:n, > I talked with you about (2.5) the session::ns (1) bei::ng (.) > I suppose about half way through no::w (2) you were quite ↓a::ngry (.) and upse:t.

(1.5)

P: I can't remember (0.5) I don't care.

(9)

P: Uh:: basically oh yeah I said that it's just going to fuck up again < afterwards, 'cause I think that's that is what's gonna happen (1) I'm not gonna lie::

(3)

T: ↑Well I think you feel(.) tha:t (.) you do put work in (0.5) here > sometimes more than others but you do (.) get here (1) hu::m and if you put work in here then (.) you should (1.) you should get an A > you know you should get a result.

P: Yeah I haven't really thought that (tone decreases and becomes inaudible)

(13) (patient can be heard yawning)

P: That's what I think- (1) < ↓ afterwards it's just gonna go back to how it was.

In this extract, Will initially responds that he does not care about the ending and then expresses the idea that he is going to "fuck up again" once therapy is over. The therapist picks up on his despair and interprets his wish to get a result, making a link with the grievances about school he expressed earlier in the session. Will continues to express his hopeless view of his future where there is no room to think about development, with a feeling that life can "only go back to how it was". On the audiorecording, Will's tone is low and often becomes inaudible and confused with the yawning and mumbling; the speech is interrupted with several pauses, some of them quite significant of 9 and 13 seconds.

While the therapist's interpretations try to interpret what is going on in some detail, Will's responses are short and expressive but do not elaborate on what the therapist's is saying. Twenty minutes later in the session (43 minutes into the session), he expands on this by revealing his suicidal thoughts about the future.

P: '>' This what I see I see this ending ↓ and then when I leave my school and I have a shit time at school and then go off to university, > get depressed and kill myself. < °That's what, that's what I see in the future°

Here Will's response is initially pronounced in quite an assertive way and also the emphasis is on how he will "get depressed and kill myself"; the tone then diminishes significantly in the last phrase.

The following extract from session 15 with Francesca shows that she also expresses worry about the future in response to a comment about the ending of the therapy, made 23 minutes into the session; her tone shows an alternation of excited/assertive with a sad/grave one, and the use of swearing by expressing an idea of "fucking up" in the future.

T: well I am wondering if we are talking in general or we are talking about you:- ↑ how do I know that things are >> really really ba:d < outof he::re

P: (Laughs) hhhh- oh nonononono I'm not planning to like to like stop going to therapy and fuck myself up just to come back like but (.) ↓↓ I think like in general (.) people must do that -like (.) people must like,

T: But it must be really ha::rd for people to be able to let their therapist know about (.) how they might feel, (.) out the session:n

P: > Or just like ↑genera:lly they might be fine and then they leave and it's like oops- (1)so:

T: because of course that's the hard thing about therapy(.) is that is not- it's- the person you might want to talk to: > isn't there a::ll the time and what about that particular moment where you might be feeling particularly bad and that person < isn't there

P: ye::ah or like I don't know I gue::ss > for some people it's not a:lways like(.) I feel sad at this time (.) < these ma:ny ti:mes a week (.) like someone could be fine for a ti:me and the:n

T: then something could happen that just (.) that it's just (.) too much

P: yeah

(.) so::

Francesca asks her therapist questions about what happens if she still needs therapy after the twenty-eighth sessions come to an end. She is laughing and talking about "other people" and what happens to "them" when they are in the position of needing more therapy

after they end treatment. The therapist is initially posing a direct question to Francesca, asking her if that's about "you" and not "other people"; however later she aligns with Francesca's wish to speak about "other people" and explore the issue as if related to an external "third" rather than trying to use "you and I" to address the anxiety Francesca expresses. Francesca initially responds with a laugh and her tone becomes lower and slower as the session progresses. She also expresses an idea that "fucking herself up" could be something that could ensure a possibility of coming back to therapy.

It appears that Francesca, although expressing a worry about what will happen when she ends therapy, relies upon "what people do" in order to express what is easily recognisable as her own preoccupation. The therapist also talks about "people" and adapts to the patient's wish to speak about endings through a third party. The therapist voices the limitation and the frustration of being in a predefined setting where boundaries are so tight and there can't be communication about therapist and patient outside the once weekly sessions. The therapist's exploration enables Francesca to express a worry about a time when "they leave and it's like oops" (line 38) and then later she talks about someone "could be fine for a time and then oops". The therapist finishes the sentence on behalf of Francesca (line 50 and 51): something might just happen once therapy is over. This appears to resonate with Francesca, who gives a 'hmm' of agreement.

In these two sessions both Will and Francesca express strong reactions to the idea that their meetings with their therapists are going to come to an end. These patients are particularly preoccupied by 'what next'? They both use the expression "I am (not) going to fuck myself up", suggesting anxiety around what is going to happen once they end therapy; their tone also emphasizes a charged emotional state. The idea of "trouble telling" gives an indication of these patients' responses in these instances: they are letting their therapists know with strong language that they do not like the idea

of the ending and giving a tragic view of how they see their future post- therapy. Voutilainen (2010), in a study of adult cognitive psychotherapy, identified the practice of trouble telling as one whereby the patient is looking for affiliation: they express their emotionality implicitly by asking for the therapist to respond with an affiliative response, namely a sympathetic emotional direct response. This suggests that patients by "trouble telling" may be asking for an interaction (i.e. reassurance) which is not usually offered in psychoanalytic psychotherapy, and so misaligns with the therapist.

"Down-playing" responses to interpretations which focus on the meaning of separation from therapy and therapist

In the other two sessions analysed in this study, the patients, Kirstin and Lisette, respond to the therapists' interpretations around the ending by saying that not only do they feel fine about it, they even feel they have had enough already. They differ to the dramatizing patients' main characteristic ways of responding. Firstly, while the patients who responded in a dramatic way, focus on the future and how problematic it will be for them, the ones who respond in a down-playing way bring into the dialogue the past to prove that they have moved on from the difficulties which originally brought them to therapy. Secondly, in contrast with the "dramatizing" patients, the "down-playing" patients' tones remain stable: there are no noticeable variations in their tone, and the mood tends to remain the same throughout the session. Thirdly, these patients seem to get into a sort of "battle" whereby they are trying to prove to the therapist that they are now better than they used to be and ready to do without therapy. They seem to be arguing back in a way that is quite abstract and intellectual rather than "trouble telling" in the way that dramatizing patients do. There is a focus on the part of the therapists to frame this response as a 'resistance', and hence to analyse the defenses of the patients

against the loss which comes with the ending and their perceived devaluation of their need and attachment to their therapist.

The following extracts from the two sessions show these "down-playing" responses in the interaction with the therapists and what dialogue developed.

In her twelfth session Lisette's therapist reminds her about how many sessions are left, 22 minutes into the session. Lisette is adamant that she is fine and doesn't need therapy, and tries to prove it to her therapist.

T: really and I thought you are s- worrying about (.) feeling that you need to come and it might feel really hard if you feel you need to come if it is that twenty eight weeks (.) twenty eight sessions and that's it (.) because what happens the:::n (.) and we just have to say goodbye and that's it (2) you might feel annoyed (.) furious (.) upset (.) even (0.5) that that's it (.) there's a limit (.) ↑ I was also thinking that other times you talked about (1) you know (.) sometimes thinking you nee-not maybe in the last couple of weeks but before sometimes thinking I need to see him to come and talk,

P: Yeah

T: and then having to wait,

P: yeah-

T: and although maybe you've sort of got used to the routine ↑ I think sometimes that can feel quite annoying that is quite rigid this structure you know > that you can't ring up and say oh I can I come (.) no:::w?

P: mmh::

T: maybe you did that with your counsellor (.) or something in the pa:::st but this isn't the way < this wo:::rks

P: yea:h

(2.3)

T: so there's a whole kind of set of ru::les (.05) which are (.) pretty irritating

P: mmh mmh

(4.3)

P: yeah like that kind of blu-bla-blu that DID bother me in the pa:st obviously coz like (.) things had happened during the week and they would like (.) proper annoy me and I like >> wouldn't be able to say anything cause I'd like either forget it by the time I got here or it wouldn't be the same talking about it coz it wasn't really like < fresh feelings if that makes sense but (3.2) and then now like in the last couple of weeks I-I can't think of like < one serious incident >>where I've got really really upset like I went (0.5) out Saturday night and I (2.0) drank °quite a bit° ↑ and normally like when I drink I get kind of upset like especially like normally I'm fine for ages and >> then I'll get home and I'll be home alone and I'll get really upset just coz I guess alcohol heightens like your emotions and what not but emm I was fine it was like no I can't think of

The extract shows how the therapist is trying to make interpretations around the patient's fear of ending, while Lisette seems puzzled about what the therapist means when he talks about her defensiveness and argues her point while challenging the male therapist's point of view. The therapist brings in the fact that the therapy is half way through and links this to Lisette's difficulty in coming to see him. He suggests she may feel "annoyed, furious and upset". Lisette initially listens as if waiting for the therapist to finish his interpretations and just signals her attention. Then Lisette talks about how she feels better than she used to when she began and she can't think of anything to say.

Both therapist's and patient's turn are quite long and each is expanding their initial point and trying to reinforce their point of view in their turn.

The second session present the same characteristic, as Kirstin is also trying to prove that she is now much better than she used when she started therapy. It is ten minutes in to the 19th session. The extract presents an interaction whereby Kirstin has asked the therapist how long she has left in therapy, and the therapist replies that they have nine session left and asks Kirstin how she feels about having this limited time together.

P: I feel like it was it was I don't know I just kind of imagine like now today I feel like I just can't imagine living this way like completely depressed not caring about anything it was just I don't know these weeks were really hard and terrible for me and if I if I have to think what how it would look like if I was still to feel this way I imagine it would be terrible and for example now [my boyfriend] is away for four days and probably will completely (inaudible) myself at home just doing nothing there, and (now) I spend a good time with my family or with my friends and this is different I don't know like I enjoy my time during those four days and probably if I wouldn't feel better I would have just stayed feeling depressed at home for the whole time I don't know it just feels good I don't know I just feel very good now I feel I don't know I'm quite happy because I feel I'm less dependent on [my boyfriend] because he was four days away and I actually completely like don't feel like I needed him at all so I feel quite good

T: .hh and perhaps you want to show me:: something (.) simila::r (1.5) in thinking about ↑the Christmas brea:k (1.6) hum:: wanting me to see that actually (2.3) < you won't meet me for an extra wee:k > and it will be ok (0.5) you will- you can manage (1) there is-

there is an inde:pende:nce fro::m ↑ me::, that can continue .hu:m for three weeks and ° not only for two weeks°

P: hu::m ma:ybe:: > but at the same time I guess that's just like for three wee::ks (2) ↑ and I know that during these three weeks there is < no:: chance that > I can excuse- iso:la:te myself from people for example 'coz in [country A]well I'm in [country A]for a week and >> it's not going to happen coz there are so many things to do (1.0) < then I come back like hh. all:: my friends have made pla::ns for different thi::ngs and [my boyfriend] is going back as we::ll (.) a::nd it's the only time we are going to spend together like (1.3) and ↑↑at the same time like (0.7) I'm going to [country A] almost in a weekend today and I still haven't packed and that's terrible (1.0) it just went really fast and I know that these three weeks > are also going to go so fast so::

T: so you'll be [OK

P: [hhhhh.

(laughing)

T: £ you'll be too:: busy £

P: £hopefully£

T: °you 'll be too busy to miss the sessions (1.0) you won't notice°

P: hh. < I don't know that > (1.5) Coz there still might be times when (1.0) ↑ well I can't say > I'm going to be happy for the entire of my rest life and I don't need anything else < coz I never know what's gonna happen (1.5)

T: no

At the start of this extract Kirstin explains that she feels better now compared to how she used to feel when she first started therapy; she now feels more independent and in control of her feelings. She compares how she may have felt in the past in the context of her boyfriend being away and how she may feel now, "very good". The

therapist talks about how Kirstin may begin to feel independent from her as well, making an explicit transference interpretation where she links Kirstin's feelings about being away from her boyfriend with her unspoken feelings about being separated from the therapist over the upcoming holiday. The therapist frames this as a defensive reaction to Kirstin's own 'needy' feelings. When Kirstin keeps asserting she will be fine, the therapist challenges her with humour about her assertion, which leads to Kirstin making some acknowledgement of how she will always need other people at times.

One dynamic which emerges with both patients who respond by down-playing their response to the therapist talking about upcoming endings is that both patients and the therapists can get into a *story telling* way of relating to each other. This can be described as when one party delivers a speech or narrative while the other listens for an extended period of time, meaning that the speaker gets to maintain control 'of the floor' for a considerable period of time and can effect a topic-shift (Sidnell and Stivers, 2013). This reflects the sort of "battling" interaction described earlier, where each party wants to prove a point and is offering a prolonged speech. This differs from the demands implicit in the "trouble telling" approach of the patients who were more dramatic in their responses.

Discussion and clinical implications

The different practices of "trouble telling" and "story telling" used by the two pairs of patients show that that transference interpretations around endings may trigger different conversation techniques on the part of adolescent patients. These may be a reflection of the ways they find to deal with the anxiety around ending and separation from the therapists.

The trouble telling tendencies of some patients point to the invitation these patients pose to their therapists in giving in to their desperate demands of being reassured, or treatment continuing.

On the other hand, the down-playing patients could, through their story telling, trigger a defensive response in therapists who may feel compelled to persevere in opposing the patients' view and talking about their wish for dependency, which the patients cannot own. The different responses of these two pairs of patients show not only how they rely on different conversational techniques, but also how different trends in the relationship with the internal object seems to be behind their inclinations to become dramatic or defensive.

The current study suggests that adolescent patients who respond by "dramatising" see the separation as equated with disaster. They are giving a hopeless view of what is going to happen to them, attacking themselves and their future, which seems an expression of their anger towards their therapist for bringing up the separation. It is clear that these patients are aware that the therapeutic relationship matters to them and that the interpretations offered by the therapists are "emotionally immediate" (Strachey, 1934); and the high intensity of emotionality in the dramatic responses supports the idea that transference interpretations touch on something live and potentially helpful. The description that Blatt (1998) gives of dependent depression seems to fit these patients who behave in a dramatic way. The dependent or anaclitic patients often come from enmeshed families where separation has not been encouraged, they are particularly sensitive to loss, in particular in relation to the therapist and the separation from others may be experienced as a threat to the sense of self. The quality of the therapeutic alliance is the key element in the outcome of therapy with these patients (ibid). This is a key indicator that reflecting on the relationship, which includes analysis of the transference, can be a helpful way of helping those patients who show these traits. Keeping in mind their need and hunger for a meaningful relationship, we can reflect to what extent we should explore transference issues. Conversation analysis is here a helpful tool in guiding the clinicians as to *how* to talk about the relationship. For example, the extracts reported show that

a general conversation about relationship issues might be more digestible than a "you and I" conversation.

The down-playing patients, on the other hand, seem to be saying that they don't need their therapist. Sandler (1996) writes about how infantile, or regressive pulls, get in the way of transference work being accomplished with some adolescents. This is because these patients "have, in a sense, tremendous fear of regressing towards a very early mode of gratification in their object relationship, a type of close relationship with the object which they unconsciously yearn for but in no way can permit" (). Narcissistic vulnerability (Anastopolous, 2007) also seems to hinder the capacity of some adolescents to be able to helpfully explore the transference relationship. This term refers to depression as a consequence of the challenges posed by the tasks of growing up and the real or potential "failure" to fulfill the ego ideal. The patients who are producing down-playing responses could be orientated to maintain or restore their narcissistic defences in a desperate attempt to prove independency and self-worth, and so the therapist's focus on speaking about the reaction in terms of transference may be experienced as an existential threat. This consideration can help us to pay more careful attention as to when to interpret and carefully take into account the need for a defensive system and how its deconstruction may bring consequences that we may not have time to deal with in short term psychotherapy.

Some psychoanalysts have considered narcissism in adolescence not only as a pathological defence but also as a developmentally appropriate step. Waddell (2008) for instance looked at the narcissistic aspect of adolescence as a way of working through internal identifications and conflicts: the adolescent organisation offers the preconditions for exploration of relationships which is reliant upon one's own internal parents but also distinct from these. Similarly Blos (1980) describes the adolescent as being preoccupied with his internal world as a means of restructuring his mind and relationships. Blos suggests that transference work with adolescents

is something that should be paced to the particular expression of the transference or lack of it, noting that "*due to the typical adolescent oscillation between regressive and progressive movements, transference manifestations, while passionate and revealing, tend to be meteoric or kaleidoscopic*" (p.147). When working clinically, it may be worth considering that those adolescents who are inclined to down-play the therapist's interest in exploring the emotional meaning of endings it might make sense to consider their reluctance to engage in a transference talk as a way of preserving a much cherished privacy rather than as a defence against relating.

In the light of the findings of this study, it may be that the focus on transference should be paced according to the kind of depression patients display. The way that conversation was managed by patients and therapists in the extracts from sessions analysed in this study also points to the risks of putting an explicit focus on the relationship ending, as this may incite acting out in the verbal exchange. In these circumstances talking about the forthcoming end of therapy in displacement could be a safer way of discussing the issue for some adolescents.

The issue of when to interpret, and the timing needed, is also crucial in this research. There may be instances where patients benefit from an in-depth focus on transference from beginning to end of treatment, while others may need to address it explicitly only at certain points and when they feel ready. While the manual for short-term psychoanalytic psychotherapy used in this study (Cregeen et al., 2017) suggests that issues around ending and the transference should be explored in more depth in the middle phase of treatment, this may not always be the case, and considerations about the use of transference interpretations in relation to the ending of therapy may depend more importantly on the personality structure of the particular adolescent, and whether such interpretations are experienced as a threat to the sense of self.

These reflections can help clinicians take a more flexible approach to such interpretations; they also remind us of the fact that open receptivity and flexibility is at the core of psychoanalytic psychotherapy, and may need to be accounted more in work with adolescents, even in the context of a manualized therapy.

Conclusion

Given the relatively small number of sessions that were analysed, this study is of course preliminary, and further work needs to be done before one can say with confidence how much the patterns identified here may be characteristic of adolescents in therapy more generally. Nevertheless, in view of the findings of this study regarding the different ways adolescents may respond to interpretations about endings in short-term psychoanalytic psychotherapy, it may be worth considering whether transference interpretations linked to endings are more appropriate with certain kind of adolescent patients than others, and whether it is important to maintain a flexible approach to the exploration of transference in relation to endings and separations when working with adolescents.

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