

Dissertation volume:

*Exploring the therapeutic process in therapies with young people using the
Adolescent Psychotherapy Q-set*

Literature Review
Empirical Research Project
Reflective Commentary

PDWX6

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Adolescent)

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DECLARATION

I declare that the material submitted for examination is my own work. The ideas and findings of others have been referenced in accordance with the guidelines provided and any work by others has been acknowledged.

I understand that anti-plagiarism software may be used to check for appropriate use of referencing.

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Part 1: Literature Review

How has the Adolescent Psychotherapy Q-set been used in research and practice and what could be its future applications?

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Abstract

Background: The Adolescent Psychotherapy Q-set (APQ) is a pan-theoretical empirically validated process measure with potential for statistical analysis describing the unique characteristics of therapy sessions conducted with adolescents.

Aims: This literature review aims to examine the development of the APQ and its applications in research and practice to guide future applications.

Methods: A literature search on the PsycInfo and UCL Explore search engines and subsequent scanning of search results yielded nine published studies using the APQ. One unpublished study was made available to the author by the measure developer.

Process: Studies were critically reviewed one by one paying attention to their research methodology, innovative use of the APQ, and their contributions to the field of adolescent psychotherapy process research. The APQ's applications in this small body of literature was then evaluated. A review of relevant applications of the APQ's child and adult equivalents highlighted directions for the APQ's future potential.

Results: Following its empirical validation, the APQ has been applied theoretically, in research of clinical practice, and in supervision. The APQ's application to create therapy prototypes of therapy modalities has shown its good discriminatory quality and suitability to study treatment adherence. Using the APQ across therapies

has shown it can detect important trends in therapy processes across large data sets. The APQ's applications in single-case studies has shown the measures' suitability to this research methodology, having already produced important insights in adolescent therapy process research. The review found the APQ to be sensitive to subtle differences in therapeutic techniques and interactions whilst possibly missing non-verbal factors and within-session variability. The APQ's use of direct observation in real-life clinical settings, suitability for various statistical analyses and triangulation as well as its potential to find process-outcome links in adolescent therapy are clear advantages.

Conclusions: Although empirical research conducted with the APQ is in its infancy, its applications so far have shown the versatility of this measure and its potential to add knowledge to the field of adolescent psychotherapy process research. The review highlights important methodological directions for future research, including a move beyond research based on modality prototypes.

Introduction

The APQ is a 100-item instrument suitable for quantitative analysis that aims to provide a basic language for describing psychotherapy processes in adolescent therapies (Calderón, Midgley, Schneider, & Target, 2014). It arose from the need to develop an instrument 'sensitive and comprehensive enough' (Bambery, Porcerelli, & Ablon, 2007, p. 407) to adequately capture therapeutic processes with young people taking into account the unique developmental tasks and typical themes emerging with this patient group: the strive for autonomy affecting engagement and attendance, adolescents' tendency to evoke strong feelings in therapists (di Lorenzo, Maggiolini, & Suigo, 2015), and their unique expectations from therapy (see Midgley et al., 2016; Weitkamp, Klein, Hofmann, Wiegand-Grefe, & Midgley, 2017), amongst others.

Currently, there is a wide range of treatments for young people's psychological difficulties that are evidence-based (Fonagy et al., 2015). However, moderate effectiveness (Goodyer et al., 2017), low attendance rates (Gearing, Schwalbe, & Short, 2012; Shirk, 2001), and substantial rates of treatment drop-out (de Haan, Boon, de Jong, Hoeve, & Vermeiren, 2013) limit most treatments. Hughes (2000) described that unless we understand the mechanisms responsible for attendance and drop-out, as well as for therapy benefits, a clinician in real-world practice cannot make informed decisions about how to tailor the evidence-based treatment to a particular client with particular needs. There is now a consensus that we know too little about what exactly facilitates therapeutic change in therapeutic work with young people (Fonagy et al., 2015; Kazdin, 2009; Lis, Zennaro, & Mazzeschi, 2001). The aim of continuously developing treatments and their mode of delivery, in order to not only improve outcome but also engage a larger proportion of patients, has been addressed in a developing field of research: psychotherapy process research.

The primary objective in the field of psychotherapy process research is to understand the mechanisms by which treatments achieve therapeutic change (Fonagy et al., 2015; Kazdin, 2009; Levy & Ablon, 2012). Insights in this area could, in turn, improve (and make more cost-effective) (Fonagy et al., 2015) psychotherapy theories and techniques (Bambery et al., 2007), the training of new therapists (Knox, 2013) and ultimately patient care. Empirically informed psychotherapy research with adolescents comes with its 'unique conceptual, methodological and design issues' (Midgley et al., 2018). In so called 'process-outcome designs', observable therapy processes are linked to therapy outcomes (Elliott, 2010; Knox, 2013; Lis et al., 2001; Shirk, 2001). Systematic observations and detailed descriptions of these 'techniques and patterns of therapeutic interactions' (Lis et al., 2001, p. 46) are sequenced and linked to psychological changes captured by outcome measures. The hope is to detect specific therapeutic interactions and their potentially causal effect on therapy outcome (Levy & Ablon, 2012). A key methodological goal in process research is therefore the design of comprehensive yet concise measures that define, describe, quantify, and make comparable aspects of clinical material over time, utilising the principles of empirical science (Ablon & Jones, 2005; Ulberg, Amlo, Critchfield, Marble, & Høglend, 2014).

Some highly nuanced empirical measures do exist to capture aspects of the therapeutic process with adolescents. Thus far, however, most measures have focused on single mechanisms and often originate from the adult or child literature without adolescent-specific adjustments (Calderón, Schneider, Target, & Midgley, 2017). Following the need to study change processes more broadly, across therapy types and directly within the patient group in question (Zack, Castonguay, & Boswell, 2007), the Adolescent Psychotherapy Q-Set (APQ; Calderón et al., 2014) was

developed to address this gap within the field of adolescent psychotherapy process research.

The APQ and its Development

The APQ and its Properties

The APQ is comprised of 100 statements (the Q-set) describing the therapeutic process with adolescents that are ranked with regards to their prominence within a therapeutic session. The set of 100 ranked items creates an individual session profile, or Q-Sort, which allows for statistical analysis of all its constituent parts, rather than focusing on a particular dimension (Ablon & Jones, 2005; Calderón et al., 2017). The items describe three aspects of psychotherapy sessions: the young person's feelings, experience or behaviour (n=40, e.g. item 84 "Young person expresses angry or aggressive feelings"); the therapist's actions and interventions (n=30, e.g. item 27 "Therapist offers explicit advice and guidance"); the interaction between the therapist and young person (n=30, e.g. item 38 "Therapist and young person demonstrate a shared understanding") (Calderón et al., 2014).

A rater studies the entire therapy session in the shape of a transcript, audio recording or video tape and rates the session immediately after. In accordance with a Q sorting procedure, each item is sorted into one of nine categories on a continuum ranging from 'least characteristic or negatively salient' to 'neutral/irrelevant' to 'most characteristic or salient' according to a fixed normal distribution. Each pile therefore has a dedicated number of items permissible (pile five: 18 items; pile four and six: 16 items each; pile three and seven: 12 items each; pile two and eight: eight items each; pile one and nine: five items each). Ablon and Jones's (2005) justification for a forced normal distribution, namely bias reduction through imposing multiple discriminations and facilitation of statistical analysis, are convincing.

A digital sorting application aids the sorting and forced distribution (Dawson, 2013) whilst the APQ manual (Calderón et al., 2014) specifies conditions for sorting items and provides supplementary examples for each item to aid decision-making. The ipsative rating and analysis method contrasts with commonly used Likert-scale models by forcing raters to prioritise one item over another. As an example, a rater has to make a decision whether a certain therapist intervention (e.g. rephrasing a communication) has been more prominent than another (e.g. encouraging reflection on affect). What matters in this scale is how the various items relate to one another for the session in question, rather than how they relate to a normative session (Ablon & Jones, 2005). Each individual rating of a treatment hour, therefore, is an individually patterned description of the therapy hour in question. As such, a Q-sort is also referred to as a *gestalt*, evidencing the primary ways in which items are interconnected and related to each other (Watts & Stenner, 2005).

Methodologically, the APQ is a Q-set measure, given its Q sorting procedure and its potential to be used for Q pattern analysis (see Watts & Stenner, 2005).

Development of the APQ

The selection and development of APQ items occurred in a series of steps: using the Psychotherapy Process Q-set (PQS; Jones, 2000) and the adapted Child Psychotherapy Q-set (CPQ; Schneider, 2004) as a template; reviewing relevant modality-based and core therapeutic qualities; translating modality-based jargon into a neutral language to achieve 'theoretical neutrality' (Bychkova, Hillman, Midgley, & Schneider, 2011, p. 335; Calderon et al., 2014), making the measure accessible across therapy orientations. In order to ascertain face and content validity, the 100-item prototype underwent an iterative process of consulting expert clinicians and the coding and analysis of real-life psychotherapy sessions across a range of different

therapists, adolescent patients and therapeutic modalities (Bychkova et al., 2011; Calderón et al., 2017). The process included an exercise from here on called the 'prototype paradigm': clinicians from different therapy orientations created an APQ rating of their typical practice, producing an APQ-sort prototype of their modality. Across modalities, prototypes mainly differed from each other, and at times showed similarities, often in a way that was theoretically expected, e.g. psychoanalysis resembling psychodynamic psychotherapy (Bychkova et al., 2011). Given that modality-specific items are presumably drawn from the very same literature that informs modality training, this is hardly surprising, yet it confirmed the APQ's ability to differentiate between modalities and detect similarities. In this way, the prototype paradigm is a useful step in the development of the APQ. The prototype paradigm does not, however produce new insights about process in adolescent psychotherapy, nor does it use the APQ as it is intended to be used: as a rating of real-life treatment sessions. By the end of validation, 45 APQ items were shared with the PQS and CPQ, 18 items with the PQS only, 4 items with the CPQ only and 33 items were unique to the APQ (Calderón et al., 2017), making the scale sufficiently adolescent-specific. The APQ reportedly could express a wide range of techniques across modalities whilst capturing adequately adolescents' thoughts, feelings and actions, as well as characteristic therapeutic interactions in sessions with them.

Critical Review of Studies Using the APQ

As a fully validated measure, the APQ has experienced a quick and international uptake by researchers based in Brazil, Italy, Norway, and the UK. In order to capture the APQ's full range of applications, the current review will include all published studies, studies that are yet unpublished or that used the CPQ with adolescents previous to the APQ's validation, as well as the studies involved in its

validation. Studies were identified through a literature search on the PsycInfo and UCL Explore search engines using two searches: “adolescent psychotherapy q set” or “apq therapy”. Subsequently, results were scanned for relevant studies. Communication with the measure developer ensured unpublished studies known to them were made available to the author (Calderón, 2018, private communication). Table 1 shows a list of these studies.

Table 1*Studies Using the APQ*

#	Authors	Study title	Usage
1	Bambery, Porcerelli, & Ablon (2007)	Measuring psychotherapy process with the Adolescent Psychotherapy Q-Set (APQ): Development and applications for training	<ul style="list-style-type: none"> • Prototype • Session rating • Supervision
2	Benetti, Eisswein, Bohn da Silva, Bernardi, & Calderón (2017a)	Adolescent psychotherapy process research: Adaptation of the instrument APQ	<ul style="list-style-type: none"> • Translation • Prototype
3	Benetti, Vieweger de Mattos, Bohn da Silva, & Alvares Bittencourt (2017b)	Avaliação de processo em psicoterapia psicanalítica na adolescência (Process evaluation in psychoanalytic psychotherapy in adolescence)	<ul style="list-style-type: none"> • Session ratings • Triangulation
4	Bychkova, Hillman, Midgley, & Schneider (2011)	The psychotherapy process with adolescents: A first pilot study and preliminary comparisons between different therapeutic modalities using the Adolescent Psychotherapy Q-Set	<ul style="list-style-type: none"> • Prototype • Narrative
5	Calderón, Schneider, Target, & Midgley (2017)	The Adolescent Psychotherapy Q-Set (APQ): A validation study	<ul style="list-style-type: none"> • Session ratings • Triangulation
6	Calderón, Schneider, Target, the IMPACT Consortium, & Midgley (2019)	'Interaction structures' between depressed adolescents and their therapists in short-term psychoanalytic psychotherapy and cognitive behavioural therapy	<ul style="list-style-type: none"> • Session ratings
7	Di Lorenzo, Maggiolini, & Suigo (2015)	A developmental perspective on adolescent psychoanalytic psychotherapy. An Italian study with the Adolescent Psychotherapy Q-Set	<ul style="list-style-type: none"> • Prototype • Triangulation
8	Elvejord & Hooper Storeide (2018)	Using the Adolescent Psychotherapy Q-Set to examine the process of time-limited psychodynamic therapy involving two adolescents diagnosed with depression	<ul style="list-style-type: none"> • Session ratings • Triangulation

9	Grossfeld, Calderón, O’Keeffe, Green, & Midgley (2019)	Short-term psychoanalytic psychotherapy with a depressed adolescent with Borderline Personality Disorder: An empirical, single case study	<ul style="list-style-type: none"> • Session ratings
10	Ness, Johnsen Dahl, Critchfield, & Ulberg (2018)	Exploring in-session process with qualitative and quantitative methods in psychotherapy with an adolescent	<ul style="list-style-type: none"> • Session ratings • Triangulation

Studies Using the Prototype Paradigm

In 2007, Bambery et al. conducted a study using a non-validated adapted version of the CPQ. This study marks the starting point of APQ research, given its clear focus on adolescents and guiding impact on subsequent studies. The authors introduced the 'prototype paradigm', a design frequently used with the PQS (cf. Ablon & Jones, 1998), to the APQ field. Expert psychodynamic and cognitive-behavioural theorists and practitioners (N=22) used the 100 APQ items to express an 'ideally conducted' psychodynamic or cognitive-behavioural therapy (CBT). Prototype ratings were highly internally consistent ($\alpha > .92$ for both psychodynamic and CBT).

Q-factor analysis on all prototype ratings then identified two statistical 'factors' within the data, i.e. two groups of items that all highly load on the respective factor. One factor strongly corresponded to psychodynamic principles, the other strongly corresponded to CBT principles. In turn, individual experts' ratings loaded strongly onto the respective factors (.71 to .89 for CBT, and .59 to .86 for psychodynamic therapy). Interestingly, however, the two factors were also significantly and moderately correlated ($r = .31, p \leq .01$), indicating shared processes. Comparable data from an adult study (Ablon & Jones, 2000) had not yielded a significant correlation between the otherwise similarly emerging two-factor prototypes. Ideal CBT and psychodynamic therapies in adolescents seem to have more shared processes, as measured by the APQ, than the same ideal therapies when imagined with adults. Of course, this study used essentially a child version of the APQ with many of the items not representing adolescent-specific processes yet. Whilst the study introduced a paradigm for research and showed that practitioners agree on an ideal adolescent psychotherapy session, its use of the CPQ might not have produced prototypes that will stand the test of time in adolescent psychotherapy research.

As indicated above, Bychkova et al. (2011) also used expert ratings to create prototypes through a 5-point scale, this time of the five modalities of psychoanalysis, psychodynamic psychotherapy, CBT, mentalisation-based therapy (MBT) and interpersonal therapy (IPT). Shared and diverging descriptors were easily drawn out through APQ items, highlighting what experts perceive certain therapy types to look like. This study worked with an unfinished version of the APQ, but the paradigm seems valid for exploring the preliminary measure's face and content validity. It goes beyond the two most commonly contrasted psychotherapeutic approaches (CBT and psychodynamic), showing its commitment to a wider representation of new and diverging models of adolescent therapy.

Shortly after the APQ's formal validation, Benetti, Eisswein, Bohn da Silva, Bernardi and Calderón (2017a) translated the APQ for usage for Brazilian Portuguese speaking clinicians and researchers. Attention was paid to make items culturally and linguistically meaningful. Prototypes were then created by ten psychoanalytic experts and ten CBT experts and analysed with factor analysis. Two factors explained 48% of variance. Internal consistency was high for both factors (.86 for CBT and .85 for psychoanalytic), whilst each therapist's loading on the factor ranged between .49 to .80 (CBT) and .61 to .73 (psychoanalytic). Values of internal consistency and individual factor loading are comparable to those reported by Bambery et al. (2007). Moreover, seven of the ten most relevant items in the psychoanalytic prototype matched the items in Bychkova et al.'s (2011) psychoanalytic prototype and there existed some overlap with the CBT prototype in these two studies, too. Even in these early studies, the advantage of using the same measure with similar paradigms can be observed, as studies from different countries and presumably therapy trainings can compare and contrast their results, pooling evidence. It also allows to infer that there is a broad

consensus internationally as to what constitutes ideal psychotherapy sessions with adolescents in the psychodynamic and CBT approaches, possibly due to similar theoretical underpinnings and training standards. Benetti et al.'s (2017a) translation and prototype study confirmed the APQ's discriminatory capability and thus paved the way for psychotherapy process research using clinical material. Moreover, the Brazilian Portuguese prototypes can provide the opportunity to measure adherence to therapy in future study designs in Brasil.

Prior to the APQ's formal validation, di Lorenzo et al. (2015) used an un-finished version of the APQ to explore cultural and theoretical differences within Italian Adolescent Psychoanalytic Psychotherapy (IAPP), a fusion of psychoanalytic and developmentally-informed therapeutic principles. Forty-nine Italian adolescent psychotherapists created prototypes of their ideally conducted practice, classed their orientation as 'developmental' or 'psychoanalytic', and completed the Therapist Response Questionnaire indicating typical countertransference reactions. The APQ was shown to be sensitive to the particularities of IAPP, defining it in a standardised manner. A comparison of the IAPP prototype with the five Bychkova et al. (2011) prototypes highlighted shared and different elements of practice with the different therapies explored. Further Q-factor analysis created two factors within IAPP practice, accounting for 45.9% of variance. The two factors significantly matched the self-reported 'developmental' and 'psychoanalytic' leanings of the therapists. This finding highlights the APQ's sensitivity to subtle differences in therapeutic attitudes within prototype responses of a sample of clinicians drawn from the same psychotherapeutic orientation. This is an important finding showing the APQ can detect nuance within traditional psychotherapy orientations. Furthermore, the study's sampling procedure was of note in that experts and practitioners were recruited from meetings of the

'Association of IAPP Groups'. This might suggest that they are a particularly active and theoretically interested group of therapists, making them not only more reliable experts but also, if not active in research already, potential target groups for increasing interest in adolescent psychotherapy research. However, the authors did not state whether they used the English version or a translated Italian version of the APQ, which leaves some lack of clarity about the results obtained. Benetti et al.'s (2017a) protocol might serve as a blueprint for future translation of the APQ into Italian.

Although a broader critique of this paradigm will follow, usage of the prototype paradigm has already set an important example of how insights gained with the APQ can be compared and contrasted across studies and countries as a way of pooling evidence.

Across-Treatment Studies

The APQ's first large-scale application to session material was undertaken in Calderón et al.'s (2017) validation study. The recordings of 35 CBT and 35 short-term psychodynamic psychotherapy (STPP) routine clinical practice sessions were rated with the APQ, a double-coding system ensuring consistency (interrater agreement >.7). A Q-factor analysis yielded three factors that mirrored the modality used by the therapist and corresponded to a validated comparison measure for therapist behaviour. Used commonly for mutual verification purposes (Brender, 2006), triangulation of the two measures strengthened the finding of the APQ's convergent and discriminant validity in real-world practice. The attainment of good interrater agreement indicated that training, practice and rating procedures are valid, an important prerequisite for the APQ's dissemination and usage. Nevertheless, as the authors noted themselves, triangulation of the APQ codings was only undertaken for therapists' techniques, not for the young person's feelings, nor interactions. Further

triangulation of those items might be difficult given the dearth of any other adolescent process instruments (Bambery et al., 2007). Another limitation was that raters' blindness could not be established as for most experienced raters therapeutic modality is evident from accessing session data.

Progressing from modality-focused research, the authors (Calderón, Schneider, Target, the IMPACT Consortium, & Midgley, 2019) explored the theoretical idea that therapeutic change might be linked to changes in patient-therapist interactions. Within Q-set measures, interpretable clusters of items appearing repetitively together describe the 'interaction structure' between a therapist and a patient (Jones, 2000, p. 284). The abovementioned 70 session ratings were analysed through cluster analysis to identify potential 'interaction structures'. Beyond their modality (CBT vs. STPP), sessions were categorised into 'beginning' or 'middle' phases of treatment. Three clusters of divergent interaction structures were found: a strong working relationship with a therapist who helps an involved young person reflect (mostly STPP, some CBT sessions); a strong working relationship with a collaborative young person and an active therapist (CBT sessions only); and a difficult working relationship between a non-engaged young person and a hard-working therapist who does not make much progress (both treatments equally represented). Interaction structures did not seem to change across treatment phase. Yet some key items in cluster 1 and 2 overlapped, highlighting common core techniques when working with depressed but engaged adolescents. The third cluster showed that when working with disengaged adolescents, therapists from both modalities struggled in similar ways to engage them, seemingly being pulled into a more active position. As such, this might be the first real and generalisable process observation the APQ highlighted and it has serious implications for practice and further research: the therapist's pull to become

more active might be associated with different outcomes and treatment approaches could be adjusted accordingly. Baseline data was compared between clusters but was not significantly different and outcome data was not available at the time of study in order to test for process-outcome links. However, triangulation of the clusters with other measures of interest, e.g. working alliance, could have provided further insights.

The author's successful use of cluster analysis widened the options for statistical analyses that can be used on APQ data and introduced a research paradigm that moves away from modality-focused research questions. With sessions being drawn from 70 different treatments, insights from the two studies (Calderon et al., 2017; 2019) reflect the APQ's ability to detect important trends observable across treatments and within large data sets.

Session-By-Session Case Studies

The APQ has experienced good uptake for tracking the process of entire treatments in single-case designs, perhaps because it ensures 'the depth and complexity of the case analysis, (...) whilst systematically generating empirical data' (Benetti et al., 2017a, p. 198).

All four studies were of females between the ages of 16 and 18 years with a diagnosis of depression (Elvejord & Hooper Storeide, 2018; Benetti, Vieweger de Mattos, Bohn da Silva, & Alvares Bittencourt, 2017b; Grossfeld, Calderón, O'Keeffe, Green, & Midgley, 2019; and Ness, Johnsen Dahl, Critchfield, & Ulberg, 2018). Except for Ness et al. (2018), studies used the APQ to code all available therapy sessions, meaning all aspects of the process could be looked at and potential change could be detected irrespective of when it occurred (Kazdin, 2009). Three of the studies (Elvejord & Hooper Storeide, 2018; Grossfeld et al., 2019; and Ness et al., 2018) followed a 'cases-within-trials' model (Fishman & Edwards, 2016). Here, a case is strategically

drawn from a larger study to complement the sometimes-limited conclusions drawn from quantitative results, or to address a specific question arising from the data (e.g. divergent outcomes, drop-out). The following review will consider the APQ's application in those single-case studies, how successfully or creatively it was integrated to answer the respective research questions, and the merits and limitations in designs and reports that can be learned from.

Set within a Norwegian large-scale trial on time-limited psychotherapy for adolescents with depression, Elvejord and Hooper Storeide (2018) compared the therapeutic process of two same-aged adolescent girls with depression, treated by the same therapist but showing divergent outcomes (poor vs. good). The strategic sampling was advantageous to answering a range of research questions that revolved around 'interaction structures': how they change over time and how they link to outcome or other factors relevant in the process or client. In addition to the APQ, relevant outcome and process measures were used.

Reporting outcome measures to begin with, the study achieved a rich comparison of the two participants at baseline, post-treatment and follow-up. After identifying the 10 most and least common APQ items in each treatment, all APQ ratings were used in a Q-factor analysis and Principal Component Analysis, extracting 5 relevant interaction structures that accounted for 68.13% of total variance. The factors 'making sense of relationships', 'working with anger and vulnerability' and 'fragile self-image' were more typical of the 'good outcome' case, whilst 'fearful but suppressed' and 'working with low mentalisation' were more typical of the 'poor outcome' case. Rich description of each interaction factor and expressive graphs tracing both cases' loadings on specific factors illustrated the process over time. The study offered a sound integration of baseline measures of perceived parental styles,

socioeconomic status, level of family conflict, symptom severity, and psychodynamic functioning within the therapeutic process. It also discussed with attention to detail how the differing values on the Working Alliance Inventory came into play in the process. A strength of the study was that the APQ mirrored observations from these other measures, and added illustration on what these observations looked like in practice, e.g. a bad working alliance. This was also reflected in therapist techniques, with the APQ illustrating the therapist moving away from more prototypically psychodynamic interventions in the interactions with the poor working alliance / poor outcome case.

There are several pointers for practice gained from this study: how pre-treatment factors such as the adolescent's home environment link to interaction structures in therapies, how differing processes may link to outcome on a range of measures, as well as some lessons related specifically to the usage of the APQ. The authors openly discussed the lower average coding reliability for the poor outcome case, possibly influenced by the young person's display of ambiguity within the session. This highlights that the APQ is best suited to measure variability between sessions but struggles to code for 'complexity and variability within a session' (Elvejord & Hooper Storeide, 2018, p. 50), a view echoed in Levy, Ablon, Ackerman, Thomä, & Kächele's (2012) study using the PQS. Coding the audio-recorded sessions chronologically, however, could be seen as a methodological flaw in the authors' usage of the APQ. Having a third researcher put sessions into random order at the point of APQ coding could prevent any bias about 'seeing' development in the data when there might not be any. Conversely, within the Stephenson tradition of Q-methodology, it is exactly the rater's subjectivity that is of interest (Rost, 2021). From

that perspective, the subjective influences on coding are not seen as an obstacle to coding but rather as an inherent part of what is being studied.

Either way, this study exemplifies a meaningful integration and discussion of the contributions of different measures on the therapeutic process and outcome and the resultant insights on the therapeutic process. Going forward, the comparative study of two single cases is a promising paradigm for future APQ studies, as it links process and outcome in aggregated cases.

Most similar in aim and methodology is Grossfeld et al.'s (2019) case study of a 16-year-old girl with a diagnosis of depression and borderline personality disorder (BPD). With the aim of finding an empirically validated description of the therapeutic process for adolescents with BPD, therapist-patient interaction structures were analysed for a good-outcome case strategically sampled from a UK randomised controlled trial (Goodyer et al., 2017). All audio-taped sessions were coded blind to session number and good interrater reliability was ensured following double-coding of several sessions. Principal Component Analysis yielded five interaction structures, explaining 63.38% of variance, comparable to Elvejord and Hooper Storeide's (2018) values. The five interaction structures, 'animated fantasies being challenged', 'process stuck as therapist probes 'protective shield'', 'challenging helplessness through tackling painful emotions', 'anger and injustice but no time for reflecting on loss', and 'deep depression and powerlessness meeting a gentler therapist' identified preoccupations and relational focuses that echoed the BPD literature. The interaction structures were fleshed out through displaying the relevant items and were further discussed with regards to the treatment phase they were loading most heavily onto. Even without the use of any other in-session process measures, the study succeeded in illustrating the patient's oscillation between different interaction structures, e.g. from

lively engagement to impenetrability, representing the push-pull tendency reflected in the BPD literature. It also identified moments of extraordinary use of technique by the therapist when the patient appeared particularly helpless. Finding these moments of special technique allows for further consideration of these moments as a necessary adaptation to the needs of the patient or as a form of enactment on behalf of the therapist. This study replicated Elvejord and Hooper Storeide's (2018) finding that the APQ successfully identifies sessions in which the therapist changes their technique in response to patient characteristics. This is encouraging, given that the development of paradigms to study therapist responsiveness was one of Levy and Ablon's (2012) research recommendations for adolescent psychotherapy research. Yet the APQ's contribution also lay in highlighting contradictions in the data, for example when the APQ items indicate hopelessness and not feeling helped but outcome measures report improved depression scores. Such insights can further the theoretical debate as to how to understand these contradictions in patients with a BPD diagnosis. Similarly, some of the problematic interaction structures persisted until the end of therapy, posing several theoretical questions. More long-term therapy could be beneficial for this presentation despite improvements on the depression scales (BPD outcome measure not available). Conversely, problematic interaction structures might not be linked to the related depressive state as closely as expected. More generally, with the help of the APQ the study captured some of the particular challenges that can occur in the psychotherapy process with BPD adolescents. In this way, the authors showed that the APQ is sensitive to aspects of the distinct phenomenology of different psychopathologies. It remains on firm empirical ground whilst doing so, effectively turning therapists' narratives into empirically accessible data.

The third single-case study coding all treatment sessions was of an 18-year-old girl with depressive symptoms and an ADHD diagnosis treated in private treatment (Benetti et al., 2017b). The study focused on exploring in-treatment processes before and after a sudden mid-treatment interruption. Next to a symptom checklist, the APQ was triangulated with the self-report Defense Style Questionnaire (DSQ) and clinical notes. This is the only study using videotapes for session ratings. The authors simply reported the ten most and least characteristic items of the first twelve sessions (leading up to drop-out) and subsequent eight sessions (returning from drop-out). Averaging the APQ items across the two treatment phases risked losing the richness of the process. However, the authors overcame this potential shortcoming with a comprehensive yet digestible and easy-to-follow session-by-session integrative analysis of all clinical measures and notes. For example, the process was explored in-depth when linking APQ item 26 '(Young person experiences or expresses troublesome (painful) affect)' to the use of the DSQ defensive style 'isolation against affect', illuminating why this phase of treatment provided limited opportunity for linking and insight. In another example, clinical notes showed that the patient verbalised that therapy was making her reflect on the sad facts of her life, and since she understood everything about that she considered therapy unnecessary. Concurrent APQ data showing consistent interpretative interventions without adjusting to the patient's reaction allowed researchers to speculate whether this could have been a factor in the patient abandoning therapy. Coupling the DSQ, APQ and clinical notes helped to empirically demonstrate that interpretative work in the face of resistance might not have the desired goal of relieving anxiety for this patient, linking therapist technique, the young person's defensive structure, and therapy outcome. It also showed that reliving some of the conflict was hard to tolerate for the young woman, even with an

empirically demonstrable gentle and non-judgmental therapist. Understanding this is a helpful insight into therapy process, namely that some processes are so painful, they are hard to contain regardless of the techniques employed by therapists – and the APQ can support that understanding across therapeutic modalities. In this way, the application of the APQ can also be an empirical way of allowing interested parties understand the complexities and vicissitudes of the adolescent population and adolescent processes – with the APQ, these narratives are not just a personal account of a struggle, they are a validated account of a struggle.

The Benetti et al. (2017b) study cited above offered multiple insights into APQ usage and therapy process. Importantly, however, the study showed the meaningful integration of clinical practice and research by combining validated process and self-report measures with clinical notes, arguably producing a result that is bigger than the sum of its parts. It is also a promising example of a good research process – where the validated translation and adaptation of the APQ (Benetti et al., 2017a) leads to an application to real clinical material for non-anglophone audiences.

Finally, Ness et al., (2018) aimed to explore in-session processes in a successful therapy of a 16-year-old depressed girl within a cases-within-trials methodology (Fishman & Edwards 2016). The case was strategically selected to be representative of the larger sample whilst also presenting with self-harm, a widespread but under-reported symptom accompanying depression likely to evoke distinctive interactions when emerging within the therapy process. In addition to the APQ, the authors accessed clinician-rated and patient-rated measures on functioning, symptoms, working alliance and observer-based in-session process instruments. The authors wanted to understand which of the measures best captured the occurrence of a mid-treatment crisis in the treatment. They therefore focused analysis on a selection

of sessions preceding and following the mid-treatment crisis (sessions #8, #11-14, #20-28). However, the clear methodology and positive mix of measures was let down by a disorderly integration of results. Data was not reported chronologically and could have been helped by a visual representation. There was an attempt to create a narrative through integrating measures, but it remained unclear when and which measures were chosen to be reported or omitted. For example, the APQ was used on 6 sessions but its data only reported on 2 sessions, leading up to the mid-treatment crisis. The study is a reminder of the difficulty of integrating measures within (and across) treatments successfully. More measurement does not necessarily imply richness, as interpretative work and theoretical integration must be reported in a meaningful way.

In summary, the APQ's employment in single-case studies has yielded a small but substantial body of insights around processes and advantageous APQ usage. If anything, it has shown that adolescent girls with depression are not at all a homogenous group: the APQ helped to better understand the ways that comorbidities, pre-treatment characteristics and therapists' techniques have influenced the therapeutic process and outcome in individual treatments.

Methodologically, these case studies, performed with the APQ as a Q-sort, are examples of gleaning subjective knowledge, or a viewpoint, from the observer of the therapy sessions in question and studying it empirically. The rankings, or viewpoints, achieved in each study can also be interpreted and analysed by a third person (e.g. the researchers, the readers) starting a cycle of subjectivity (Rost, 2021). Using Q-sort methodology in these single-case studies has the unique advantage of reliably and experimentally capturing subjectivity (Watts & Stenner, 2012). Rather than striving for an objective take on data, Q-sort methodology acknowledges and captures not only

the complexity of the subject matter but also the multiple subjective viewpoints on it (Rost, 2021). Q-methodology, where used, was optimally placed to identify congregations of similar elements within complex data (Rost, 2021).

Other Applications

Bambery et al. (2007) have combined within-treatment session-ratings and prototype-paradigm methodology to track the development of a child and adolescent psychotherapy trainee in supervision. Their aim was to observe, articulate and measure therapeutic process during the trainee's desired development of a more psychodynamic and less cognitive-behavioural therapeutic style. Four consecutive audio-recorded sessions drawn from the first and second year of treatment with a 14-year-old were contrasted (#12-15 vs. #43-46). Q-sorts from all sessions were compared to CBT and psychodynamic ideal prototypes. During therapy training, where anxiety regarding professional development into a therapist is running high, using audio-recordings circumvents the often-deemed self-serving recollections of process notes (Fonagy, 2009) and provides objective data that might have otherwise remained unexpressed in supervision (Bambery et al., 2007).

Over the course of training, correlations with the CBT prototype reduced and correlations with the psychodynamic prototype increased. Whilst this was a single example of APQ usage in supervision, experiential feedback from the trainee was positive. The use in supervision could be expanded to identifying recurrent patterns of interactions within a treatment and mapping process and outcome in a treatment case.

Of course, it is questionable whether clinicians' and supervisors' ratings on their own cases are reliable, but colleagues could be recruited to aid ratings. If this exercise was repeated today with the formally validated APQ, scores might more accurately represent the process. A concern with this paradigm is that clinicians in

psychodynamic or psychoanalytic trainings are encouraged intentionally to rely on using countertransference feelings to inform them about a patient's experience and hence choice of technique. In this respect, using a structured measure such as the APQ for supervision could be perceived as a defence against using the feeling states aroused in the developing trainee. APQ use for this purpose might therefore best be explored on a case-by-case basis. More generally, the study introduced the paradigm of comparing prototypes to real session ratings, highlighting the possibility of the APQ to assess treatment fidelity in many contexts (e.g., research, supervision) in the future.

Exploration of Potential Uses of the APQ

Critical Review of the APQ's Application and Potential

At the stage of full validation, the APQ appeared compatible with the adolescent psychotherapy process research agenda in several ways. Firstly, the APQ permits systematic and direct observations of therapeutic processes in naturalistic settings. Direct observation of therapy processes has been advocated widely due to being seen as more accurate than therapist memory or post-hoc inferences (Bambery et al., 2007; Avdi & Seikkula, 2019). Due to providing an 'ecologically valid perspective' (Ablon, Levy, & Smith-Hansen, 2011, p. 24), direct observation could also stimulate interest in research amongst practitioner groups that have traditionally avoided this area: Midgley (2004, p. 89) found that one of the reasons psychodynamic psychotherapists typically did not participate in research was that traditional research did not seem to do 'justice to the complexities of therapy'. It is possible that the APQ with its ability to capture the particularity of the therapeutic encounter might allow more adolescent therapists to get engaged with research and research findings. In the era of evidence-based practice, clinicians' continued engagement with research is an issue of existential significance and aids the dissemination of research findings into routine

clinical practice, continuously aiming to improve patient outcomes (Yanos & Ziedonis, 2006).

Nevertheless, even in direct observation there is a range of observable and impactful clinical interactions that the APQ does not capture: non-verbal interactions such as postures, gestures, movements, facial expressions, gaze, and tone of voice (Avdi & Seikkula, 2019; Lepper & Riding, 2006; Odhammar, Goodman, & Carlberg, 2019) are likely to be missed in detail. Two APQ items make explicit reference to non-verbal displays of feelings (e.g., item 1: 'Young person expresses, verbally or non-verbally, negative feelings towards therapist') and one item addresses generic non-verbal behaviours (item 2: 'Therapist draws attention to young person's non-verbal behaviour'). Nevertheless, the important ways that the subtle non-verbal aspects of therapeutic communication co-create meaning in the therapeutic process are likely beyond the scope of the APQ. This point is related to another possible weakness of the APQ, namely its inability to capture micro-processes or highly complex processes in therapy. Empirically assessing moments of change, Krause, Fernández, and Bräutigam (2015) suggested that therapeutic change consists of micro-processes that occur continuously throughout therapy. The APQ strikes a difficult balance between capturing 'a wide range of interventions, events, and processes that could be observed in several treatment orientations' (Calderón et al., 2017, p. 108), whilst also maintaining a lens focused enough to be expressive about the minute details and complexities of the therapeutic process, such as moments of change (Gonçalves et al., 2012). By having cast its net widely, more microscopic processes, as well as more multi-faceted constructs, are arguably better captured by more specific measures. This has been partly confirmed in Elvejord and Hooper Storeide's (2018) finding that

the APQ's interrater reliability decreases in sessions that feature more complex and ambivalent processes.

Direct observation, however, also means that the APQ is marked by limited access to the patient's inner feelings or the feelings provoked in the therapist (Odhammar et al., 2019), unless they become observable through actions. In this way, the APQ's strength of allowing objective and systematic observations is at the cost of allowing for subjective and internal experiences to become part of the observation. Imagine 'Item 32: Young person achieves new understanding' in the context of a patient responding '*hm*' to a suggestion made by the therapist. Something might have changed for the young person, yet unless they make their thought process explicit, the item cannot be rated as characteristic of this phenomenon. Failing to capture young people's experience of therapy can be costly as Krause et al. (2015) have found adolescents' experience predictive of treatment outcome and have advocated for increased measurement of subjective experience in adolescent therapy research. Similarly, Jørgensen (2004) warned that measures focused on 'objective' factors will struggle to capture change arising from the therapist and patient's process of intersubjectively generated meaning. The APQ's blind spots are those processes that are subjectively meaningful to young people in therapy but not overtly expressed. For example, item 9 describes 'Therapist works with young person to try to make sense of experience'. Depending on the young person's history, this could be subjectively experienced as being understood and engaged with, or alternatively as insistent and intrusive. Either of these subjective experiences, or any other possible one, are likely inaccessible to the methodological grip of the APQ but might well determine the item's impact on the therapeutic process, if any.

The APQ's applicability in naturalistic clinical practice, featured in Levy and Ablon's (2012) list of child and adolescent psychotherapy research recommendations, does come, however, with certain advantages. The problems usually encountered in transferring treatment knowledge from research into direct clinical practice (Fonagy et al., 2015; Hughes, 2000; and Lis et al., 2001) with regards to clientele, setting and treatment conditions are significantly reduced if findings are gained from ordinary clinical practice. Further, the APQ's adaptability is also evident in its effortless triangulation with other process and outcome measures. Triangulation, in turn, can facilitate multi-faceted empirical process analyses of successful and unsuccessful treatments and their variables (Levy & Ablon, 2012), which Bambery et al. (2007, p. 407) called 'the next logical step in youth psychotherapy research'.

From a methodological perspective, the APQ's versatile Q-sort methodology has allowed usage and statistical analysis within a single session, within an entire treatment, across treatments, and across studies. Levy and Ablon (2012) and Kazdin (2009) have stressed that a session-by-session approach permits the arrangement of mediators of change and symptom improvement in the order of their occurrence whilst still accounting for the individually unique therapy process. Through using a validated empirical measure, the single-case studies conducted with the APQ so far have arguably circumvented the commonly identified criticism that interpretation of data is not rigorous, systematic and comprehensive enough (McLeod, 2010). Most studies achieved a meaningful integration of various measures over time so that the different aspects of the process were pulled together to create something new in detail or description. This is a promising area of application for the APQ with substantial potential to better understand the active ingredients of therapeutic change.

Items of interest can also be pooled across treatments to understand therapeutic processes related to them. Kazdin's (2009, p. 424) vision of finding factors that 'repeatedly emerge' as relevant points of interest whilst others repeatedly remain less salient has been achieved in Calderón et al.'s (2019) interaction structure study and could continue to be realised with widespread use of the APQ. Given the idiosyncrasies to each individual therapeutic relationship, it would require an extremely widespread use of the APQ and a subsequent integration of results in order to detect those overarching ingredients of change. However, the APQ's good interrater reliability means the therapeutic process is measurable across independent raters, facilitating wide usage and comparability of the measure across studies.

The paradigm that benefited most from combining insights from different studies has been the prototype paradigm, used in almost half the APQ studies conducted to date. Often used as an initial procedure to ensure validity as part of measure creation or translation, it evidenced the APQ's discriminatory capacity. From a methodological and theoretical perspective, however, the prototype paradigm appears rather circular: as described, items were created based on studying relevant literature on dominant modalities, presumably the same theoretical literature that informs the training of clinicians in this modality. Going forward, there is a risk of using the APQ to perpetually reconfirm the theories and techniques of well-established psychotherapy schools rather than identifying those factors actually linked to change. Moreover, imagined therapy sessions differ from actual therapy sessions. Whilst 'ideal' sessions confirm that the APQ captures what practitioners imagine sessions to be, it remains unclear whether they capture relevant processes in the actual therapy hour. Surprisingly, this has not been taken up as a methodological flaw in any of the studies reviewed. Examining those items that feature as least salient in adolescent

psychotherapy in general and also in some of the prototypes, one can find 'Item 44: Young person feels wary or suspicious of the therapist' and 'Item 41: Young person appears to feel misunderstood by the therapist' (Bychkova et al., 2011, pp. 343-345). The 'ideal prototypes' do in fact appear to be idealised versions of adolescent therapy, in the way that they tend to avoid the non-harmonious aspects of the relationship. In terms of face-validity, sessions with young people can include those awkward and frustrating interactions, although practitioners might well avoid thinking of them in their 'ideal practice'. Whilst the prototype might describe the main techniques in the practitioner's toolbox, Calderón et al. (2019) showed that when real world practice becomes challenging, therapists from different orientations are pulled to abandon some of their supposedly 'ideal' ways of working, maybe even using an unusual amount of clinical skills. In other words, for most therapists the question of what we should be doing is easily answered, but to find guidance on how to respond and what we are doing in those much harder, awkward and challenging sessions is really what we want answered – and what the APQ can help us answer. Consequently, real-session application is to be favoured over prototype paradigms going forward.

This links with the APQ's capacity to explore the therapeutic process from a pan-theoretical view, focusing on items that emerge as relevant from the data, rather than on pre-determined theories of change. Levy and Ablon (2012) have argued that research will have to move away from focusing on competing psychological theories if it wants to identify relevant change-inducing treatment processes. Of course, the APQ is by no means an entirely neutral measure, given that its individual items are derived from relevant existing psychological theory and reviewed by experts trained in distinct therapeutic approaches (Calderon et al., 2014). It might be better described as theoretically balanced, incorporating items from different theoretical origins in

neutral language, with the result of being adaptable across theoretical orientations. Some have argued that theory, especially a general understanding of developmental change and developmental psychopathology, is essential when wanting to research the more specific mechanisms responsible for treatment outcome in child and adolescent psychotherapy (Hughes, 2000; Levy & Ablon, 2012). The APQ, with its grounding in theory but a potential for pan-theoretical application, is arguably well suited for the cooperation 'between empiricism and theory' (Hughes, 2000, p. 302). The APQ appears theory-informed enough in its development yet bottom-up enough in its mechanism of detecting therapeutic processes to facilitate a multiple factor model for therapeutic change and aid manual development (Gaston & Gagnon, 1996). Given how little is known about factors in therapy-induced change, casting a wide net with a sensitivity for a range of pre-selected possible mediators might be favourable (Jørgensen, 2004). Levy and Ablon (2012) have also stressed how measures that can capture both relational and technical factors relevant in psychotherapy process are much needed, a combination that very much characterises the APQ. In this way, the APQ also maximises its own applicability, the advantages of which have been summarised above.

Focusing on the APQ's application as a Q-sort measure, several merits stand out. Firstly, the APQ allows for both quantitative and qualitative analysis, making it suitable for the versatility needed in the therapy process research field. Within quantitative analyses, both Q-analyses and aggregating mean item scores are possibilities, and both have already been applied in studies mentioned above. Within qualitative analyses, detailed exploration of each session's Q-sort, the Q-sorts of an entire therapy, as well as 'interaction structures' are possible. However, what sets the APQ as a Q-sort apart in particular is its *gestalt* character, i.e. the configuration of the

entire Q-set and how each item's placing is interdependent on the other items' rankings. Using the APQ repeatedly for psychotherapy sessions can then allow for qualitative or quantitative analysis of the resulting Q-sorts, assessing how the whole shape of a psychotherapy session (i.e. the process of psychotherapy) changes over time (Rost, 2021). This latter aspect of the APQ being a *gestalt procedure* also allows for the complexity of psychotherapy sessions to be expressed: rather than focusing on single variables, an APQ Q-sort can relate different aspects in a therapy session to one another other.

Finally, the APQ's sensitivity to the adolescent process is arguably its biggest contribution to the adolescent psychotherapy process research field. Items in relation to sexuality, peer relationships, feeling misunderstood, irritation, and others all ensure that the distinctive features of the adolescent process can be identified and examined in the context of the therapeutic relationship and its outcome. In this way, it is an unprecedented measure that, in summary, allows for a wide variety of experimental designs aimed at shedding light on the adolescent psychotherapy process.

Learning From Previous Experience

The PQS and CPQ have been used since 1988 (Ablon et al., 2011) and 2004 (Schneider, 2004), respectively, offering a longer period of trial-and-error of successful research paradigms. Due to the three scales' nearly identical structure, paradigms that led to new insights or lines of enquiry are easily transferrable.

Within single-case studies, researchers have successfully used time-series analysis to trace treatment processes co-created by therapist and patient (Ablon et al., 2011). Rather than averaging items or creating clusters, this analytic technique allows tracing in detail how certain therapeutic interventions influence a patient's reaction and, vice versa (see Jones, Ghannam, Nigg, & Dyer, 1993; Spence, Dahl, & Jones, 1993). This

method could prove useful in the examination of therapy with youth, which is so often marked by ambivalence, fickleness and powerful emotions that can make it difficult to establish sequence and direction of interaction processes. Using interaction structure clusters, Goodman and Athey-Lloyd (2011) employed the CPQ and statistical analysis to reveal how several identified interaction structures wax and wane over the course of a treatment. The authors also showed that the CPQ can detect individual therapist contributions with the same client, which is something still to be demonstrated with the APQ. Similar to Jones et al. (1993), it would help to explore how in therapy with adolescents, the therapist's and client's behaviors are mutually influencing, giving depth to the study of the therapeutic process over time. Furthermore, for single-case studies or use in supervision, developing a case-specific ideal technique prototype driven by case formulation has proven useful to monitor adherence and trace process (Ablon et al., 2011).

In contrast, applying the APQ to a large number of sessions, similar to Calderón et al.'s studies (2017; 2019), but with the addition of making links to outcome, will allow the detection of 'empirically supported change processes' (Ablon, Levy, & Katzenstein, 2006, p. 216). Importantly, large scale application of the PQS to sessions has shown that the items linked to positive change are not necessarily the most characteristic ones. Importantly, this finding calls into question the perhaps intuitive practice of listing the ten least and most characteristic items of a treatment and should encourage researchers to become more innovative to detect active ingredients of change (Ablon et al., 2011). To finish on one such creative design, Lilliengren et al. (2019) compared successful and unsuccessful cases from different modalities for a particular patient group, identifying different sets of items that characterised successful and unsuccessful treatments respectively. There are other variables according to which

cases can be grouped and compared, e.g. rapid vs. slow response to treatment (Ablon et al., 2011). The above paradigms inspire innovative ways to use the APQ whilst tailoring it to adolescent therapy related research questions.

Conclusion

In summary, studies using the APQ so far have highlighted the APQ's versatility and its clear contributions to adolescent psychotherapy process research. The studies demonstrated the APQ's strong discriminant validity, i.e. its sensitivity to subtle differences in therapeutic techniques and interactions. Whilst possibly missing non-verbal factors and within-session variability, the APQ's use of direct observation in real-life clinical settings, suitability for various statistical analyses and triangulation as well as its ability to facilitate process-outcome links give the APQ great potential and flexibility for future use. Taking account of the adolescent process in psychotherapy through a neutral language and across therapy modalities gives the APQ potential to significantly contribute to the study of empirically supported factors in therapeutic change.

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Part 2: Empirical Research Project

What therapy processes precede dissatisfied dropout in STPP for adolescent depression: a single-case qualitative exploration guided by the Adolescent Psychotherapy Q-set

PDWX6

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Abstract

Background: A significant percentage of young people in treatment for depression drop out of psychotherapy, some due to dissatisfaction with the therapy offered. The therapeutic processes preceding dissatisfied dropouts in the adolescent population are insufficiently understood.

Aims: The current single-case study aimed to explore the therapeutic process of a 12-session, prematurely-ended therapy with a young person dissatisfied with short-term psychoanalytic psychotherapy (STPP) received for depression.

Methods: The Adolescent Psychotherapy Q-set (APQ), an empirically validated process measure, was used in tandem with clinical case analysis to explore the therapy process over time.

Results: The analysis of twelve APQ ratings found a productive patient-therapy couple working collaboratively to understand the young person's experiences and emotions. Following an initial phase of the young person presenting as emotional and vulnerable, she became increasingly ambivalent about partaking in psychotherapy. A lively and argumentative period exploring the young person's ambivalence and increased sense of well-being culminated in eventual dropout.

Conclusion: Even in a strong, collaborative working relationship with an engaged young person, ambivalence around dependency and vulnerability can threaten treatment completion. The APQ is a suitable measure to explore general treatment processes preceding dropout, but its usefulness could be enhanced through systematic methodological pluralism.

Impact Statement

The current empirical single-case study offers a range of insights and additions to knowledge that are potentially beneficial to the research community and to clinical practice in the public health care system.

The fields of psychotherapy research and practice are most likely to benefit from the current study. Its impact will be greatest in the two areas of a) measure development and usage and b) knowledge and knowledge development in adolescent psychotherapy processes.

Measure development and usage: The data analysis of the current study is guided by the use of a relatively new empirically validated psychotherapy process measure tailored to the therapy process with adolescents, the Adolescent Psychotherapy Q-set (APQ). The APQ's application is still limited to a handful of studies. At this early stage, new studies using the measure are likely to discover new and innovative ways of using it, experimenting with the measure's potential and inspiring other researchers in its usage. With an increased number of studies using this measure also comes the benefit of comparative knowledge and cumulative knowledge in research fields, e.g. interaction structures detected with the measure that are observed across therapies / primary diagnoses, etc. Furthermore, every time the measure is used, it goes through a process of testing and refining its applicability,

which will slowly refine what is known about its strengths and weaknesses and thus inform judgment on choice of research measures in future studies.

Knowledge and knowledge development in adolescent psychotherapy processes: The study anticipates being of use in the research field of adolescent therapy processes as well as the clinical practice of psychotherapies offered to adolescents. As has been highlighted in the study's review of the literature, therapy processes leading up to dropout in therapies with adolescents have hardly been explored empirically, although some important insights guiding further research have been published recently (O'Keeffe, Martin, & Midgley, 2020; O'Keeffe, Martin, Target, & Midgley, 2019b). In order to observe, think about, and conceptualise what might happen in therapies that end with the young person leaving therapy prematurely, more knowledge in this area has to be gathered and shared within the professional and research community. Single-case studies are in a good position to engage the community of practitioners. They are also a good starting point for theory production and conceptualisations of dropout. The study aims to generate discussion and thinking about the findings relating to therapy processes in premature endings with adolescents amongst the clinical therapist community and to invite further research; guidance on this is given within the paper. For example, the study explored one layer of in-treatment processes but suggested how these will be complemented by other research methods and sources to yield a more multi-faceted picture of therapy dropout.

Further down the line, this research might benefit the health care systems (economically) and their recipients, i.e. young people in therapy. If therapists can enhance their sensitivity to relevant processes in therapy dropout and keep young

people in therapy for longer, more optimal outcomes might be expected and resources for recurring treatments spared.

Introduction

Different psychological and developmental approaches agree that adolescence is a time of great change and potential turmoil with unique developmental tasks and challenges. Psychodynamic conceptualisations of adolescence include adolescents' high levels of ambivalence, the negotiation of peer and romantic relationships, their growing independence and separation from parental figures and the task to establish a stable adult identity (Stambler, 2017). Young people are at significant risk of failing to adapt adequately to these developmental demands. Such failure can cause troublesome internal and external conflict and, in some cases, psychopathology (Cicchetti & Rogosch, 2002).

One such psychopathology is adolescent depression, which presents a significant individual, societal and public health burden (TADS team, 2004). Next to pharmacotherapy, a range of therapies have been identified as effective, including cognitive-behavioural therapy (CBT), short-term psychoanalytic psychotherapy (STPP), or a combination of psychological therapy and anti-depressant medication (Goodyer et al., 2017; TADS team, 2004; Young et al., 2016). Nevertheless, regardless of overall effectiveness, between 28% and 75% of young people drop out of therapy (de Haan, Boon, de Jong, Hoeve, & Vermeiren, 2013). In the most recent large-scale naturalistic UK-based trial comparing treatments for adolescent depression, the dropout rate was 37% (O'Keeffe et al., 2017). These numbers raise concerns about engaging young people in therapy effectively for optimal treatment benefit (Shirk, 2001).

Treatment dropout is widely defined as an ending of therapy not mutually agreed between patient and therapist, but can have different definitions, e.g. minimum treatment length or independent patient decision (O’Keeffe et al., 2017). Research exploring dropout in adolescent therapies has primarily focused on risk-factor models (Kazdin, 1996), examining the effects of pre-treatment factors, treatment factors and patient characteristics. O’Keeffe et al. (2017) found that older age, the presence of antisocial behaviour, lower verbal intelligence, lower early therapeutic alliance, and early missed sessions were all factors that increased risk of therapy dropout. Ormhaug and Jensen (2016) found that lack of caregiver attendance and low parental treatment approval also predicted adolescents’ dropout of therapy. It is unclear, however, whether dropping out of treatment necessarily leads to poorer outcome in adolescent samples. O’Keeffe et al. (2019a) found that dropout from STPP increased the risk of meeting criteria for depression in the medium but not the long term, whilst dropout from CBT increased the odds of meeting criteria for depression in the long-term only. There is a clear need to better understand the diversity within therapy dropout among adolescents, and potential treatment failure, to increase the effectiveness of treatments for these young people.

A crucial approach to improving our knowledge about dropout in adolescent therapy is a client-led perspective (Elliott, 2010). In the first study of its kind, O’Keeffe, et al. (2019b) used retrospective client and therapist reports to differentiate between adolescents dropping out of treatment for different reasons. Some young people reported they ‘got what they needed’ from therapy, whilst others appeared ‘too troubled’ by other life stressors to focus on therapy. A third group explicitly expressed dropping out because of dissatisfaction with treatment. In particular, these dropouts expressed that they left therapy due to a perceived lack of benefit. The therapists of

such dropout cases reported a reluctance in the young person to engage. This type of dropout was particularly common amongst STPP cases, suggesting there might be particular aspects of STPP that young people are more easily dissatisfied with (2019b). The above distinction of dropouts into three different categories helps to further identify particular types of dropouts that might be expected to fare worse in therapy, e.g. 'dissatisfied dropouts'. However, adequately powered studies to investigate whether treatment effectiveness does actually differ between dropout types are still needed (O'Keeffe et al., 2019b).

Despite progress in understanding pre-treatment risk factors and retrospective patient and therapist accounts with regards to dropout, limited conceptual knowledge regarding the in-therapy processes leading young people to drop out of therapy exists. Typically, conceptualisations are theoretical in nature. Blotcky and Friedman (1984) suggested dropout is likely determined by processes at multiple levels. Their conceptualisations of potential processes in treatment dropout include that young people deny depressed feelings by translating them into action and drop out of treatment to free themselves of the exploration of emotions in therapy; that unaddressed difficulties in the adolescent-therapist relationship, such as rebellious feelings towards parents in the transference, contribute to dropout; that a strict adherence to a therapeutic model without attention to the young person's suitability to the treatment might leave the young person feeling misunderstood and left out of treatment decisions; that young people's parents can undermine the therapeutic work through overtly and covertly pressurising the young person to abandon treatment.

Only limited empirical research on in-therapy processes preceding dropout in young people that could illuminate the applicability of these theories exist. O'Keeffe, et al. (2020) directly observed that within treatments of 'dissatisfied dropouts'

(O’Keeffe et al., 2019b), more in-process confrontational and withdrawal ruptures happened, that these ruptures had higher therapist contributions and were less likely to be resolved when compared to ‘got-what-they-needed’ dropouts and therapy completers. They also observed that ‘dissatisfied dropouts’ had comparably lower working alliances than the other two groups and that their working alliance diminished over the course of therapy. Taken together, this research supports some of Blotcky and Friedman’s (1984) conceptualisations of dropout. Importantly, it highlights in-therapy processes, patient-therapist interactions and therapist activity as highly promising areas of research into the potential factors contributing to dropout.

A search of relevant databases, however, has failed to identify any other studies on therapy processes before dropout, including dissatisfied dropout. Of the three distinct groups identified in O’Keeffe et al.’s (2019b; 2020) research, the dissatisfied group is particularly worthwhile to examine further because of the potential to learn about therapeutic processes influencing dissatisfaction and dropout. Cases that used STPP are of particular interest given their overrepresentation in the group of dissatisfied dropouts and the status of STPP as a recommended treatment in the 2019 National Institute for Health and Care Excellence (NICE) guidelines for moderate to severe depression in adolescents (NICE, 2019). Further examination of this group might allow for adaptations of technique that could have abated the aspects of therapy experienced as negative to the young people.

The current study addresses the question of what therapy processes precede dissatisfied dropout in STPP for adolescent depression. Through doing so it aims to improve our understanding of processes leading up to dropout in young people who reported being dissatisfied with their treatment. The study findings could help inform

future practice and retain young people in therapy for longer, possibly leading to better outcome.

Methods

a. Methodology

To address the study aims, the study used an exploratory, single-case, direct-observation design to produce a process-outcome study, i.e. exploring the therapeutic processes preceding the outcome of dropout.

Due to the scarcity of research in this field, an exploratory design is beneficial as it minimises the risk of overlooking potentially relevant avenues of inquiry. Additionally, in psychotherapy research, single-case studies are favoured as the primary means of discovering concepts and of illuminating meaning and intersubjective processes in under-researched fields (Midgley, 2004). As single-case studies are criticised as potentially creating seductively compelling but highly subjective narratives (Midgley, 2006), the current study addressed these limitations through using direct observation and combining a qualitative reading with systematic ways of analysing clinical data. Direct observation of the therapy process, e.g. through audio recordings, circumvents potentially erroneous therapist recollection and provides objective data (Bambery et al., 2007). Direct observation studies might also attract interest by psychodynamic psychotherapists, who Midgley (2004, p. 89) found were 'least likely to find research helpful' because it did not do 'justice to the complexities of therapy'. Qualitative reading of the data for identifying therapy processes is an essential part of the analysis as it is highly suitable to generate new understanding from a small data set (Midgley, 2004), illustrates how interactions manifest in practice, and is a sought-after element in the empirical study of child and adolescent psychotherapy (Ansaldo & Papadima, 2020). To achieve more systematic

observation, observer-based empirical measures were employed to define, describe, quantify and make comparable aspects of clinical material over time, utilising the principles of empirical science (Ablon & Jones, 2005).

b. Setting

The study drew on data from the IMPACT study (Improving Mood with Psychoanalytic and Cognitive Therapies; Goodyer et al., 2017), a randomised controlled trial assessing the effectiveness of CBT and STPP against a brief psychosocial control intervention (BPI) in the treatment of adolescent depression in a UK naturalistic public health care setting. Of the 470 young people aged 11 to 17 years, the mean age was 15.6 years, 75% were female and 85% were of white ethnic origin (Goodyer et al., 2017, p.39). Twenty percent of young people were prescribed antidepressant medication prior to the study (Goodyer et al., 2017, p.39).

With regards to overall effectiveness, all three treatments were effective at reducing the primary outcome measure of self-reported depression symptoms. By 86 weeks, all treatments succeeded in roughly reducing these symptoms by half (BPI: 46.2 to 23.6; CBT: 46.2 to 22.3; and STPP: 45.4 to 21.8; Goodyer et al., 2017, p. 50). When measured at 36 weeks, 52 weeks and 86 weeks from baseline, there was no significant difference in effectiveness between CBT and STPP, nor between CBT and STPP combined when compared to BPI (Goodyer et al., 2017).

With regards to therapy attendance and dropout, the number of recommended treatment sessions differed between the three treatments, with 12 being recommended for BPI, 20 for CBT and 28 for STPP. Whilst the median number of treatment sessions attended was significantly different, with 6 sessions in BPI, 9 in CBT, and 11 in STPP, the average duration of treatment was not significantly different (Goodyer et al., 2017). Across all three treatments, the overall therapy dropout rate

was 37%. Dropout rates were 32% in the CBT arm, 36% in the BPI arm, and 43% in the STPP arm, with none of those differences reaching significance (O’Keeffe et al., 2017). As reported above, in this sample dropout from STPP increased the risk of a poor outcome in the medium but not the long term, whilst dropout from CBT increased the odds of a poor outcome in the long-term only (O’Keeffe et al., 2019a).

The current study also references audio data from the IMPACT-My Experience (IMPACT-ME) study, a qualitative, longitudinal addition to the IMPACT trial investigating expectations and experiences of young people, their parents, and therapists (Midgley, Ansaldo, & Target, 2014). Data collected in the IMPACT-ME study included: an “Expectation of Therapy Interview” with young people and parents entering the IMPACT trial at time point 1 (T1) pre-treatment; an “Experience of Therapy Interview” offered to all families at time point 2 (T2) and time point 3 (T3) post-treatment; an interview with the young person’s therapist at T2, with the young person’s consent (Midgley, Ansaldo, & Target, 2014).

c. Ethical considerations

Ethical approval for the IMPACT and IMPACT-ME studies was granted by the Cambridgeshire 2 Research Ethics Committee (reference 09/H0308/137). Written informed consent was obtained from all participants in the IMPACT and IMPACT-ME studies. To ensure anonymity, identifiable details in the data have been removed or disguised (Morse & Coulehan, 2015).

d. Operationalisation of dropout

For the purpose of this study, and in line with O’Keeffe et al.’s (2019b) subsample of dissatisfied dropouts, dropout was defined as the young person ending therapy without the prior agreement of the treating therapist, as reported by the therapist.

e. Sampling

An STPP case was purposefully sampled from O’Keeffe et al.’s (2019b) subsample of 16 dissatisfied dropouts (see their paper on sampling). STPP cases made up the largest share of O’Keeffe et al.’s (2019b) dissatisfied dropouts (12 out of 18). Additionally, being ‘dissatisfied’ was the most common type of dropout for STPP cases, with only one ‘troubled’ STPP case and one ‘got-what-they-needed’ STPP case (O’Keeffe et al., 2019b). This highlights the importance of focusing on this subgroup.

STPP is a manualised psychoanalytic once-weekly treatment model for adolescents delivered in 28 sessions (Cregeen, Hughes, Midgley, Rhode, & Rustin, 2017). STPP is designed to respond to adolescents with a complex clinical picture including losses, trauma and developmental difficulties. In application for depressed adolescents, STPP builds on theoretical formulations of depression and has clearly formulated aims and techniques based on psychoanalytic principles (see Cregeen et al., 2017 for details).

Sampling criteria constituted: an STPP case; attendance of a minimum of 6 sessions; sufficient audio data to enable therapy process exploration of an entire therapy. Of the three cases meeting these criteria, one was selected at random.

f. Participant and case background

The young person sampled for this single-case study will from here on be called ‘Megan’. Megan started treatment aged 17 years and had a baseline Mood and Feeling Questionnaire (MFQ) score of 46, indicating high levels of depression representative of the baseline score for young people in the STPP arm (M=45.4, Goodyer et al., 2017, p. 50; IMPACT clinical significance set at ≥ 26 , Goodyer et al., 2017, p. 33). Megan also met the DSM-IV criteria for a diagnosis of major depressive disorder at baseline level and at 52 weeks from baseline. Scores on the Revised

Children's Manifest Anxiety Scale (RCMAS; all scores below 27) and the short Leyton Obsessional Inventory (LOI; scores 0 to 1) indicated that Megan had no clinically significant comorbidities in the areas of anxiety and obsessive-compulsive symptoms before, during or after treatment (see Appendix 1). However, Megan repeatedly reported more than one count of antisocial behaviour on the Antisocial Behaviour Questionnaire (ABQ, scores 2 to 3; see Appendix 1). Her Health of the Nation Outcome Scale for Children and Adolescents (HoNOSCA) score was 11 at baseline peaked at 15 at 52 weeks and fell to 6 at 86 weeks post baseline.

Megan in total attended 12 out of the 28 sessions offered. She missed sessions 9, 10, and 14 before finally dropping out after session 15. After dropping out of her psychotherapy, Megan continued to engage with the IMPACT and IMPACT-ME research teams, providing outcome data and interviews about her experience all the way up to 86 weeks after baseline.

At the time of therapy, Megan's parents were separated and Megan was living with her mother. She reported overall positive relationships with her mother and step-father with an ordinary amount of parent-child conflict. She also reported an overall good relationship with her father who had remarried and had two more children within this new relationship. However, neither of Megan's parents or parental figures were aware of Megan's difficulties. When Megan talks about her family, there is no mention of any mental health difficulties in the family.

More subjectively, Megan's depression presented in the form of marked periods of feeling depressed and unmotivated, as well as emotionally overwhelmed and angry, sometimes resulting in extensive periods of crying. When feeling stressed, lonely, miserable or heartbroken, Megan described drinking alcohol or self-harming as her go-to coping mechanisms. However, Megan also periodically functioned well: in

therapy, she mostly presented as upbeat, chatty, and thoughtful. With regards to education, she regularly reported good grades despite struggles with motivation. She makes regular references to friendships and romantic relationships and appeared to generally function well within her social and family life.

Megan's journey to seek psychological support started with school counselling. After several weeks, Megan's counsellor recommended seeking psychotherapeutic support from CAMHS. Notably, Megan had not shared the referral or commencement of psychotherapy treatment with her parents or step-father. The therapy took place within a CAMHS clinic as part of the IMPACT trial and was delivered by a senior male qualified psychoanalytic child and adolescent psychotherapist. Halfway through therapy, Megan opened up to her parents about her depression and psychotherapy, but her parents did not take up the parent support offered.

The early therapeutic alliance between Megan and her therapist was high at 53 (Megan) and 54 (therapist) but decreased to 42 (therapist) and 33 (Megan) (see Appendix 2). Although STPP offers 28 sessions, Megan did not return to the therapy after session 15, having missed three previous sessions. At 6 weeks from baseline, Megan's MFQ score had reduced to 37 and continued to decrease to 30 at 36 weeks (several weeks after leaving treatment), to 21 at 52 weeks, and to 8 at 86 weeks after baseline, 1 year post treatment conclusion. Compared to average follow-up scores, Megan improved more than the average young person in the STPP study arm (see Appendix 1). Taken at face value, these scores also indicate that she was not experiencing clinical depression from about 1 year after treatment start. Megan never took anti-depressant medication, although this had been offered.

Megan announced her treatment dropout following session 15 by phoning the therapist and informing him of her decision. Despite dropping out of treatment, Megan

continued to engage with the IMPACT-ME study and attended interviews at 36 weeks and 86 weeks. In these interviews Megan expressed dissatisfaction with her therapy, which placed her into the 'dissatisfied dropout' category of O'Keeffe et al.'s (2019b) study. Her therapist's interview at 36 weeks also complied with the conditions for the 'dissatisfied dropout' category.

g. Data and analysis

Primary data The primary data used for analysis of the therapy process were the twelve audio recordings of Megan's psychotherapy. Primary analysis was undertaken using the APQ.

Adolescent Psychotherapy Q-set (APQ) The APQ is a pan-theoretical therapy process measure suitable for quantitative analysis, describing the psychotherapy process in adolescent therapies in a basic language (Calderón, Midgley, Schneider, & Target, 2014). It is comprised of 100 statements on the therapeutic process that are ranked according to their prominence within a session. The set of 100 ranked items creates an individual session profile, or Q-sort, which allows for statistical analysis of all its constituent parts, rather than focusing on one particular dimension (Ablon & Jones, 2005; Calderón, Schneider, Target, & Midgley, 2017). The items are grouped to describe: the young person's feelings, experience or behaviour (e.g. item 84 "Young person expresses angry or aggressive feelings"); the therapist's actions and interventions (e.g. item 27 "Therapist offers explicit advice and guidance"); the interaction between the therapist and young person (e.g. item 38

“Therapist and young person demonstrate a shared understanding when referring to events or feelings”¹) (Calderón et al., 2014).

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

As a *gestalt* procedure, the APQ is optimally placed to assess the shape of an entire psychotherapy session, through analysing how each item’s placing is interdependent on the other items’ rankings, not ever focusing on single variables. When used for successive psychotherapy sessions, the APQ allows for the complexity of the psychotherapy process to be captured as the change in shape of sessions over time can be analysed. Both quantitative and qualitative methods of analysis are applicable (Rost, 2021).

Primary data analysis

- Step one: The author was trained in using the APQ and attained reliability.
- Step two: The author listened to, transcribed, and coded with the APQ all twelve audio sessions. The author was blind to the order of sessions unless reference to this was made during the therapy session.

¹ From here on, ‘young person’ will be abbreviated to YP and ‘therapist’ will be abbreviated to T in the APQ item descriptors.

- Step three: Twenty-five percent of sessions were randomly selected by the research supervisor and double coded by another two reliably trained coders. The overall intraclass correlation coefficient was 0.722, which lay above the acceptable level (Ablon et al., 2011).
- Step four: Simple descriptive statistics (means and standard deviations) were performed in Microsoft Excel on all twelve APQ session ratings to identify the most salient items throughout treatment.
- Step five: The order of therapy sessions was unblinded and session transcripts and audio recordings were put in chronological order.
- Step six: The author listened to and re-read the entire data set of audio recordings and performed a clinical case analysis. Paying attention to changes in the therapy process allowed the author to identify two distinct phases of engagement.
- Step seven: As a result of the clinical case analysis, the author divided the APQ ratings of the twelve sessions into two sections of four and eight sessions, respectively.
- Step eight: In order to identify differences in therapeutic process between the two phases identified, APQ item means were computed for each phase. Following that, differences between each item's two means were then calculated and put in order of magnitude of change.
- Step nine: The author identified APQ item clusters that were relevant to the research question: The first APQ three-item cluster was named 'disengagement process', consisted of items 73 (YP committed to therapy), 75 (T focuses on ending) and 95 (YP finding therapy helpful) and was tracked across all twelve sessions. The second APQ three-item

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

- Step ten: The author created a narrative consisting of: the ten most and least APQ ratings across all twelve sessions; the phase differences in APQ ratings; the trajectory of the two APQ item clusters. The narrative created through the APQ ratings and clinical case analysis was then presented in combination with supportive excerpts from the session transcripts, which would serve as examples of the narrative.

APQ codings were the starting point of analysis, yet qualitative readings and APQ codings were returned to in an iterative way in the steps described above to piece together a dynamic and rich picture of the therapeutic process preceding dropout. Session transcript excerpts evidence and provide examples of the identified findings.

Additional data The MFQ, the primary outcome measure in the IMPACT trial, was used to track the young person's depression severity over time (Appendix 1). Standard IMPACT study secondary outcome measures (RCMAS, LOI, ABQ, and HoNOSCA, as mentioned above; see Appendix 1) were used to describe Megan's comorbidities. The Working Alliance Inventory (WAI), completed by patient and therapist, was used to elucidate the therapeutic alliance (Appendix 2). Audio recordings or transcripts of the IMPACT-ME interviews with the young person (at T1, T2, and T3) and the therapist (at T2) were consulted to provide case background information. For example, it was in one of the posttreatment interviews rather than a session audio recording, that the author found out about how the young person terminated treatment.

Additional data analysis

Additional data was not formally transcribed or analysed and was only drawn upon to situate the case and enhance perspectives on the therapy process as presented in the primary data analysis. In order to prevent biases gained from this information, additional data was only consulted after all primary data coding and the clinical case analysis had been completed.

h. Reflexivity & validity

The author has a prior interest in psychoanalytic psychotherapy and is currently completing their training as a psychoanalytic child and adolescent psychotherapist. The author hence had an interest in STPP and in contributing to the growing adolescent therapy process literature. Regular supervision and double-coding provide a layer of validity to the findings. The triangulation of findings with outcome data enhances internal validity.

Results

Findings resulting from the APQ analysis will be presented together with therapy session excerpts illustrating these findings. Together, they create a narrative account of the trajectory of the therapy.

a. Overall therapy process descriptors

The seven 'most characteristic' and the three 'least characteristic' APQ items across all twelve sessions are shown in Table 2².

² The relative importance of the top and bottom end of a q-sort distribution is in practice not necessarily symmetric. Inclusion of items into the ten most salient characteristics was decided by the author upon qualitative analysis of salience.

Table 2

Overall Therapy Process Descriptors. Ten Most Prominent (7 Most and 3 Least Characteristic) APQ Items Overall

Item no.	Item description	M	SD
9	T works with YP to make sense of their experience	8.83	0.39
60	T draws attention to YP's way of dealing with emotions	8.58	0.51
98	The therapy relationship is a focus of discussion	8.50	1.00
6	YP talks about emotional interactions with others	8.00	1.28
50	T draws attention to unacceptable feelings	7.75	0.75
74	Humour is used	7.33	0.65
97	T encourages reflection on internal states	7.25	0.62
5	YP does not understand T's comments	1.67	0.89
15	YP does not initiate or elaborate on topics	1.33	0.49
58	YP resists the T's attempts to explore	1.17	0.39

Note. This table shows each item's mean placement (between 1.0 and 9.0), and their standard deviation

The therapist consistently works hard to make sense of Megan's experience (item 9) by focusing on her internal states (97), the way she deals with emotions (60) and feelings she might find difficult to accept (50). Megan, in turn, initiates topics and elaborates (15), readily understands the therapist's comments (5) and allows further exploration (58). Their exchanges are also marked by humour and wit (74). Finally, the therapist consistently brings the therapy relationship into sessions (98). The following extract from session 2 gives an example of the above:

YP: I guess in the past (...) it never really occurred to me majorly until, like, going out with [ex-boyfriend] or like, certain things made me really angry and stuff. Like, I noticed that I had to, like, breathe and calm down and stuff, erm. But yea.

T: So, it sounds like (...) you could have quite a powerful response to these things. And it quite worries you how much you can react (*yea*) and feel out of control. And I don't know, I was thinking, maybe, maybe there was something about, thinking about "what's this going to be like, coming here". And whether you're going to have a bit of a reaction to it, (...) am I gonna upset you (*yea* '*laughs*') are you gonna feel vulnerable, are you going to feel all of those things, or are you going to feel cross, and would you really want to?

YP: Yea. Yea, that was kind of one of the first things that came into my head when they, like, suggested, erm, like in kind of therapy (*right*). Just 'cause talking about things brings up a lot and it just makes me think about more things, so (...) '*laughs*'.

Megan and the therapist began to talk about how Megan manages emotions and relationships early in the therapy. Megan appears in touch with her feelings and the therapist follows her narrative and highlights the way of her internal workings. From the beginning he brings the feelings voiced by Megan into the therapeutic relationship. In this vignette, Megan agrees with him and elaborates on her fears about therapy. This robust interaction structure of a curious therapist exploring the unconscious workings of Megan's affect in the transference and Megan as an open and collaborative young person persists throughout therapy. However, Megan's discourse on talking about her emotions markedly changed through the course of therapy. The following vignette is drawn from session 7:

YP: I'm the kind of person that if I'm upset, I'm upset. But if something's happened that's really upset me and, like, I'm explaining it but not thinking about it, I don't really feel it. (...)

T: So, you're distancing yourself from the feeling.

YP: Yea. Which I don't think is a problem. 'Cause it's just like, it's like a way of confiding in someone without getting tears out of -

T: Without it becoming overwhelming. Well, I suppose, (...) maybe you wonder whether I can cope with you being distressed, actually. Whether I'd be interested or whether I'd say that "that's enough, actually, sorry, we gonna end the session now". (...)

YP: '*Laughs*'. No, not so much, 'cause, like, it's your job, so you kinda have to deal with it, '*laughs*'.

Megan and the therapist continue to work together in line with the most salient APQ items, yet Megan's view on how talking about herself affects her in the moment has changed. Whilst in session 2 the idea of talking evoked a lot of feelings in Megan and made her feel vulnerable, she now reports that it leaves her emotionless and that she cannot be in touch with her experiences.

b. Two phases

A marked change in attitude towards therapy was identified in session 5. Megan starts this session by saying:

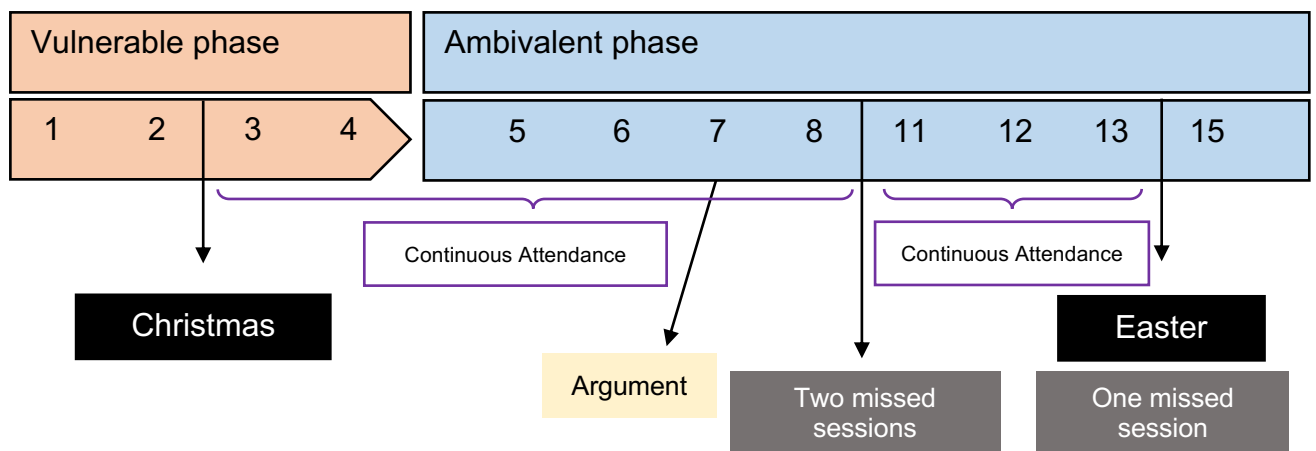
YP: Hello '*laughs*'. Erm. (*Silence*) I was thinking about like how I am now compared to how I was like, kind of, the start of last year, kind of middle of last year. And I was thinking, like, how, I'm still feeling the same, like, sadness most of the time, (...) I don't know. I was thinking about the whole, like, this. And I'm not sure how it's supposed to help. (...). Like, I don't see how, like, talking about things helps.

From here on, the idea of psychotherapy being useless was repeatedly expressed by Megan. Qualitative analysis identified two phases: phase 1 includes sessions 1 to 4 and was dominated by a discourse focusing on Megan's emotional

struggles and how the process of therapy brings up emotions and makes Megan feel vulnerable, uncomfortable and overwhelmed. Phase 2 includes sessions 5 to 15 and focuses on an exploration of Megan’s ambivalence and emotionlessness in therapy, with the dominant discourse of ‘this isn’t helping’. Figure 1 offers a visualisation of the therapy process including these phases.

Figure 1

Phases, Attendance, Breaks, and Missed Sessions in Megan’s Therapy



APQ items from phase 1 and phase 2 are presented in Tables 3 and 4, respectively.

Table 3

Phase 1 Therapy Process Descriptors. Eleven Most Characteristic and Ten Least Characteristic APQ Items of Phase 1

Item no.	Item description	M ₁
6	YP talks about emotional interactions with others	9.00
9	T works with YP to make sense of their experience	9.00
8	YP expresses feelings of vulnerability	8.75
98	The therapy relationship is a focus of discussion	8.50
64	Feelings about love and relationship are a topic	8.25
60	T draws attention to YP's way of dealing with emotions	8.25
50	T draws attention to unacceptable feelings	8.00
24	YP links mental states with behaviour	7.75
19	YP explores loss	7.50
84	YP expresses anger or aggression	7.50
97	T encourages reflection on internal states	7.50
58	YP resists the T's attempts to explore	1.00
42	YP rejects comments and observations	1.25
5	YP does not understand T's comments	1.25
15	YP does not initiate or elaborate on topics	1.50
14	YP does not feel understood by T	2.00
44	YP feels wary of T	2.00
53	YP discusses experience as if distant from feelings	2.25
86	T encourages reflection on thoughts and behaviours of others	2.25
52	YP has difficulty ending the session	2.50
67	YP finds it difficult to concentrate	2.50

Note. This table shows each item's mean placement (between 1.0 and 9.0)

Table 4

Phase 2 Therapy Process Descriptors. Eleven Most Characteristic and Fourteen Least Characteristic APQ Items of Phase 2

Item no.	Item description	M ₂
9	T works with YP to make sense of their experience	8.75
60	T draws attention to YP's way of dealing with emotions	8.75
98	The therapy relationship is a focus of discussion	8.50
72	YP demonstrates lively engagement with thoughts and ideas	7.88
50	T draws attention to unacceptable feelings	7.63
68	T encourages YP to discuss assumptions underlying experiences	7.63
6	YP talks about emotional interactions with others	7.50
74	Humour is used	7.50
75	T pays attention to endings and breaks	7.50
97	T encourages reflection on internal states	7.13
99	T raises questions on YP's view	7.13
58	YP resists the T's attempts to explore	1.25
15	YP does not initiate or elaborate on topics	1.25
5	YP does not understand T's comments	1.88
86	T encourages reflection on thoughts and behaviours of others	1.88
30	YP has difficulty beginning session	2.50
67	YP finds it difficult to concentrate	2.63
53	YP discusses experience as if distant from feelings	2.75
23	YP is curious about other people's thoughts and feelings	2.75
93	T refrains from taking position towards YP's thoughts and behaviour	3.00
51	YP attributes own feelings to therapist	3.13
66	T is directly reassuring	3.13
69	T encourages exploration of YP's impact on others	3.13
94	YP feels sad or depressed	3.13
95	YP feels helped by the therapy	3.13

Note. This table shows each item's mean placement (between 1.0 and 9.0)

The largest differences in APQ items between phase 1 and phase 2 are presented in Table 5. The differences indicate trends as no inferential statistics were performed.

Table 5

Phase Averages for Sessions 1 – 4 and Sessions 5 – 15 and the Ten Highest Mean Differences (Change) Between Phase 1 and Phase 2 Means

Item no.	Item description	Sessions	Sessions	Change
		1 – 4	5 – 15	
		M_1	M_2	
8	YP expresses feelings of vulnerability	8.75	5.75	-3.00
68	T encourages YP to discuss assumptions underlying experience	4.75	7.63	+2.88
17	T actively structures the session	3.25	6.13	+2.88
42	YP rejects comments and observations	5.75	7.88	+2.88
41	YP feels rejected or abandoned	6.25	3.75	-2.50
64	Feelings about love and relationship are a topic	8.25	5.75	-2.50
95	YP feels helped by the therapy	5.50	3.13	-2.38
93	T refrains from taking position in relation to YP's thoughts and behaviour	5.25	3.00	-2.25
14	YP does not feel understood by T	2.00	4.13	+2.13
72	YP expresses lively engagement with thoughts and ideas	5.75	7.88	+2.13

Note. Items are ranked in order of size of change, starting with largest change

Phase 1

The item differences highlight that Megan talking about love and relationships (64) and about feelings of vulnerability (8), rejection and abandonment (41) was indeed more prominent in phase 1 of therapy. At times, romantic relationships were talked about as stabilising and fulfilling, as in session 3:

YP: So, he was, like, always there. (...) And like, I could cry in front of him. Like, he's probably like the only person that I can, like, that I was...

T: Why do you think you could cry in front of him?

YP: I don't know, I think 'cause he was so, like, open with his emotions. (...) if I did cry in front of him, he'd be like, really, like, supportive and, like, cuddly and stuff, if that makes sense. So, yea, it just didn't feel awkward being upset in front of him.

Yet feelings of having a reliable other and enjoying emotional and physical intimacy could quickly change into feelings of dependency (session 3):

T: You're saying something about really wanting something close and intimate and you're not sure whether you will find it, really.

YP: Yea but it's also, like, I'm not sure whether I *want* to find it. (...) Like, for everything not to bother me in the way it does now, I'd have to have someone to lean on. Like, which insinuates that the whole, the only way I can be, like, happy in life is if I have someone else I'm with. Which is like, ridiculous.

T: You'd hate that.

YP: Yea.

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

YP: Yea.

In phase 1, talking about rejections (41) was also more prominent, like in this example from session 3, where Megan described looking on as her crush began an intimate relationship with another girl:

T: You ended up, actually, feeling on the outside (*hm*) (...), really left out.

YP: Yea, and -

T: And that made you feel really miserable.

P: Yea. And (...) it, like, got to me more than it should have. Erm, and I ended up going home instead of staying the night. And like, I walked home. And like, cried most of the way.

Maybe because of this fear of rejection (41) and feeling vulnerable (8) with someone else, Megan reports struggling to show her emotions to others. In session 1, Megan and the therapist discuss:

YP: I don't open up to anyone with my emotions. Like none of my friends would see me cry ever. (...) I just don't talk about my feelings with anyone.

T: Because you're worried that people won't take them seriously?

YP: Yea, I guess so. And I don't like getting emotional, I feel really, like, uncomfortable being emotional in front of other people. (...) *'laughs'*.

Feeling 'vulnerable' (8) seems to also become something that related to how Megan felt in therapy. The early sessions of phase 1 are characterised by Megan describing how she would hold back talking about certain things, as she was worried she would not be able to hold herself together emotionally. This example is from session 4:

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

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

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

Phase 2

Megan's readiness to admit that talking about her emotions in therapy makes her feel vulnerable drastically changes as she arrives in session 5, when she announces "*I'm not sure how it's supposed to help. (...) I don't know what I'm supposed to get out of it*".

Although Megan and her therapist continue to discuss experiences that she talks about spontaneously, over much of phase 2, Megan voices her doubts and ambivalence, which the therapist tries to engage with in increasingly lively discussions (72). As table 3 shows, in this phase, the therapist's actions are comparatively more marked by being active in the discussions (17), challenging Megan's assumptions (68), and taking position (93). Within these exchanges, Megan rejecting the therapist's comments (42) becomes a more dominant feature than before, whilst feeling understood (14) and feeling that therapy is helping (95) become less typical of the sessions. An example of these exchanges can be seen in session 7. The therapist and Megan discuss the events of the previous week when Megan broke down and told her mother about her depression and psychotherapy. The therapist frames this as a potential change in Megan's attitude towards sharing her emotions, something she disagrees with:

T: You actually just said [to your mum] "this is how it is, this is how I feel, I want you to know."

YP: Hm, not really.

T: Well, you didn't?

YP: No, I more broke down, she looked at me like I was crazy 'cause I was crying, then I was explaining why I was crying.

T: Well, what's wrong with crying? I know you think it is... but (*T and YP talk over each other*) no, no, no, no, no (louder).

YP: *'Laughs'*. It's not just my personal perception. Just crying because of [that] is a little bit crazy.

T: Well.

YP: Hm-hmmm.

T: But you also were saying about how you've been feeling. How much have you, how often have you told your mum that, recently?

YP: Never.

T: Never ever.

YP: Yea, she doesn't know anything about it.

T: So, you've never ever told her, and yet this week you do. (...) you weren't the girl who pretended it was all alright, who got up and said, "I don't need anybody". You were actually saying "I need you to help me here".

YP: I was more saying...

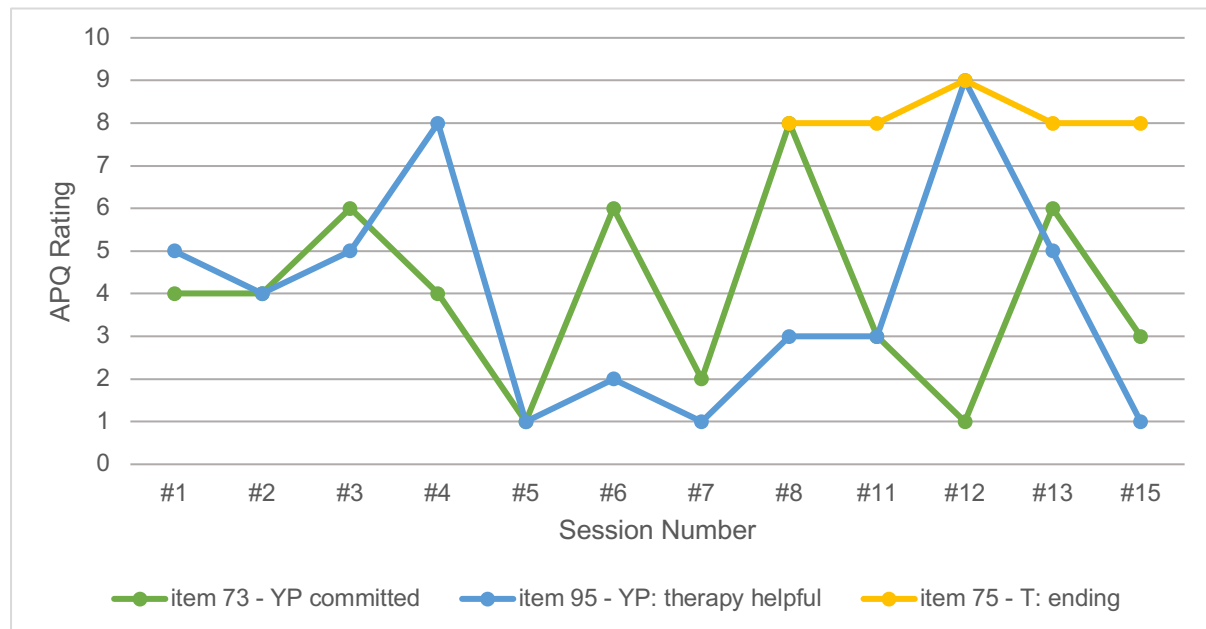
In these argumentative exchanges, a sticking point is Megan's insistence that therapy is not helping her (95) and that she cannot understand its mechanisms. In session 7, she asserts:

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

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

Figure 2

Select APQ Items Relevant to the 'Disengagement Process': Items 73 (YP Committed to Therapy) and Item 95 (YP Finding Therapy Helpful) Tracked Across All Therapy Sessions; Item 75 (T Focuses on Ending) Tracked Across the Last Five Therapy Sessions



Megan's sense that therapy is helping (95) and her commitment to return (73) fluctuate strongly and do not necessarily go in tandem. For example, in session 8 Megan agrees with her parents who are sceptical about therapy ('helping' rating '3') yet states that she will continue to attend despite this ('commitment' rating '8'). The opposite happens in session 12, in which Megan's lack of commitment (rating '1') and her expression of therapy having been helpful (rating '9') stand out:

YP: It sounds mean and blunt.

T: Go on.

YP: Because obviously you're here to help me and the whole thing is, like, set up to help me and stuff. But (...) it doesn't bother me either way if I have to stop or not because I feel like you helped me be better and that was pretty much the aim.

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

T: I think that's the really hard thing, to know that (...) you might need somebody else to kind of work things out a bit.

Yet Megan expresses that she believes this is exactly what she has learned in therapy:

YP: If there was anything, '*laughs*', I can say that psychotherapy has helped me with (*yea?*) it would probably be that side of things. Like, it might be the fact that - obviously I went psychotherapy same time as I met [new friends] at school (*yea*), it might be that they, like, coincided, and that I had someone who I was comfortable talking to, at the same time as you were telling me that it was ok to need someone to talk to. Do you know what I mean?

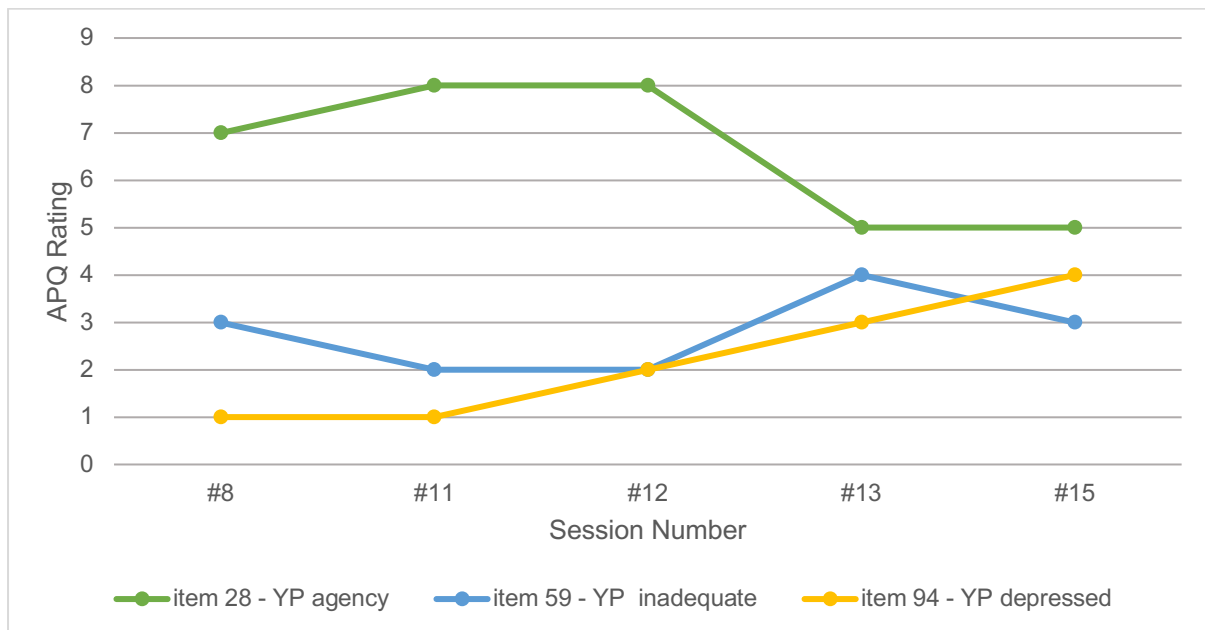
It appears that Megan's increased determination to leave therapy coincides with her noticing a change in herself and her help-seeking outside of therapy. In session 11, after two missed sessions and in line with her intent to leave therapy, she reflects on having in fact 'triallyed' a period without therapy:

YP: I knew I can't make it anyway, and I didn't think we could rearrange it. And erm, I kind of just wanted to see how I'd be not coming at all. Because I had like a really good week last week and this week has been pretty good (...).

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

Figure 3

Select APQ Items Relevant to a 'Sense of Wellbeing': Items 28 (YP Communicates Sense of Agency), 59 (YP Feels Inadequate) And 94 (YP Feels Depressed) Tracked Across the Last Five Therapy Sessions



Sessions 8, 11, and 12 stand out by Megan reporting a sense of confidence (28), effectiveness (59) and happiness (94). In session 12, for example, after Megan and the therapist disagreed on her feelings around leaving therapy, Megan explains:

YP: In the last couple of weeks, I really, kind of, like, set out what I need to do in the next couple of years. (...) Like, things just seem a little bit more optimistic and (...) getting my grades back and whatnot was, I don't know, I think I just kind of...

T: (warm tone) You thought there was a future for you.

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

The lively explorations of Megan's ambivalence around therapy took up a large part of phase 2 of the therapy. After session 15, Megan stopped attending her

sessions. As she explained in her IMPACT-ME T2 interview, she phoned the therapist and informed him of her decision. The last session yielded no noteworthy clues about the exact timing of Megan's dropout.

Discussion

This study aimed to explore in-treatment therapy processes leading up to a dropout in adolescent STPP for depression. It sought to identify therapeutic processes, techniques or interactions potentially associated with the premature ending.

Overall therapy process descriptors

Salient processes in the treatment overall were that the therapist and Megan were consistently engaged in collaborative therapeutic work focused on Megan's way of dealing with emotions in her interactions.

This strong early working relationship is mirrored in the WAI scores given by Megan and the therapist at 6 weeks, which were 53 and 54, respectively. Interestingly, these relatively high scores would have been more indicative of completing than non-completing treatment (completers: $M=55.7$; non-completers: $M=47.9$; O'Keeffe et al., 2017). To find such a strong working alliance, also mirrored in Megan's consistent early attendance (Figure 2), at the beginning of a dissatisfied dropout treatment is surprising as dropout has previously been linked to weaker therapist-rated and youth-rated alliance (Ormhaug & Jensen, 2016; O'Keeffe et al., 2017) and a pattern of early missed sessions (O'Keeffe et al., 2017). Dissatisfied dropouts in particular typically have had comparably lower observed working alliance than completers or other dropout types (O'Keeffe et al., 2020). The overall descriptors of the treatment as expressed in the APQ appear consistent with measures of early engagement and

therapeutic alliance but gave few indications of disengagement from the therapeutic processes.

Reviewing the non-process risk factors for treatment dropout in Megan's case however, her older age, significant antisocial behaviour scores (O'Keeffe et al., 2017) and the fact that her parents did not support therapy and were not participating in parent sessions statistically increased her risk of dropout (Ormhaug & Jensen, 2016). Megan's parents' opposition to her therapy might have also further influenced her decision to leave therapy, a conceptualisation expressed by Blotcky and Friedman (1984).

With regards to techniques used, all the therapist's dominant techniques (items 9, 50, 60, 97 and 98; Table 2) closely mirrored 'psychodynamic-interpersonal' techniques used by IMPACT study STPP therapists (Midgley et al., 2018). Seven of the ten most prominent items (items 5, 6, 9, 15, 50, 58, and 97) also matched with APQ items typical of interaction structures observed in IMPACT study STPP sessions (Calderón et al., 2018). This suggests that overall therapy processes and therapist techniques resembled overall processes in STPP treatments within the IMPACT study. An adherence to STPP techniques would be seen as favourable, given that working with young people's resistance and negative feelings towards therapy is seen as a key area of work in STPP treatments (Cregeen et al., 2017). Again, the overall process descriptors provide few clues for treatment dropout.

Further interpreting some of the therapist's dominant techniques might prove useful when considering dropout. The high overall placement of items 50 (T draws attention to YP's way of dealing with emotions) and 60 (T draws attention to unacceptable feelings) reflect the therapist's early and continuous emphasis on showing the young person her typical ways of emotional functioning, including those

feelings that are difficult to manage. The APQ does not have an explicit item for the therapist interpreting defences, but these two items might well capture this therapist action. It is possible that engaging in these techniques heavily and right from the beginning of therapy (as Phase 1 means indicate) created a high level of emotional intensity for the young person. As presented, the young person had announced in her first session that she does not like getting emotional and that she feels uncomfortable being emotional in front of other people. It is possible that the therapist attempted to explore the young person's capacity for reflection, an important element of the early stages of STPP (Cregeen et al., 2017), by seeing how she would react to these interventions. However, a technical approach that emphasises building a relationship of trust over several sessions before focusing on the young person's ways of dealing with emotions and unacceptable feelings might have made this work more bearable for the young person and evoke fewer doubts about the benefits of treatment.

Two phases and tracking items

The analysis found that the treatment could be divided into two distinct phases of engagement. Phase 1 was marked by Megan's discussions about relationships, feelings of vulnerability and rejection. Phase 2 was marked by a discourse whereby therapy left Megan emotionless as well as by Megan's pronounced ambivalence about continuing therapy. Item differences between the two phases might highlight interactions that could help understand the premature treatment ending.

Firstly, Megan's announcement of not understanding how therapy and talking are supposed to help, makes her doubts very clear. As such, her dropout from treatment is certainly not unexpected. The consistently high placement of item 75 (T discussing endings) showed that Megan's doubts were engaged with rather than avoided. The STPP manual, in fact, states that the emergence of doubts about therapy

shows the young person's sufficient trust in the therapist to work with her resistance (Cregeen et al., 2017). Promisingly, this case highlights the opportunity for therapists to demonstrate they can bear the young person's doubts (Cregeen et al., 2017) and, if necessary, adjust therapeutic technique to prevent treatment breakdown.

In the current case, comparing mean APQ rating during the first and second phases of therapy revealed that when faced with Megan's intention to leave therapy, the therapist's reliance on active (93), structuring (17) and challenging (68) techniques increased. Conversely to the overall therapy process descriptors identified, all three of these items pertained to interaction structures of CBT treatments (Calderón et al., 2018). It appears that faced with Megan's doubts, the therapist increasingly uses techniques more typical of CBT sessions and less typical of STPP sessions and the manualised STPP approach. Interestingly, Calderón et al. (2018) have found that when faced by challenge or resistance, STPP and CBT therapists alike are pulled into actions that seek to engage the young person but depart from their therapeutic model. In this therapy, it could also have been the case that the therapist's anxiety of losing Megan's commitment to therapy created a slightly more argumentative and defensive stance in their exchanges, possibly at the cost of fully exploring Megan's fears or doubts. The argumentative exchanges appear to also mirror O'Keeffe et al.'s (2020) findings that in 'dissatisfied dropout' therapies there are more confrontational and withdrawal ruptures, more ruptures to which the therapist contributes and more unresolved ruptures. Although it cannot be said whether the confrontational interactions identified in treatment phase 2 were responsible for dropout, the findings might highlight the need for a non-defensive engagement in the face of resistance, a key part of STPP treatment (Cregeen et al., 2017). Della Rosa and Midgley (2017)

suggested discussing feelings in displacement as a technical alternative that might feel more accessible to some adolescents.

Nevertheless, the therapist's growing awareness of changes to the therapeutic relationship is reflected in his WAI score given at 12 weeks, which decreased to 42, now more typical of a non-completer's score (Megan's score missing; O'Keeffe et al., 2017). This is also in line with O'Keeffe et al.'s (2020) finding that in dissatisfied dropouts working alliance decreases from early to late sessions.

With regards to Megan, she became comparatively livelier in her discussion and more rejecting of the therapist's comments in phase 2. The argumentative exchanges of this particular therapist-patient couple have also been identified in an aggregated case study (which coincidentally included Megan's case), describing it as a "battling" interaction (...), where each party wants to prove a point' (Della Rosa & Midgley, 2017, p. 287). These 'battles' might highlight the prominence of ambivalence in adolescence around endings (Cregeen et al., 2017) and the difficulty of Megan pulling away from a parental figure whilst also attempting to get something helpful from them. Indeed, Megan's commitment and her expressions of finding therapy helpful both oscillated from session to session. Rather than a linear process of increased dissatisfaction, the process was marked by occasional expressions of gratitude, siding with the therapist against her parents' opposition to therapy, and Megan formulating her own change. Theoretically speaking, this fluctuation of feelings and expressions is a well-observed feature of adolescence, where 'shifts between one state of mind and another can be very rapid and often inexplicable' (Waddell, 2018, p. 55). In psychoanalytic theory, it is seen as normative that the adolescent's affect is unstable and goes 'from love to hate, often enough directed toward the same object' (Tyson & Tyson, 1990, p. 313). Feeling the struggle of love and hate for the same object, i.e.

intense ambivalence, in itself has been described as being a factor in experiencing 'melancholy', Freud's (1916-1917) early formulation of depression. In this therapy, the fluctuating profile, and the fact that intensely fluctuating feelings can be normative for young people and in depression as described above, arguably made it harder for the therapist to anticipate Megan's final dropout. It might have remained unclear each session whether dropout is imminent or whether Megan is still playing with ideas. It highlights the careful balancing act required when engaging with a young person who is explicitly ambivalent about the therapy process, something that will be discussed further below.

A psychodynamic reading of the APQ item differences for phase 1 and phase 2 provides further potential to understand Megan's dropout. Her discussions with the therapist about relationships (64), painful rejections (41) and vulnerability (8) in phase 1 might have been the early signs of just how ambivalent Megan would feel about an intimate therapeutic relationship. Indeed, her predominant assertion in phase 2, that talking about emotional experiences leaves her disconnected from her feelings, the opposite of the phase 1 narrative, allows her to gradually disengage and disinvest from therapy. Psychoanalytically, this is interpreted by the therapist, as a defence against closeness, emotionality, vulnerability and dependency. This interpretation would be in line with Blotcky and Friedman's (1984) conceptualisations of treatment dropout as the adolescent's way of avoiding engagement with depressed feelings by leaving behind therapy and its potential exploration of these feelings. Salzberger (1963) agreed that resistance to further therapeutic work can be a young person's way of avoiding anxiety whilst preserving mental stability. Just as vehemently as the therapist might have voiced his interpretations, Megan denies any avoidance despite her earlier assertions about her fears of dependency and intimacy. This finding highlights the

importance of careful timing and wording of 'defence interpretations' (Cregeen et al., 2017) as they easily can leave patients feel accused and misunderstood, mobilising further resistance (Jones, 2000).

With regards to thinking about the clinical implications of this study, the above processes raise the question whether there was an alternative way to respond to the young person's expressed wish to end treatment. Even if understood as resistance, the young person's intention to leave treatment could be responded to by inviting the young person to think together where this wish came from, overall showing a more accepting stance. An alternative technique could be the therapist sharing and owning the view that it might not be the right time to end treatment and invite the young person to explore those thoughts in a non-argumentative fashion. The young person's ambivalence could also have been acknowledged more openly, i.e. the idea of being in two minds about something. It could have been reflected to the young person that it was 'okay' to not be sure about psychotherapy, whilst continuing to engage with it and see whether it could hold some benefits. This might have modelled to the young person that it does not have to be 'one or the other', meaning also that leaving is not the only response to feeling frustrated with therapy.

Conversely, one could argue that the couple's argumentativeness held something beneficial for Megan. As described, Megan did not share her mental health difficulties with her parents for a long time, maybe feeling she would burden them or overwhelm them. In therapy, by contrast, Megan voiced her adolescent struggles and struggles with depression and found in the therapist a responsive adult. Her ability to be outspoken and argumentative might imply that she thought the therapist robust enough to withstand her strong and conflictual feelings.

Dropout and outcome

For Megan, the ending of treatment seemed logical in the face of her increased feelings of agency (28) confidence (59) and wellbeing (94). She reports feeling more upbeat and hopeful for the future. Notably, these instances are acknowledged warmly by the therapist as per their strong overall working relationship. The outcome measure for the late treatment phase was not available, but Megan's MFQ score continuously decreases in the period post dropout. At 16 months after treatment dropout, her MFQ score is 8, reflecting a state of wellbeing. In this way, Megan's hopes and confidence for the future might have become reality.

Previous investigations have linked STPP dropout to an increased risk of depression in the medium but not the long term (O'Keeffe et al., 2019a) and Megan's case is consistent with this. Despite dropout, Megan's improvement with regards to depression severity was remarkably bigger than that of her study cohort. Some might call into question the categorisation of Megan as a necessarily 'dissatisfied' dropout as opposed to a young person who dropped out after she 'got-what-she-needed' (see O'Keeffe et al., 2019b). After all, Megan herself asserted the changes she could attribute to therapy, namely allowing herself to 'need' people, e.g. to draw on friends to talk about difficulties. One might argue that by allowing others to deal with her needs, Megan has successfully internalised the psychotherapist's ability to deal with her level of conflict and disturbance, a treatment aim of STPP (Cregeen et al., 2017, p. 58). Alternatively, Megan might have been both 'dissatisfied' with treatment and 'got what she needed'. A more detailed analysis of her IMPACT-ME interview data in conjunction with the current findings might provide a more nuanced answer to this question.

Strengths and limitations

The current study's strength lies in studying an entire prematurely-ended course of therapy with a validated therapy process measure. Through highlighting noteworthy and surprising interactions between therapist and patient, as well as the overall lengthy withdrawal process from therapy, the study provides thought-provoking training material. It allows practitioners to discuss and consider the skills needed for a careful engagement with an ambivalent and withdrawing adolescent in therapy. Clinical case analysis illustrated how changes in attitude manifested and how a young person conceptualised her own changes in therapy. Another strength is the contribution this research makes to a vastly under-researched phenomenon. There are clear limitations to the current study.

APQ Whilst the APQ describes therapy processes in one session and can detect variation across several sessions, within-session complexity and ambivalence are more difficult to capture due to the one-item-per-session design (Elvejord & Hooper Storeide, 2018). To understand within-session processes and the direct effect of therapist intervention on Megan's response and vice versa, moment-by-moment analyses are better suited (Elliott, 2010). Furthermore, the author noticed the absence of items accounting for an argumentative couple, symbolism in session, and the therapist interrupting the client, all treatment aspects characteristic of the current case.

Q-methodology Writers on Q-methodology have emphasised the benefits and natural fit of analysing Q-sorts with Q-factor analysis, e.g. a by-person factor analysis (see Watts & Stenner, 2005). It is a limitation of this study that Q-factor analysis and a successive examination and interpretation of Q-factors has not been used on the APQ Q-sorts of the twelve psychotherapy sessions. Furthermore, as an alternative to the current method of analysis (APQ aggregated scores and clinical case analysis), a

thorough qualitative analysis of the entire 100-item APQ Q-sorts of each psychotherapy session could have provided a complete image of all the constituent parts of the Q-sorts. Future studies might benefit from using the above quantitative and qualitative measures to re-examine the Q-sorts and inquire whether different methods of analysis indeed produce converging results.

Design One of the major outcomes of the current study, the identification of two phases within the therapy, was reached using a subjective analysis, namely clinical case analysis. Using Q-analysis or established qualitative approaches such as narrative analysis or discourse analysis as an alternative would have lent the study more scientific rigor.

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

Elucidating the therapeutic processes leading to dropout in the current case could have been enhanced by the integration and triangulation of a wider variety of sources and perspectives (Iwakabe & Gazzola, 2009), which Elliott (2010) calls systematic methodological pluralism. Notably, the study is missing the intersubjective dimension to the processes identified through APQ items, i.e. the inclusion of

retrospective patient and therapist report (Elliott, 2010), especially given the availability of this data through the IMPACT-ME study.

Conclusion

The current study has illustrated the therapy processes preceding dropout of a young person identified as dissatisfied with their treatment. Through using a validated therapy process measure and additional data, the study highlighted the complex and at times contradictory reality of Megan's dropout. A reciprocal and strong working relationship allowed for lively discussions and confident therapist interventions, yet dissatisfaction with treatment continued and was voiced repeatedly. A range of treatment processes indicating a change in attitude, increased ambivalence, yet also increased wellbeing, were identified by the APQ and illustrated through vignettes. The young person's long-term follow-up outcome data was made available to consider therapy gains in context.

The current study provides empirical research that stays close to the data, allowing dynamic engagement with data for a specialist group of practitioners who are invited to revise, expand and integrate study findings into their developing frameworks of clinical knowledge (Iwakabe & Gazzola, 2009). A recent contribution by Ansaldo and Papdima (2020) exemplified that there is indeed a desire in the child psychotherapy profession to engage with empirically explored session material in a dynamic way. Whilst first descriptive findings like the ones presented here do not provide evidence in themselves to inform manualised treatments, they might 'improve practice' by provoking structural discussion and thought amongst practitioners in the face of impending dropout. Therapists' enhanced sensitivity to relevant processes in therapy dropout has the potential to keep young people in therapy for longer, create more optimal outcomes and spare resources for recurring treatments.

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Appendices Part 2

Appendix 1 – Outcome Measures

Table 4

Outcome Measures for Megan and a Comparative STPP Sample in the IMPACT Study

Week	MFQ		RCMAS		ABQ*		LOI		MDD diagnosis [†]		HoNOSCA	
	Megan	IMPACT STPP	Megan	IMPACT STPP	Megan	IMPACT STPP	Megan	IMPACT STPP	Megan	IMPACT STPP	Megan	IMPACT STPP
Baseline	46	45.4	22	40.5	2	3.3	1	9.2	Yes	100%	11	18.2
6 weeks	37	34.9	27	36.7	2	2.1	0	7.6	No	62.6%	10	14.6
12 weeks	-	33.1	-	34.3	-	1.5	-	7.3	-	54.5%	-	12.9
36 weeks	30	26.6	23	28.6	3	1.4	0	5.2	No	35.7%	-	10.3
52 weeks	21	23.0	20	25.5	3	1.1	0	4.9	Yes	26.4%	15	8.6
86 weeks	8	21.8	4	23.8	0	0.9	0	4.0	No	15.2%	6	8.2

Note. MFQ = Mood and Feelings Questionnaire. RCMAS = Revised Children’s Manifest Anxiety Scale. ABQ = Antisocial Behaviour Questionnaire. LOI = short Leyton Obsessional Inventory. MDD diagnosis = Major Depressive Disorder diagnosis. HoNOSCA = Health of the Nation Outcome Scale for Children and Adolescents.

*ABQ data is given as number of antisocial behaviour symptoms reported.

† MDD diagnosis was reached via the Kiddie-Schedule for Affective Disorders and Schizophrenia Present and Lifetime (K-SADS). Megan's MDD diagnosis is reported as Yes/No. IMPACT STPP MDD diagnoses reported as percentage of participants receiving a diagnosis.

Outcome measures for IMPACT STPP sample from tables in Goodyer et al. (2017, pp. 76-77, p. 82). IMPACT STPP data based on all data available from between n=83 and n=156 cases.

Appendix 2 – Working Alliance Inventory (WAI)

Table 5

Working Alliance Inventory (WAI) report for Megan and her therapist

Week	WAI	
	Megan	Therapist
6 weeks	53	54
12 weeks	-	42
36 weeks	33	-

Appendix 3 – APQ Codings

Table 6

APQ Codings, Coding Means and Standard Deviations for All Sessions

Items / Session	1	2	3	4	5	6	7	8	11	12	13	15	MEAN	SD
1	5	4	6	4	8	6	7	3	4	3	5	7	5.17	1.64
2	5	5	6	7	6	5	5	5	5	5	4	5	5.25	0.75
3	3	6	3	5	3	4	5	5	4	4	4	2	4.00	1.13
4	4	5	3	5	9	3	5	6	7	9	4	5	5.42	2.02
5	1	2	1	1	1	1	2	2	2	1	2	4	1.67	0.89
6	9	9	9	9	6	6	9	8	8	6	8	9	8.00	1.28
7	2	6	4	3	7	2	4	2	4	2	4	3	3.58	1.62
8	8	9	9	9	8	5	8	6	6	4	3	6	6.75	2.05
9	9	9	9	9	9	9	8	9	9	8	9	9	8.83	0.39
10	5	4	6	2	9	5	8	2	6	6	6	8	5.58	2.19
11	7	7	7	4	4	5	5	7	5	5	5	8	5.75	1.36
12	6	6	4	6	6	5	6	5	5	5	6	6	5.50	0.67
13	5	6	5	6	5	5	4	9	9	7	5	3	5.75	1.82
14	2	1	3	2	3	4	7	1	6	4	2	6	3.42	2.02
15	2	2	1	1	2	1	1	1	1	2	1	1	1.33	0.49
16	6	5	2	5	6	4	6	4	5	4	4	5	4.67	1.15
17	3	3	3	4	4	6	6	6	7	7	7	6	5.17	1.64
18	7	8	4	5	4	6	4	8	4	3	6	4	5.25	1.71
19	8	8	8	6	6	8	5	6	4	2	8	7	6.33	1.92
20	6	3	3	6	8	4	7	5	7	8	4	6	5.58	1.78
21	5	4	4	5	4	5	4	5	5	4	5	4	4.50	0.52
22	7	2	6	3	5	3	5	3	4	4	2	3	3.92	1.56
23	2	2	5	3	3	3	3	6	1	4	1	1	2.83	1.59
24	8	7	8	8	7	6	7	8	6	6	7	7	7.08	0.79
25	6	2	2	7	4	1	2	5	4	5	3	4	3.75	1.82
26	6	6	6	3	7	7	7	4	5	4	5	6	5.50	1.31
27	4	4	2	4	4	4	4	4	5	6	4	4	4.08	0.90
28	5	1	6	6	2	5	4	7	8	8	5	5	5.17	2.12
29	7	3	8	7	5	9	3	3	6	6	5	6	5.67	1.97
30	4	7	2	3	2	2	3	4	3	2	1	3	3.00	1.54
31	7	6	7	7	8	7	5	6	6	6	8	8	6.75	0.97
32	5	7	7	6	4	6	6	7	7	6	9	6	6.33	1.23
33	3	4	5	3	4	4	4	4	4	4	3	4	3.83	0.58
34	4	3	5	6	1	7	6	5	5	5	6	7	5.00	1.71
35	6	5	7	6	4	7	6	5	6	5	7	5	5.75	0.97
36	5	6	5	5	6	6	8	7	7	7	5	7	6.17	1.03
37	5	7	6	6	7	7	1	5	4	3	6	2	4.92	2.02
38	5	5	5	6	4	6	2	7	3	3	6	4	4.67	1.50
39	6	5	5	5	5	6	2	4	2	6	5	5	4.67	1.37
40	7	6	7	8	7	7	7	8	6	5	8	7	6.92	0.90
41	6	6	8	5	5	4	5	2	2	4	2	6	4.58	1.88
42	1	1	2	1	3	5	9	1	6	4	2	3	3.17	2.48

43	3	2	4	2	4	3	5	6	2	4	7	2	3.67	1.67
44	2	2	3	1	5	6	5	2	6	3	2	3	3.33	1.72
45	8	4	8	3	6	6	6	6	6	8	5	5	5.92	1.56
46	7	4	7	7	5	4	4	3	3	3	4	6	4.75	1.60
47	4	4	3	5	7	4	4	4	4	3	4	4	4.17	1.03
48	5	4	5	5	5	8	5	6	5	6	6	5	5.42	1.00
49	2	5	5	4	3	4	3	3	5	5	5	5	4.08	1.08
50	7	8	8	9	8	9	7	8	7	8	7	7	7.75	0.75
51	3	3	2	3	3	3	3	3	3	4	3	3	3.00	0.43
52	3	4	1	2	2	3	6	2	3	6	3	3	3.17	1.53
53	2	3	2	2	3	1	4	3	2	3	3	3	2.58	0.79
54	6	6	6	7	6	5	3	7	6	5	4	6	5.58	1.16
55	4	5	7	5	5	5	7	6	7	7	7	7	6.00	1.13
56	6	6	6	8	6	6	6	7	7	7	6	6	6.42	0.67
57	4	3	3	4	2	7	4	4	3	3	2	1	3.33	1.50
58	1	1	1	1	1	1	2	1	1	1	1	2	1.17	0.39
59	6	5	5	4	6	3	3	3	2	2	4	3	3.83	1.40
60	8	8	8	9	9	9	9	9	8	8	9	9	8.58	0.51
61	3	4	4	3	6	6	3	3	3	6	6	2	4.08	1.51
62	6	7	5	7	8	8	4	5	5	7	6	6	6.17	1.27
63	7	8	7	5	5	5	7	6	5	5	8	7	6.25	1.22
64	9	9	9	6	6	4	5	7	5	5	6	8	6.58	1.78
65	8	4	6	6	3	5	3	6	6	4	3	4	4.83	1.59
66	3	1	4	4	2	3	4	4	3	1	4	4	3.08	1.16
67	2	3	2	3	3	2	3	3	3	2	3	2	2.58	0.51
68	4	5	4	6	7	7	7	7	9	8	9	7	6.67	1.67
69	1	6	5	4	2	3	2	6	2	5	4	1	3.42	1.83
70	5	5	5	7	5	7	4	4	6	6	5	4	5.25	1.06
71	5	7	6	7	5	9	6	5	4	7	4	5	5.83	1.47
72	7	8	6	2	7	8	7	9	8	8	9	7	7.17	1.85
73	4	4	6	4	1	6	2	8	3	1	6	3	4.00	2.17
74	7	7	6	8	8	8	8	7	7	7	7	8	7.33	0.65
75	4	8	7	5	7	6	6	8	8	9	8	8	7.00	1.48
76	6	6	6	5	4	7	3	6	7	7	6	6	5.75	1.22
77	3	5	4	7	8	5	4	5	5	5	5	5	5.08	1.31
78	4	5	5	4	3	3	1	4	3	5	4	5	3.83	1.19
79	4	5	4	6	5	4	5	5	5	5	5	5	4.83	0.58
80	4	7	5	8	6	7	9	8	7	6	7	6	6.67	1.37
81	4	3	4	4	5	5	6	5	6	7	3	5	4.75	1.22
82	3	5	4	5	4	5	5	4	5	4	3	5	4.33	0.78
83	6	3	4	5	6	4	5	4	4	2	2	4	4.08	1.31
84	9	6	7	8	5	8	6	6	9	6	6	8	7.00	1.35
85	3	4	3	2	3	4	6	4	4	5	4	2	3.67	1.15
86	1	3	1	4	3	2	1	2	1	3	1	2	2.00	1.04
87	4	3	3	2	4	2	6	3	5	3	3	4	3.50	1.17
88	4	5	4	4	5	4	4	4	4	3	5	3	4.08	0.67
89	3	2	4	3	4	2	3	4	2	7	7	4	3.75	1.71
90	5	7	3	5	4	5	5	5	8	5	5	4	5.08	1.31
91	8	6	3	6	5	3	5	5	4	4	5	9	5.25	1.82

92	6	4	6	5	6	7	8	5	5	5	8	5	5.83	1.27
93	5	7	5	4	2	2	2	2	4	1	6	5	3.75	1.91
94	5	6	4	3	5	3	6	1	1	2	3	4	3.58	1.73
95	5	4	5	8	1	2	1	3	3	9	5	1	3.92	2.64
96	5	5	5	8	6	5	8	5	8	6	7	6	6.17	1.27
97	8	8	7	7	7	8	7	7	6	7	7	8	7.25	0.62
98	9	9	9	7	9	6	9	9	9	9	8	9	8.50	1.00
99	6	5	7	6	7	8	8	6	8	9	6	5	6.75	1.29
100	7	7	8	4	7	4	5	7	7	6	7	7	6.33	1.30

Part 3: Reflective Commentary

Reflective Commentary

PDWX6

Word Count: 3,851

As an addition to the literature review and empirical study, this commentary reflects on the process of undertaking the above research whilst training to become a psychoanalytic child and adolescent psychotherapist. I surprised myself by being more passionately engaged in this research than I had anticipated. I hope to convey my ambivalence in this process and the continuous struggle to grapple with the meaning and importance of research to my practice and vice versa.

Indifferent beginnings

My experience in research started before my training to become a child psychotherapist. I had gained a good grounding of research methods during my undergraduate course in Psychology. The emphasis on good research skills and critical research thinking on my subsequent MSc made me confident in undertaking research. When graduating with a Master's dissertation, I felt I had evidenced my research skills sufficiently.

Knowing about the research component of the IPCAPA doctorate left me feeling almost indifferent. It was an area I felt confident in, and this was contrasted by some of my colleagues' anxiety about research teaching. The idea of undertaking the different parts of research did not fill me with dread, but neither with excitement. After all, my primary interest for the training was to develop professionally as a child psychotherapist, and I saw clinical work, personal psychoanalysis, and teaching on practice and theory as the most important means to that end. Because I trusted my

research skills to carry me through the experience, perhaps arrogantly, I thought of the research component as something I would find time to do 'on the side', protecting all possible time for my clinical work and thinking.

Ambivalence

Nevertheless, I was keen to work on a topic that I had some interest in, and I welcomed being assigned to investigating the mixed outcomes of STPP within the IMPACT trial. The clinician in me felt relief that I would be researching a psychoanalytic treatment in real-world practice and I got tentatively excited.

However, I remained ambivalent about our research projects on STPP. By now I had started offering long-term psychotherapies to several adolescents who struggled with low mood or depression, all with very different backgrounds and stories. Sexual assault, physical disabilities, selective mutism, and self-harm were some of the contexts in which their symptoms of depression had developed. I noticed that to me, the idea of a manualised and short-term psychoanalytic psychotherapy intuitively felt at odds with the needs and complexity I was perceiving in my patients. Yet I sensed a pressure from the wider community, including the Anna Freud Centre, to 'like' STPP, and to find value in this short-term treatment in a display of openness to change, modernisation and a commitment to providing an evidence-base for child psychotherapy.

As a group of four, nonetheless, we began exploring valuable research questions with the help of our first research supervisor. The research area of dissatisfied dropouts from STPP instantly struck me as an important topic. Engaging with the topic of therapy dropout forced me to think in very different ways from my own experience of personal therapy – which I not only was finding helpful but was feeling a strong commitment to. I felt the need to understand more about what would make it

hard for young people to engage with psychoanalytic therapy. I realised that my commitment to my clinical and therapeutic work had to include openness to think of shortcomings in therapy models, blind spots in the therapist and a willingness to understand what is not working from a young person's perspective.

As a group, we started to be introduced to the measure that had been suggested to us as the appropriate tool to analyse our data. The APQ would allow us to quantify the actions and interactions happening in each therapy session whilst promising various ways by which we could later compare sessions across time. My initial enthusiasm towards the measure was curbed as I became increasingly frustrated with it. In our practice and training sessions, we listened to entire sessions, then painstakingly coded them with the one-hundred-item measure. As we discussed our finished codings with the trainer (and creator) of the measure, our codes often were at a mismatch with the model codes established by the trainer. We had listened to the same session, but we did not identify the same aspects as prominent, or at least not exactly the same aspects. I felt challenged by the question of there being a 'right' way of looking at a therapy session. Slowly, I accepted that even within the measure there was a level of subjectivity, but wondered what that would mean for the sessions we would code for our own research study. However confident I had felt as a researcher early on, I was now much more aware of my subjectivity. I desperately wanted the outcome of my research to be more than just 'my take' on a treatment, hence my hope for this empirical measure, the APQ, to establish something indisputable about the therapeutic process. It frustrated me that this 'empirical' measure might not be able to fully do this. I remember being preoccupied with this deeply, in particular during the 'reliability' process. Keen to get some kind of confirmation of my thinking about subjectivity and empiricism, I wondered whether my

codings would 'stand up' to the standard expected by the measure creators. Secretly, I feared that my subjective application of the measure could differ too much from the agreed-upon coding of the session in question, which in turn would undermine my confidence in commencing analysis on my case study.

Although these paragraphs read like a period of much frustration and anxiety, I feel glad I engaged with the frustrations the APQ training presented to me. Over time, it allowed me to conclude that 'empirical' in the context of the APQ might simply mean that different raters only more or less agree on a session's most and least prominent aspects. These reflections, however, also strengthened my opinion that I wanted a good measure of control within my own coding. We decided to not only double code a percentage of each other's sessions, but also to blind ourselves to the session order, preventing us from imposing too much of our unconscious biases and expectations onto the sessions according to order of appearance.

Literature review

Before beginning to listen to our individual case study data, however, I had chosen the topic of APQ-based studies for my literature review. My aim was to have a 'convenient', well-defined and accessible topic, so that it would not encroach too much on my time prioritised for clinical work. This was clearly in line with my initial thoughts of doing my research 'on the side'. As a result of this mindset, I was surprised to find myself struggle with the literature review, but also benefit from it. Reviewing the uses of the APQ, I found myself extensively reading on therapy research, process research and critical thinking about methodologies within process research that spanned more than three decades. I also learned about the sobering delay that exists from evidence gathered to its actual use in practice, the research-practice gap. I became accustomed to feeling how minuscule my own empirical case study would be

within the expanding field of process research. It also created ample opportunity for me to think about the single-case study design as a tool for theory creation. I found myself reading and re-reading published articles by Nick Midgley (2004; 2006) that examined the virtues and limitations of single-case studies, and qualitative approaches more broadly. Those readings reflected my own concerns: was I at risk of simply 'liking' the case study, because it stays as close as possible to the clinical encounter, allows for depth and complexity in the patient's psychopathology, allows detailed thinking about the impact and choice of therapeutic techniques and can bring all of this to the reader through a compelling narrative? More worryingly still, an unsystematic but coherent account of a clinical encounter could run the risk of being so persuasive that it leaves the audience with little space to assess the data and elaborate alternative ways to view it (Tucket, 1993). I was clearly attracted to an in-depth case study approach as a way of clinical thinking in my training, yet that did not answer the question of what benefits it had with regards to creating research knowledge, i.e. adding meaningfully to the evidence base of child psychotherapy. Evidently, my fears that my own subjectivity could make my research less trustworthy or valid returned during the review of the literature.

Beyond an engagement with the methodological questions behind the research I was to undertake, the literature review concerned with the APQ's applications also highlighted further pitfalls and limitations, as well as good examples of practice. It provided me with pointers for my own research, for example the value of analysing an entire treatment, i.e. all treatment sessions available, and helpful ways of integrating the main analysis with additional data available in a case. Making my final corrections to the literature review was to take a long time for me: in my efforts of reading widely, perhaps to know everything there was to know on the methodological roots of process

research, I had produced an overly long review that needed substantial editing. It was not until the first COVID-19 lockdown, 6 months after the recommended deadline, that I could refocus my writing. In the meantime, I had already begun my engagement with the empirical project.

Listening to data

By now, it had become clear to me that I was not doing my research ‘on the side’ anymore. Conflict and doubts were still prominent, but I was also curious to listen to the session data of my selected case. One of the reasons this felt so unique was the chance to observe a senior child psychotherapist’s therapeutic practice in a way that we do not get to experience anywhere else. There are no sessions we observe from behind a double-mirror, no one we get to shadow. When we hear of other colleagues’ practice, it is through session notes of one or two sessions at a time. We sometimes hear the accounts of a longer treatment, notably when trainees graduate, but by then the clinical material has been processed substantially. Often, published treatment accounts had intimidated me, as despite the writer’s admission of difficulty, they read with clarity and as if in the end the therapist’s skill had cut through the difficulties and found a connection with the patient. It might well be my own tendency to idealise more senior child psychotherapists that I read accounts of therapies in this way. However, I knew that to get the chance to ‘listen in’ to a real-life treatment, see the minute-by-minute process, as well as the ‘arch’ of sessions, was rare and special.

I was given some limited information about the case of the young person – age, gender, and data on her session attendance. I had decided to not access more information for now, as I wanted to take my cues for coding from session material as much as possible. Of course, one of the most important outcomes, the eventual dropout due to dissatisfaction, was well-known to me and the reason I had sampled

this case to begin with. However, I was unaware of where each coded session fell within treatment. Any session I was listening to could potentially be that 'last' session before the walk-out and the blinding protocol we established meant I did not have any prior knowledge of which session that would be. In connection to this, I also had some heightened alertness to particular items within the APQ: item 73, which states "the young person is committed to the work of therapy" and item 95 stating "the young person feels helped by the therapy". Although with each code I had a strict requirement to find 'evidence' in the transcript to justify my placing, with these items I insisted on an even stricter protocol. Furthermore, I consciously decided to keep three types of reflections after the listening and coding of each session. The first was a narrative summary of the session. This served to remind myself later of the session's content, and to record the major themes or conflicts happening in this session, from my perspective. I could then compare this to what I called the 'coding summary'. My 'coding summary' combined the five top and bottom APQ items after my coding was completed into a narrative. I was interested at a qualitative level whether this 'coding summary' read like an adequate presentation of the session or whether it was missing things that I had picked up in my more subjective 'narrative summary'. Finally, I would keep reflections on my experience of coding each session in a third paragraph called 'reflections on coding'. This could include my rationale for placing certain items, noting when there were aspects that were missing a dedicated item, and for logging general frustrations. I think keeping such reflections is good practice. However, these notes also evidenced my continued preoccupation with the capacity of the APQ to capture session content adequately and my fears around my own subjectivity getting in the way of recording observations appropriately. An example of these notes for session

number 12 can be found in Appendix A. An example of a double-coded session is attached in Appendix B.

These notes also were, I believe, my attempts to maintain a trail of thoughts in the process of listening to rich but challenging therapy sessions. The therapy featured much agreement and calm exploration, but also moments of disagreement and struggle between therapist and patient. Recording the therapist's techniques with the APQ caused me to increasingly think about his choice of technique, my own assumptions about therapeutic technique as well as my own clinical practice. When re-listening to sessions, I was engaged in a process of questioning what was happening moment by moment. I might question "*why is he doing this right now?*" when the therapist was challenging. At other times, I felt the relief when his comments were particularly attuned resulting in moments of shared understanding. Likewise, I was alert to thinking about the young person's state of mind and attitude towards therapy: what might her experience of the therapy be, what can I read between the lines, and did those conflictive interchanges push her out, or did they keep her in the therapy for as long as she stayed. Being a patient in my own psychoanalysis, as well as a developing practitioner in training, I inevitably identified with the female patient or the therapist at different times. I registered my passionate automatic thoughts in reaction to session material, for example "*can't you see where she's at right now, don't challenge her*" when identifying with the patient, or "*he's really trying so hard, I wonder if she can see that?*" when viewing things from the therapist's perspective. In this way, the experiences of patient and therapist were very alive in my own mind and constantly in conversation with each other. I noticed that moments of meeting, moments I identified as missed opportunities, or moments that somehow challenged me without yet knowing why, lingered in my mind even days after coding of a session was

completed. Although not in the room with the patient-therapist couple, I did feel strong reactions, and it was in my own analysis that I could think about what it was about those scenarios that had left me preoccupied with them. During those times I was also grateful that I had my rigorous system of notes and reflections as I prepared for data analysis.

Reflections on practice

As I was now learning from my own application of the APQ, I could not help developing a personal critique of some of the APQ's properties. I found the APQ was mainly concerned with a 'bigger picture' of the therapy process. It could indeed detect characteristic interaction structures of entire treatments or even changes from session to session, i.e. how was one session different from another, and how does a certain session stand out within a treatment. But I felt that the APQ was not fine-grained enough to follow the 'twists and turns' within a session. This challenged my own beliefs about clinical practice where reciprocal actions, attunement, reactions, ruptures and repairs were central to what made therapy therapeutic. The APQ was a generic judgment on whether the pair was generally attuned or the therapy process generally ruptured within a given session. It was less suited to capture ambiguity, e.g. the therapist paying attention to a rupture once in a session, but not the second time. I had learned during my literature review that raters find it harder to agree on codings for such sessions. This was also where subjectivity and unconscious assumptions might potentially be weighing in more than when actions are less ambiguous.

Another recurring thought that crept into my own clinical practice was about dropout. I developed a habit of scanning my session notes to consider how I would code them with the APQ. I then imagined any of the young people in therapy with me dropping out, without me having registered the precursors of their disengagement or

dissatisfaction in our sessions. My question was whether I really believed that the APQ could have captured something about these sessions retrospectively that I had missed. I don't think I ever found an answer to that question. The only way to meet the many criticisms and questions in my mind was to continue interrogating the coding data gathered.

Analysing data

There were some setbacks during that time: our first research supervisor, who had particular insight into the IMPACT trial and data and whose work gave the steppingstones for our case studies, left the centre. We were well supported in terms of thinking about our research with a second supervisor stepping in. Yet at the same time it became clear that the statistical method of analysis we had been planning to use was not actually appropriate for the low number of session codings we had. For me, it reinforced a feeling of being somewhat abandoned with less expertise on site to help us find an alternative way to analyse the data. Maybe because I suddenly felt I could not achieve a sophisticated statistical data analysis, I noticed an urge to enrich my data with more material. I felt that a case study could only benefit from additional data, to find the maximum number of meanings and viewpoints and to not draw false conclusions from a more reductionist viewpoint. There were two interviews with the young person and one interview with the therapist after the end of therapy, as well as a whole battery of outcome and process data that was routinely collected. It was difficult for me to resist including all this additional data. The wish to actually complete the project (i.e. 'keep it simple') and the fact that I did not have a structured tool to incorporate this data were the major reasons I did not formally incorporate additional data into the analysis. Instead, I decided to consult all additional data, i.e. listen to the interviews and view outcome measures, and use the information to situate my case

but also hold my data accountable. By that, I mean tracing the continuity and coherence of what my analysis yielded against the reflections expressed in the other interviews.

For my actual main analysis, I listened to all recordings again, this time in order, and reused my narrative summaries as a subjective narrative for the therapy. Now in order, the previously jumbled sessions did indicate to me that there was a marked shift in the young person's attitude towards therapy following session 4. I decided to ask the APQ data some questions: would a change also be reflected in the APQ, which had been coded out of order? I was surprised when there were some non-trivial differences the APQ data highlighted. Upon studying the APQ shifts, I decided that this would be the story I would tell. It still sits slightly uncomfortably with me that parts of this analysis resulted from my own subjective clinical reading of this data, but I have been reassured that this is a valid way to research in an iterative way. It was a creative journey to have made this step, and then use the APQ data as pointers of where to find more meaning within the text. My results section is the result of that process.

“So what?”

Although pleased that the analysis and results were done, it was at the point of the discussion that my questioning thoughts, with which the reader will now be familiar with, returned. Although I did not put into question the data or analysis achieved, I wondered about what value these results held. The question popping into my head was “*so what?*”. What difference did it make to any theory, or any therapist, that in this one single case the therapeutic process could be described in the way that I had. I described some important processes leading up to the point of therapy dropout, but how could that help anyone? I was thinking of quite direct pointers for practice that I could neatly fit into a compelling conclusion, and there were few such links.

Integration

Over time, these thoughts developed. I remember a research workshop in which I advocated for the audio data to be made available as training material for trainees and receiving a response that turned out to be a light bulb moment for me: "*it already is*". It fits in with the question of how our 'integrated' training of research and practice really achieves integration. For me, I discovered that these links were made inside of me, through the process of engaging with our clinical thoughts and questions, and from time to time subjecting them to a more research-informed approach. The other way round this works, too: I would want to interrogate any robust research that intends to be clinically meaningful according to its relevance in practice. I was reinforced in this thinking by the idea of case studies like mine being published and read by practitioners in the field. This is where the 'research-practice gap' might really be bridged: by individual practitioners who engage in clinical and research-based thinking. My results do not have to answer a generic question of 'x works for y' or inform a manual, but they can challenge practitioners to think about what their own assumptions are in practice before and when they read research, whether they find the evidence credible, and if they do or do not, how it might impact their practice. If this ongoing dialogue continues, there is a chance that practitioners are continually challenged to see something differently, remain a little more open minded about something they have not seen in their own practice before, maybe share a soundbite with a colleague. Coming to the end of my conflicted journey of research within the integrated training, I walk away with this as a hopeful thought for the future.

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Appendices Part 3

Appendix A – Example of Author’s Reflections for Session 12

Narrative summary: session 2237 YP t

A session, in which the therapist and young person discuss the young person’s intention to stop therapy, and why that might be. They also talk about potential parent sessions, but the young person’s ambivalence about these and also the therapy is clear. The young person expresses that she generally has felt better for a while and she attributes this partly to the therapy. She gives a concrete example of how she feels therapy has helped her. Even in those moment, and throughout the session, the therapist seems oppositional and challenges the young person on most statements. He is working hard to get to why the young person might want to drop out, if there are more things that she might be afraid of by really committing to a longer therapy, but the young person remains more matter of fact. The therapist also gives the young person his Easter holiday dates and in turn the young person discusses a time when she’ll be away in the summer, which leads them to look ahead at the amount of session left, finding that they would come up to 28 sessions around the time when the young person is away. There is a deflated feeling that feels hard to manage, ‘what is the right thing to do?’. My impression was that the young person might feel that ‘if it’s that complicated and it’s coming to an end anyway, we might as well finish now’ but this might be because I know she’ll drop out now or soon after this session. They do get on to talk about how to do the right thing and through discussing the therapy relationship, they get into a heated debate about therapy being personal or not, whether the young person wanting to drop out of therapy is insulting the therapist. The

therapist becomes quite challenging here again, and they end within a bit of a debatey atmosphere.

Coding summary: session 2237 YP t

In this session, the young person indicates feeling helped by the therapy (95) but indicates she is no longer committed to coming to therapy (73). She mentions what she had wished to achieve as a result of therapy (4) and that this has been accomplished, although the therapist raises doubts about her optimism, not giving her direct reassurance (66). The therapist and young person then discuss the ending, but also upcoming interruptions and breaks in the potentially continuing therapy (75). In relation to the young person's wish to end, the nature of the therapy relationship is discussed (98) and the therapist raises questions about the young person's view and expressions (99) and takes position explicitly or by implication (e.g. on the young person feeling better) (93). Although the therapist is not always fully clear, the young person readily comprehends his comments (5) and goes along with his attempts to explore her thoughts and reactions (58).

Reflections – 10th session coded:

- Done in one go.
- Seems to me this might have been the last session?
- Quicker to code than others but quite hard to decide whether item 4 (treatment goals) or item 28 (sense of agency) should go into pile 9 – I hope I can include them both in results, because they were both extremely important.

- Struggling to put anything into pile 1, but at least there are more diverse items in there than usual.

- Item 7 – ‘anxious tense’ I put into pile 2, because for what the young person was communicating, she was pretty relaxed, i.e. she was not as anxious as she could have been about telling therapist she didn’t want to come any more.

Appendix B – Double coding example

Table 7

Comparison of Ratings Between Author and Double-Coder: Example

Author's ratings	own	Double ratings	coder's	Double ratings	coder's	Author's ratings	own
<i>Most important (pile 9)</i>				<i>Most important (pile 9)</i>			
Item 4		Pile 6		Item 1		Pile 3	
Item 75		Pile 9		Item 50		Pile 8	
Item 95		Pile 6		Item 75		Pile 9	
Item 98		Pile 9		Item 89		Pile 7	
Item 99		Pile 8		Item 98		Pile 9	
<i>Least important (pile 1)</i>				<i>Least important (pile 1)</i>			
Item 5		Pile 3		Item 8		Pile 4	
Item 58		Pile 4		Item 19		Pile 2	
Item 66		Pile 5		Item 30		Pile 2	
Item 73		Pile 1		Item 41		Pile 4	
Item 93		Pile 3		Item 73		Pile 1	

Note. **Bold** for absolute agreement

Bold red for divergence >2 piles